Prevalence and Acceptability of Psychological and/or Economic Intimate Partner Violence, and Utilisation of Mental Health Services by its Survivors in Lithuania

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Declarations

The co-authors declare that there is no conflict of interest.

Abstract

(No more than 200 words)

Background: Lithuania has one of the highest average levels of psychological and/or economic intimate partner violence (IPV) in the European Union. IPV survivors are several times more likely to have a mental health condition. The aim of this article is to study the prevalence and characteristics of IPV survivors in Lithuania, their utilisation of mental health services, and predictors of receiving mental health care.

Methods: This cross-sectional study is based on a national survey conducted in Lithuania in 2021, representative of the adult population. It was implemented by a third-party independent market research company employing an online survey panel. Logistic regression models were used in the analysis.

Results: Almost one in two women in Lithuania experience psychological and/or economic IPV. Females are significantly more likely to experience it than males. The vast majority of women find it unacceptable; however, only one third of survivors seek any type of help, and only one tenth approach mental health services, with divorcees being at higher odds of doing so.

Conclusions: Further research is needed to explore broader predictors and contextual factors of (non)seeking mental health care among survivors of IPV in Lithuania. Policy implications include the need to eliminate IPV and mental health stigma in the country, develop more accessible mental health services and effective treatment approaches.

Keywords: psychological and/or economic intimate partner violence; coercive control; mental health services; public mental health; Lithuania.

(No more than 3000 words)

Introduction

Systemic intimate partner violence against women (IPV) is a global pandemic and major public health issue (1–3). At least one in three women worldwide have experienced physical or sexual violence by their intimate partner (3). However, by far the most prevalent form of IPV is psychological violence (4–6). Psychological IPV, including coercive control, as well as economic IPV, often precedes physical or sexual manifestations of abuse (7–9). Its prevalence is estimated to be from around 20% to as much as 90%, depending on the study's methods and setting (5,6,10–13).

In the European Union (EU), the average prevalence of psychological IPV is around 43%; in Lithuania, at least one in two women (51%) go through this experience at some point in their life (14,15). According to the local victims' support service Specialised Complex Support Centre, this number may be even higher at over 60% with at least 10% of them experiencing specifically economic IPV (16). Hence, the country is among those with the highest average levels of psychological IPV against women in the EU (13,14). However, the local official statistics may not reflect the magnitude of this issue since psychological and/or economic IPV still remains one of the most latent forms of crime. This is due to practical difficulties with proving it in court, as well as the fact that a large number of women (at least 30%) conceal this experience and do not seek help at all (17).

Any type of IPV and especially psychological and/or economic IPV often has serious consequences for survivors' physical and mental health (3,4,9,18–21). Women with a history of IPV are several times more likely to have a mental health condition; and even though for many different reasons, including negative societal attitudes and stigma, they might not seek help, some of them indeed approach mental health services for support (4,22–25). Hence, this type of gender-based violence is a complex global public (mental) health issue and all healthcare services, including mental healthcare providers, have an important role to play in screening for IPV, documenting it, and providing information, as well as appropriate complex support to survivors of IPV (26–29).

In Lithuania, negative societal attitudes and socially constructed 'norms' affect not only the way society reacts to IPV and the way that mental health services operate and respond to the needs of survivors of IPV, but also the way the survivors themselves see and recognise (or not) the violence, as well as mental health conditions that they are experiencing (17). For example, economic violence may go unrecognised

and be perceived as an acceptable behaviour or even as a part of a 'natural' order of the expected socially constructed gender roles and power dynamics between a husband and wife (where the husband might have and maintain full control of the family's finances) (30). On the other hand, once the IPV is publicly recognised, the general public tends to express deeply rooted 'victim-blaming' attitudes with as much as 50% of Lithuanians believing that it is the woman's own fault that she had experienced IPV (31). Moreover, mental health stigma is prevalent and negative attitudes persist towards all related matters, including the potential for seeking help and support from mental health services (32,33).

