International Psychogeriatrics (2020), 32:3, 325–333 © International Psychogeriatric Association 2019
doi:10.1017/S1041610219001431

Sexual harassment from older residents at long-term care facilities: is it really part of the job?

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ABSTRACT

Objectives: To explore the extent to which staff members in long-term care facilities (LTCF) have experienced situations of sexual harassment, how they commonly and ideally manage the situation, and how their work position influences their responses.

Design: Cross-sectional quantitative study, using the vignette technique.

Method: A total of 2,196 staff-members who were currently working in Spanish LTCF participated in the study. Data were collected using a self-administered questionnaire. Questions regarding sexual harassment were analysed by a vignette that described a case of sexual harassment. Participants had to choose common and best practices for dealing with the case, and report the frequency with which they had experienced similar situations.

Results: The results indicate that 29.9% of participants had experienced an episode of sexual harassment in a LTCF similar to the one presented in the vignette. Responses to the situation were diverse and there were significant differences between common and perceived best practices. Differences were also found depending on the work position of the participant (manager, technical staff or nursing assistant).

Conclusions: There is a need for a fuller recognition of the sexual needs of older people. However, the presence of inappropriate sexual behavior must also be acknowledged. The right of staff to work in an environment free of harassment must be respected. The need for explicit institutional guidelines and training opportunities is discussed.

Key words: sexuality, sexual harassment, residential aged care facilities, care assistants, good practice

Introduction

Workers in health care settings are at greater risk of being subject to offensive violent behaviors at work than other groups (Guay *et al.*, 2015; Piquero *et al.*, 2013). However, while physical assaults, verbal abuse and bullying have received extensive research attention (e.g. Gerberich *et al.*, 2004; Poster, 1996; Quine, 2001; Rippon, 2000; Shields and Wilkins, 2009), sexual harassment has received considerably less attention (Spector *et al.*, 2014). This study is aimed at filling this gap by exploring how staff working in long-term care facilities (LTCF) for older people manage a sexual harassment situation.

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Sexual harassment: prevalence, types and consequences

Sexual harassment has been defined as any "unwanted or unwelcome conduct of a sexual nature, in a workplace or in connection with work, which makes a protected person feel humiliated, intimidated, discriminated against or offended" (International Labour Organization, 2001) and is relatively frequent in health care settings (e.g. Çelik and Çelik, 2007; Somani *et al.*, 2015; Wang, 2012). Although the estimated prevalence varies according to country, research methodology, and specific work setting, it has been estimated that one in four nurses are exposed to sexual harassment (Spector *et al.*, 2014). The harassment might be perpetrated by a range of actors, from coworkers to patients' relatives or visitors, although patients themselves are most often responsible (Cogin and Fish, 2009; Spector *et al.*, 2014; Wang, 2012). In general, females are also more likely to be victims than males (Bronner *et al.*, 2003).

Sexual harassment encompasses diverse behaviors that may occur in different rates and have different effects depending on the health care worker. Although ranking these behaviors according to their severity is problematic and open to interpretation (e.g., National Council of State Boards of Nursing, 2009), the presence of physical contact and the frequency of the behavior have generally been considered to be key elements in the definition (Terpstra and Baker, 1987; Wang *et al.*, 2012). According to this proposal, harassment may be mild (for instance, in the form of sexual jokes or teasing sexual remarks), moderate (unwanted caresses or repeated invitations to have sex) or severe (attempted or actual rape). The milder forms are more frequent, but they are also more open to interpretation, and some health care workers tend to consider them as part of the job (Daly *et al.*, 2011), particularly if the perpetrator is frail or vulnerable (Deery *et al.*, 2011; Huebner, 2008). By contrast, when sexual incidents involve some kind of physical touching, most workers have little doubt that they constitute sexual harassment (Huebner, 2008). In a study in Taiwanese hospitals, Wang *et al.* (2012) estimated that unpleasant and unwanted physical touching was the third most frequent type of sexual harassment, after telling sexual jokes and staring in a sexual manner. In a study of nurses in Egypt, sexual harassment was associated with unnecessary or unwelcomed touching in 50% of incidents (Ali *et al.*, 2015). According to Bronner *et al.* (2003), teasing remarks were the most frequent form of sexual harassment, being experienced by 75% of participating nurses, though unwanted physical touching had been experienced by 35% of participants at some point in their careers. In addition, 17.0% of their sample had encountered intimate touching of some kind.

Unsurprisingly, experiencing sexual harassment has negative consequences for the recipient, including emotional distress, anxiety, low job satisfaction and an increased risk of absenteeism and turn-over (Ali *et al.*, 2015; Deery *et al.*, 2011; Magnavita, 2014; Malik *et al.*, 2014). Eventually, sexual harassment might even erode the view of caring as a meaningful task, and some health workers who have experienced sexual harassment might develop feelings of hate and aggression toward the harasser, potentially leading to a deterioration in the quality of care (Krøjer *et al.*, 2014; Madison and Minichiello 2000).

Despite the relevance of sexual harassment, two gaps exist in the current literature. First, research has focused on the prevalence, types and consequences of sexual harassment, whereas the ways in which staff manage sexual harassment episodes have received far less attention. Understanding these strategies may help to prevent sexual harassment and to mitigate any negative consequences. Second, most studies have focused on harassment in hospital setting, specifically among nurses, and have ignored sexual harassment at long-term care facilities (LTCFs) for older people suffered by different health care workers. However, these issues are equally relevant to understanding how staff experience and handle sexual harassment.

Managing sexual harassment

There are few published and institutionally supported documents that provide evidence-based recommendations and guidelines for managing sexual situations and sexual abuse in long-term care institutions. Most of those available center on residents as potential victims of abuse (e.g., Alliance to End Sexual Violence in Long-Term Care, 2015; Lichtenberg, 2014; Vancouver Coastal Health Authority, 2009) or on avoiding sexual misconduct among professionals (e.g., National Council of State Boards of Nursing, 2009). The few that include guidelines concerning the harassment of professionals by residents (e.g., International Longevity Centre – UK, 2011; Kettl, 2008; Syme *et al.*, 2016) recommend, as best practice, zero tolerance of verbal or physical sexual assault; instances should be reported to institutional authorities and to professionals trained to manage them and their consequences. In accordance with the tenets of person-centered care, this management should include a careful assessment of the resident's medical and health condition, sexual life story, and his/her relations with others (staff, relatives, other residents). Residents' perspectives and unmet needs, and how such needs could be channeled in appropriate ways (if this is possible), are issues that need to be taken into account.

We also have scarce information about how health care workers actually handle sexual harassment incidents. In one of the few studies we have, Bronner *et al.* (2003) classified coping strategies to sexual harassment into three groups: passive (e.g., ignoring or becoming paralyzed), assertive (e.g. objecting, resisting or complaining), and sharing (e.g., relating the event to staff, family or friends). In their study, 44.7% of nurses coped with unwelcome physical touches in a passive way, although this figure dropped to 27.1% in the case of unwelcomed intimate touches, a situation that prompted more assertive coping strategies (54.3%). In both cases, however, the percentage of nurses who mentioned the situations to supervisors, coworkers or other people was below 20%.

Other studies have emphasized that dismissing the incident is a frequent coping strategy. In a study of nurses, Çelik and Çelik (2007) found that most participants did nothing (59.3%), while others either put up a barrier (43.3%) or pretended not to see the harassment (30.7%). By contrast, only one-fifth of the participants reported the episode. Similar findings were found by Ali *et al.* (2015), who reported that 40% of nurses would ignore the episode and that only 18.2% would report the situation.

When exploring how sexual harassment is handled, it might be important to differentiate between common practices and perceived best practices (Villar *et al.*, 2019): that is, how staff think that sexual harassment is managed by colleagues (common practice) and how they think it should be managed (perceived best practice). A gap between common and perceived best practice would then indicate the extent to which staff perceive that sexual harassment is handled well at their institution. Indeed, a lack of correspondence between common and perceived best practices would suggest that professionals consider that these situations are mismanaged. Other potential issues that could be raised are the reactions that people consider to be correct (that is, the nature of the managing strategies professionals perceive as 'best practice'), and the potential for improvement if no barriers or hindrances existed.

Sexual harassment at LTCFs for older people

The strategies for handling sexual harassment may be influenced by the setting in which they appear. At LTCFs for older people, episodes of sexual harassment may occur at high frequencies (Spector *et al.*, 2014). The setting itself could possess feature that make them particularly relevant to the study sexual harassment.