The main objective of this article is to study the prevalence and characteristics of survivors of psychological and/or economic IPV in Lithuania, their utilisation of mental health services, as well as predictors of seeking mental health care.

The research questions are as follows:

1) What is the current prevalence and associated factors of women ??? exposed to psychological and/or economic IPV in Lithuania, comparing with those who have not had the experience of this type of IPV?
2) What are the acceptability levels of psychological and/or economic IPV among women ??? who experienced it and those who did not?
3) What is the prevalence of help seeking and service use among the survivors of psychological and/or economic IPV, and what are the predictors of them using mental health services?

Methods

Study design and instruments

This is a cross-sectional study which is based on the national representative survey conducted in Lithuania in 2021. This article is also a part of the broader observational cross-sectional mixed-methods study titled 'Responses to Mental Health Care Needs of Survivors of Intimate Partner Violence by Mental Health Services in Lithuania and Portugal'.

The 2021 survey was conducted in the framework of the #ItsNotOk Initiative. It was designed and coordinated by a group of scientists from Behavioural Lab LT, Human Rights Monitoring Institute of

Lithuania, Lisbon Institute of Global Mental Health, Center for Social Norms and Behavioral Dynamics at the University of Pennsylvania, Department of Psychological and Behavioural Science at the London School of Economics and Political Science, and University of Oxford. The survey was representative of the Lithuanian adult population based on gender, region, and age. It was implemented by a third-party independent market research company employing an online survey panel. Participants of the study were those who had given their informed consent to participate in the survey, who were 18 years or older, living in Lithuania, and Lithuanian speaking.

The study was approved as an integral part of the broader mixed-methods study by the Research Ethics Committee of NOVA Medical School, NOVA University of Lisbon (Ref. No. 171/2021/CEFCM).

Study sample and assessment of variables

Exposure to psychological IPV was assessed by first describing this type of violence as "*behaviour by your intimate partner that includes calling names, humiliating, isolating, hurting your pets, destroying things dear to you, threatening, frightening, turning your children against you, etc*." and then asking the question "*Have you ever experienced psychological IPV?"* (*yes* or *no* answer).

Exposure to economic IPV was assessed by first describing this type of violence as "*behaviour by your intimate partner that includes controlling your finances, not allowing you to study or work, not allowing access to your/family bank accounts, demanding detailed reports for all your spendings, etc.*" and then asking the question "*Have you ever experienced economic IPV?"* (*yes* or *no* answer).

Only experiences of psychological and economic IPV (and not other types of IPV) were analysed in this study because only this data had been included in the survey.

The sociodemographic characteristics assessed included: gender, age (categories of age groups: 18–24; 25–34; 35–44; 45–54; 55–64; 65–75); highest obtained level of education (never attended school; unfinished school; primary school; secondary school; vocational school; college; university); level of household income after tax in euros (less than 450; 451–750; 751–1100; 1101–1700; more than 1700; cannot/do not want to say); residence (large city (Vilnius, Kaunas); large town (Alytus, Klaipėda, Marijampolė, Panevėžys, Šiauliai, Mažeikiai); other town; small town/village (up to 2 000 inhabitants)); relationship status (married, has a partner – unmarried; single; divorced; widow); number of people living

together in the household (1; 2; 3; 4; more than 4; no one else (no children or they are older than 18 years)).

Acceptability levels were assessed by presenting research participants with the following statements and questions, first about psychological IPV, then about economic IPV: "*Some people in Lithuania use this type of behaviour against their intimate partners. Society may either think that it is acceptable or unacceptable. In your personal opinion, to use such behaviour against intimate partners is…*" (answer options: *acceptable; more acceptable than not; more unacceptable than acceptable; unacceptable*).