First, in contrast to other clinical settings, many of the sexual incidents that staff encounter at these LTCFs are caused by residents with dementia or other types of cognitive impairment. These behaviors, commonly labeled as inappropriate sexual behaviors (Alagiakrishnan *et al.* 2005; Bardell *et al.* 2011; Joller *et al.* 2013; Tsatali *et al.* 2011; Tucker 2010; Ward and Manchip 2013), may be difficult for staff to manage because they are often performed by people with limited self-control or with limited comprehension of the consequences of their behavior. Some care workers may even doubt whether inappropriate sexual behavior is a form of sexual harassment (Nielsen *et al.*, 2010), and some of them are likely to tolerate, excuse or dismiss such behaviors, particularly if they do not involve physical touching (Blackstone *et al.* 2014; Burgess *et al.*, 2016).

Second, the degree of intimacy between the resident and professional at LTCFs is usually far more intense than in other clinical settings. Staff working at LTCFs help residents in everyday basic daily living tasks, such as eating, bathing or dressing. Many of these involve a high degree of closeness and intimacy, and strong interpersonal ties may develop that go beyond the mere provision of care (Berdes and Eckert, 2007). If they interpret an interaction negatively as sexual harassment, distress and job dissatisfaction could ensue (Burgess *et al.*, 2016). In addition, such intimate shared situations could pose opportunities for residents to express sexual needs.

In this respect, it would be misleading to consider staff as a single unit (as most of the research in this field has tended to do: Aguilar, 2017; Mahieu *et al.*, 2011), since the position of the different professionals within the organization may influence the probability of their being sexually challenged and their views on how to manage these situations. Thus, care assistants are in charge of helping residents with activities of daily living, private tasks, which make them particularly vulnerable to sexually-related situations and to the stress they may cause. In contrast, managerial and technical staff are mainly responsible for designing policies, supervising their application and ensuring that they are suitable for dealing with challenging sexually-related situations in LTCFs. Therefore, their response is likely to be more comprehensive and reflective.

Aims

In the light of the above, the present study had two aims. First, we explored the extent to which staff members in Spanish LTCFs have experienced situations of sexual harassment, specifically involving being physically touched by an older resident. Second, we recorded the views of staff on what is commonly done (i.e., common practice) and what should be done (i.e., best practice) to manage the situation. In both cases, we analysed the influence of work position (distinguishing between managers, technical staff and care assistants) on their responses.

Methods

Participants

A total of 2,196 staff-members who were currently working in 152 Spanish LTCF participated in the study. Participants' ages ranged from 18 to 70 years, with a mean of 39.7 (10.97). Participants comprised 167 professionals working in managerial positions (7.6%), 635 technical staff (28.9%) and 1,394 nursing assistants (63.5%). By 'technical staff' we mean specialized professionals, most of them with university degrees, who do not provide care in basic or instrumental activities of daily living. Among them were

Table 1. Characteristics of the study participants

	TOTAL ($N = 2,196$)
Age (*M, SD*)	39.7 (10.97)
% Females	87.6
Education (%)	
Primary studies	9.9
Secondary studies	52.3
University studies	37.8
Religiosity (%)	
Very	8.3
Quite	28.5
Little	40.9
No religious	22.2
Work Position (n, %)	
Managers/directors	167 (7.6)
Technical staff	635 (28.9)
Care assistants	1,394 (63.5)
Years of experience (*M, SD*)	10.0 (7.24)
Size (*M, SD*)	100.5 (47.39)

368 healthcare professionals (doctors, nurses and physiotherapists) and 267 social care professionals (psychologists, social workers, social educators and occupational therapists). Women comprised 87.6% of the sample, with a mean age of 39.7 years. The composition of our sample is in concordance with the last available national data for staff working at long-term care facilities for older people (Tobaruela, 2003). Table 1 presents descriptive characteristics of the sample.

Residential facilities were approached using convenience sampling. The eligibility criteria were as follows: (a) appearance in the authorized register of residential centers of the autonomous region of Spain in which they were located; (b) they provided care to older dependent persons; and (c) they agreed to participate under the conditions stated in the study protocol.

Instruments

Data were collected using a self-administered questionnaire consisting of two sections. Section 1 included basic sociodemographic questions. Section 2 consisted of several vignettes describing a situation where one or more residents were involved in the expression of some sort of sexual need. After reading each vignette, participants were asked to answer (1) whether they had experienced a situation similar to the one presented in the vignette in the workplace; and (2) how they thought most of their coworkers would react if they encountered the situation (i.e., common practices) and how they thought it should be handled optimally (i.e., best practice). We decided to ask about how most of their colleagues would react because previous research has indicated that it is easier for participants to give judgments on sensitive matters when questions are posed in a less personal manner (Tourangeau and Yan, 2007).

In this paper, only responses related to the vignette related to a case of sexual harassment were taken into account. The vignette was "while a colleague of yours is bathing a resident, she finds that he is trying to feel her breasts and getting an erection." Participants were then allowed to respond from among six predetermined responses that were used for both common and best practice. The options were as follows: (1) pretending nothing had happened; (2) discussing the situation with a supervisor or colleague; (3) discussing the situation with the resident's family; (4) advising the resident how to express that need in an acceptable manner; (5) taking measures to prevent the situation from happening again; and (6) admonishing the resident. More than one option could be selected.

Procedure

LTCFs meeting the inclusion criteria were contacted and the study's objectives and data collection method were explained. The ones that agreed to participate were then sent questionnaires by post. We sent 3,627 questionnaires, of which 2,295 were returned completed (response rate, 63.27%).

The administration of the instruments was coordinated by a member of staff at each LTCF, who was contacted regularly by the research team to monitor the process and resolve any issues might have arisen. To standardize data collection, each center received a written protocol that included the staff inclusion criteria, recommendations to encourage participation, guarantee confidentiality and ensure that participants responded to questionnaires individually, and instructions for the receipt, storage and return of the questionnaires.

Participants were asked to answer their questionnaires at home, and either to give them back to the coordinator or to leave them in a dedicated box at the institution. On its first page, each questionnaire contained information about the objectives of the study and how all data would be treated confidentially and anonymously. Participants were then asked to sign an informed consent form after reading this information and before voluntarily completing the questionnaire. The questionnaire included the telephone number and e-mail of the first author of this study so that respondents could ask for clarifications, resolve their doubts or receive support or advice regarding the questionnaire. Participants did not receive compensation of any kind for their participation. The entire process was approved and supervised by the Ethics Committee of the University of Barcelona.

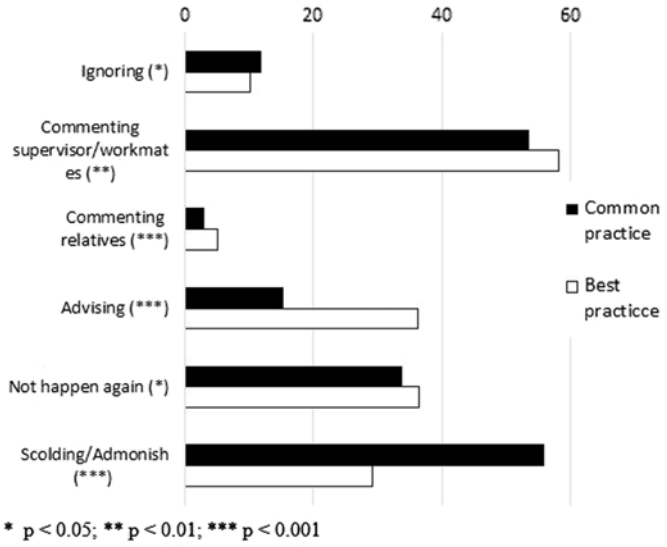

Figure 1. Frequency (in percentage) of reactions to an unwanted touching, chosen as common and best practices. Best and common practices were compared using chi-square test.

Data analysis

The frequencies and percentages for each of the response options were calculated for both questions raised by the vignette (i.e., common and best practices). Bivariate analyses were then conducted to study the differences in the frequency of alternative reactions to the vignette across common and best practices and across work positions.

Results

Our results indicate that 29.9% of respondents had experienced a sexual harassment episode similar to the one presented in the vignette at some point in their professional careers. Positive answers were far more frequent among managers (55.7%) than among technical staff (25.3%) or care assistants (29.1%), with the differences reaching statistical significance ($\chi^2(2) = 58.84$, $p < .001$), which means that these differences are unlikely (with a risk or error of 1 out of 1000) to have occurred randomly.

As for reactions to these episodes, Figure 1 shows the percentages of people selecting each option for common and best practice. In both cases, the most frequent reaction was to report the episode to colleagues or supervisors (approximately 60%). Differences between common practice and best practice, though slight (57.2% vs 60.5%), reached statistical significance ($p < .05$).

Differences between common and best practice were also significant for the option of admonishing the resident and for the option of advising the resident how to express their needs in an acceptable manner. With regard to admonishing, 47.2% of participants reported it as common practice, while 17.6% of participants considered it to be best practice; by contrast, 55.1% of participants regarded advising residents as best practice, but only 32% reported it as common practice.