To assess the utilisation of mental health services the study participants were asked questions about both seeking any kind of help and support, and also about seeking help at specialised mental health services. The questions covered the following: *"Have you ever sought help for your experiences of psychological IPV?"; "Have you ever sought help for your experiences of economic IPV?"; "Did you receive services of a psychologist/psychotherapist in the public sector?"; "Did you receive services of a psychologist/psychotherapist in the private sector?"; "Did you receive services of a psychiatrist in the public sector?"; "Did you receive services of a psychiatrist in the private sector?"; "Did you receive services in a psychiatric hospital?"* (*yes* or *no* answers).

Data analysis

For the descriptive statistical analysis, observed absolute frequencies (*n*) and relative frequencies (%) were used for all the categorical variables. For the bivariate statistical analysis, Chi-Squared or Fisher exact tests were employed to assess the association between categorical variables, as applicable. Univariate logistic regression models were performed with the dependent variables indicating whether or not various mental health services were sought by the women, considering as explanatory variables the various possible factors that might influence the outcome. These factors included sociodemographic characteristics and the different types of violence that might have been experienced.

Estimated odds-ratios (OR) and corresponding 95% confidence intervals (95% CI) were obtained for each explanatory variable of the logistic regression models, their statistical significance was assessed by likelihood ratio tests. The significance level $\alpha = 5\%$ was considered throughout the statistical analysis.

The data was analysed using the R software (34). The R *car* package (45) was used to obtain the likelihood ratio tests.

Results

In total, 1001 person participated in the survey: 534 females, 459 males, and eight people who identified as being of other gender or did not want to reveal their gender at all. A statistically significant association between gender and experience of IPV was found (p=0.020) with women being significantly more likely to experience psychological and/or economic IPV than men. Hence, the main sample included in this study was of the participants who identified as women (n=534). The sociodemographic characteristics of the study participants together with their acceptability rates of both types of IPV are presented in *Table 1*.

Wouldn't it be interesting to describe sociodemographic predictors of IPV?

The vast majority of women, regardless of whether they had experienced IPV or not, found both types of IPV either unacceptable or more unacceptable than acceptable. Among survivors of IPV there were 3% of women who found psychological and/or economic IPV either acceptable or more acceptable than not. Among women who did not experience IPV this number was 2%.

Table 1: *Sociodemographic characteristics and IPV acceptability levels of women with and without the experience of psychological and/or economic IPV (n=534)*

	Women in Lithuania who experienced psychological and/or economic IPV (*n*=233)		**Women in Lithuania who did not experience psychological and/or economic IPV (*n*=301)**		***p*-value**
Age category	***n***	**%**	***n***	**%**	0.008*
18-24	27	11.6	60	19.9	
25-34	26	11.2	48	15.9	
35-44	39	16.7	49	16.3	
45-54	55	23.6	42	14.0	
55-64	44	18.9	58	19.3	
65-75	42	18.0	44	14.6	
Education level	***n***	**%**	***n***	**%**	0.001*
Primary School	6	2.6	1	0.3	
Secondary School	37	15.9	37	12.3	
Vocational School	28	12.0	31	10.3	
College	72	30.9	67	22.3	
University	90	38.6	165	54.8	