As shown in Table 2, compared with the care assistants, the managers and technical staff tended to perceive that restrictive methods were typically employed in common practice (admonishing, or ensuring it will not happen again). As for best practice, managers and care assistants both chose options such as ignoring or reporting to relatives more often than technical staff. However, the biggest differences appeared in relation to advising residents about appropriate behavior, which was selected far more by managers and technical staff than by care assistants. Finally, managers selected admonishing as best practice less often than either technical staff or care assistants.

Discussion

Our results indicate that around one in four participants had experienced sexual harassment of the kind proposed in the vignette, which is comparable to findings in a review of other clinical settings and countries (e.g., Spector *et al.*, 2014). Such estimates are particularly high among managers, perhaps because they are informed about the cases that occur in the facility. However, the estimates might have been even higher if we had considered milder forms of sexual harassment (Bronner *et al.*, 2003; Wang *et al.*, 2012). This highlights the need for appropriate

Table 2. Selection (in percentage) of common and perceived best practices towards unwanted touching, by work position (N = 2,175)

Alternative	Directors/ Managers	Technical Staff	Care Assistants	X^2 value and significance
Ignore				
Common practice	11.7	8.6	13.5	9.69, $p < .01$
Best practice	10.4	6.3	11.8	15.16, $p < .01$
Comment with workmates				
Common practice	66.7	58.5	49.5	26.62, $p < .001$
Best practice	58.3	55.6	59.3	3.01, ns
Comment with relatives				
Common practice	0.6	4.2	2.8	6.22, ns
Best practice	4.9	8.1	3.8	16.42, $p < .001$
Advise				
Common practice	19.1	16.5	14.1	4.11, ns
Best practice	65.0	55.3	23.5	254.62, $p < .001$
Not happen again				
Common practice	34.6	41.8	29.9	26.88, $p < .001$
Best practice	35.0	39.3	35.2	3.26, ns
Scold/Admonish				
Common practice	67.3	71.1	47.4	105.45, $p < .001$
Best practice	17.8	27.7	31.6	14.59, $p < .01$

knowledge and tools to handle these situations that cause anxiety and dissatisfaction with work and may lead to a serious deterioration in the care relationship. It also underlines the need to explore how staff manage unwanted physical touching.

The diversity of responses to the vignette is the first issue that requires attention, with no unanimous agreement among participants. Even the most frequently chosen response accounted for only 60% of common and perceived best practices, while four responses were each chosen by at least 25% of participants (see figure 1). These results suggest that there are no clear and agreed policies on how staff should handle unwanted physical touching, and as a result, staff tend to follow their own beliefs, a situation that has also been reported concerning the management of other sexual issues in long-term care contexts (Simpson *et al.*, 2018). This situation could also increase the adverse consequences for staff, who lack accessible, explicit and clear responses. Arguably, factors such as differences in education, absence of authority among front-line carers or lack of development opportunities could also underlie this disparity of responses and the apparent incapability of some staff to mobilize resources to cope with the situation.

Reporting the incident to colleagues was the most common option selected by participants as both common and best practice, a reaction that has been considered as best practice by existing published guidelines (e.g., Alliance to End Sexual Violence in Long-Term Care, 2015; Kettl, 2008). This response provides an opportunity to receive emotional and practical support: colleagues can help to alleviate the negative emotional reaction associated with sexual harassment and can offer advice on how to handle the situation (Nielsen *et al.*, 2017). This is important because sexual harassment has a long history of being unreported and hidden (Çelik and Çelik, 2007; Valente and Bullough, 2004). Despite being the most frequent option, more than 40% of professionals would not consider reporting the situation to colleagues or supervisors, and around 15% would choose explicitly to ignore the situation. This result suggests that there is still work to do to make all cases of sexual harassment visible, which is a first step to putting in practice measures to eradicate them. Thus, in Spanish LTCFs, many staff members seem to solve the problem on their own, perhaps because of the absence of clear guidance on how to manage situations like those described in the vignette.

Our results also showed striking differences between common and perceived best practices. For instance, reporting the situation to a supervisor or colleague, despite being dominant in both cases, received more mentions as a best practice than as a common practice. Such a difference indicates that making the problem visible and having the opportunity or receive external support is considered ideal, but perhaps impractical, suggesting that there is still room for improving the availability of external support. However, differences were even greater among other choices. In general, the choices for best practice were more supportive (e.g. advising) and less restrictive (e.g. admonishing) compared with the choices for common practices. This shows that while some staff think that they should act in a supportive

way and in accordance with person-centered care recommendations (Syme *et al.*, 2016) that consider unwanted sexual approaches as an expression of legitimate but inappropriately expressed sexual needs, common practice dictates that they should apply restrictive solutions. Thus, barriers exist that prevent staff from doing what they think should be done. Identifying the barriers responsible for the gap between perceived best and common practice is essential in order to be able to overcome them and thus improve outcomes for the resident and staff member.

In a similar way, although many staff members responded that support (advice) probably constituted best practice, a significant proportion (around 30%) considered that restrictive measures (admonishing) to be best practice. This result suggests that the situation is sensitive enough as to legitimatize the use of whatever means is necessary, even the restrictive ones, if they can stop the immediate violation of the rights of a member of staff.

Finally, there was evidence of differences according to the work position of the participant. Technical staff and managers tended to perceive a greater gap between perceived best and common practices compared with care assistants, especially in the use of supportive (advising) and restrictive (admonishing) options. Interestingly, staff occupying these frontline positions, who are at highest risk of unwanted sexual approaches by residents, chose to handle situations in a more restrictive and direct manner. Differences in training may also have a role accounting for these differences. Technical staff and managers, who have received more formal training, take more into account supportive options as best practices but, at the same time, they seem to be more aware of the difficulties in implementing them as common practices. In contrast, care assistants, who have received less formal training, seem to be less aware of the gap between common and perceived best practices and tend to favour restrictive solutions in both cases.

When interpreting our findings, some limitations should be considered. First, despite using a larger and more diverse sample compared with earlier research on this topic, the sample was obtained with non-probabilistic methods that severely limit the generalizability of the results. In addition, using a vignette as the main basis of data collection poses key limitations. Although vignettes may be a useful way to approach sensitive issues of the type in this study (e.g., Braun and Clarke, 2013), it forces respondents to consider a very specific situation. Despite describing a situation in a very generic manner, it cannot be denied that changing any of the details could have influenced the reactions chosen (e.g., changing the protagonists' genders, the situation, the location, the cognitive status of the resident or the work position of the victim). Furthermore, as well as work position, factors like years of service, socioeconomic position or religiosity may also have affected respondent choices. These possible influences could be explored in future studies.

Despite these limitations, the study contributes to the literature on inappropriate sexual behaviors by older people at LTCFs in at least four ways. First, unwanted physical touching of a sexual nature seemed to have been experienced by at least 20% of staff. Second, there was a great degree of diversity in the responses for common and best practices when handling the situation described in the vignette, emphasizing that there is no agreed or common criteria for staff to follow. Third, there was a gap between the perceptions of common practice and best practice. Whereas best practice tended toward being more supportive, the perception was that restrictive approaches were the dominant common practice. Finally, work position influenced how unwanted sexual physical touching was handled: frontline care givers tended to focus on more restrictive-oriented measures than managerial or technical staff.

Taken together, our findings highlight the need for a more explicit recognition of the challenges posed by sexuality, sexual needs, and inappropriate sexual behaviors in older people, while at the same respecting the right of staff to work in an environment that is safe and free of harassment. This balance may not be easy to achieve, but our results suggest that practical changes could help to prevent and mitigate the negative effects of sexual harassment by older people at LTCFs. First, explicit guidelines (whether official/governmental or at the level of the individual care home) are needed to orient staff towards the appropriate management of sexually sensitive situations, and particularly how to define and handle situations that constitute sexual harassment. In any case, the development of guidelines should consider the input of care staff and other relevant stakeholders, such as families and residents.

Staff development initiatives on sexual issues, and particularly on what constitutes inappropriate sexual behaviors, should also be prioritized, considering the specific working positions and responsibilities of staff. Particularly, staff development initiatives should bridge the apparent paradox in this field: care assistants, who are those at highest risk of unwanted sexual approaches by residents, are at the same time the ones less trained and qualified to manage such difficult situations.

In conclusion, inappropriate sexual behaviors by residents should be recognized and addressed as an important issue at LTCFs. They should be openly discussed, and efforts should be made to ensure that their handling is not dependent on ad hoc or

individual reactions. Indeed, there should be a clear institutional policy with shared criteria oriented to preserving the rights of both residents and staff.

Conflict of interests

None.

Description of authors' roles

F. Villar designed the study and formulated the research questions. He wrote the paper, assisted by J. Fabà.

J. Fabà and R. Serrat supervised data collection, categorized the responses and built the category systems.

M. Celdrán and T. Martínez helped with the data analysis. They also corrected the initial draft of the manuscript.

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