Household income (per month)	***n***	**%**	***n***	**%**	<0.001*
Less than 450 EUR	33	14.2	28	9.3	
451–750 EUR	61	26.2	47	15.6	
751–1100 EUR	48	20.6	50	16.6	
1101–1700 EUR	35	15.0	58	19.3	
More than 1700 EUR	19	8.2	49	16.3	
I cannot/do not want to say	37	15.9	69	22.9	
Residence	***n***	**%**	***n***	**%**	0.004*
Large city	75	32.2	135	44.9	
Large town	63	27.0	52	17.3	
Other Town	59	25.3	60	19.9	
Small Town/Village (up to 2 000 inhabitants)	36	15.5	54	17.9	
Relationship status	***n***	**%**	***n***	**%**	<0.001*
Married	97	41.6	133	44.2	
Have a partner – unmarried	40	17.2	63	20.9	
Single	22	9.4	56	18.6	
Divorced	61	26.2	23	7.6	
Widow	13	5.6	26	8.6	
No. of persons the IPV survivor lives with (including children)	***n***	**%**	***n***	**%**	0.4
1	28	12.0	42	14.0	
2	78	33.5	88	29.2	
3	40	17.2	61	20.3	
4	24	10.3	43	14.3	
More than 4	14	6.0	11	3.7	
No one else (no children or they are older than 18 years)	49	21.0	56	18.6	
Acceptability level of psychological IPV	***n***	**%**	***n***	**%**	0.8
Acceptable	4	1.7	3	1.0	
More acceptable than not	0	0.0	1	0.3	
More unacceptable than acceptable	22	9.4	26	8.6	
Unacceptable	207	88.8	271	90.0	
Acceptability level of economic IPV	***n***	**%**	***n***	**%**	0.06
Acceptable	2	0.9	1	0.3	
More acceptable than not	5	2.1	1	0.3	
More unacceptable than acceptable	26	11.2	23	7.6	
Unacceptable	200	85.8	276	91.7	

According to *Table 2*, less than one third (27.5%) of the survivors of psychological and/or economic IPV sought any type of help, and around 13% received mental health services. The most frequently used service was that of a psychologist/psychotherapist.

No significant difference could be observed in utilisation of mental health services between the women who experienced both types of IPV compared with those who experienced only one.

Table 2: *Help-seeking and types of mental health services received by survivors of IPV (n=233)*

		Women who experienced both psychological and economic IPV (n=95) *n* (%)	**Women who experienced either only psychological IPV (n=112) or only economic IPV (n=26)** *n* (%)	***p*-value**
Public sector	Psychiatrist	1 (1.05)	2 (1.45)	0.792
	Psychologist/psychotherapist	6 (6.32)	7 (5.07)	0.684
	Psychiatric hospital	2 (2.11)	1 (0.725)	0.358
	Any mental health services	8 (8.42)	9 (6.52)	0.584
Private sector	Psychiatrist	4 (4.21)	1 (0.725)	0.071
	Psychologist/psychotherapist	4 (4.21)	7 (5.07)	0.760
	Any mental health services	8 (8.42)	8 (5.80)	0.436
Any type of mental health services at any sector		16 (16.8)	15 (10.9)	0.187
Any type of help		31 (32.6)	33 (23.9)	0.143

Out of all the potential sociodemographic predictors of seeking help and using mental health services included in this study, only one had a significant overall result: the relationship status. Divorced women were more likely to seek any type of help (p=0.002), as well as mental health services (p=0.006). For using mental health services, the only other predictor that was significant was living with more than 4 persons in the household (p=0.01), see *Table 3*for more details.

Table 3: *Sociodemographic predictors of seeking help and using mental health services (n=233)*

		Seeking any type of help for experiencing IPV OR (95%CI), *p*-value	**Seeking any mental health services for experiencing IPV OR (95%CI), *p*-value**
Age category	18-24	Reference category	Reference category
	25-34	1.354 (0.5157, 3.604) 0.536	1.1857 (0.2715, 5.180) 0.814
	35-44	1.368 (0.5478, 3.531) 0.504	1.5183 (0.4184, 6.123) 0.529
	45-54	1.585 (0.6660, 3.971) 0.306	1.6139 (0.4699, 6.346) 0.458
	55-64	0.839 (0.3128, 2.248) 0.723	1.7660 (0.5358, 6.812) 0.367
	65-75	1.543 (0.6281, 3.945) 0.349	0.7500 (0.1440, 3.502) 0.712

	Overall Test of Effect	0.675	0.791
Education level	Primary School	0.167 (0.00784, 1.43) 0.1355	2.6667 (0.1366 17.061) 0.378
	Secondary School	0.500 (0.14317, 1.73) 0.2688	1.4118 (0.4880, 3.619) 0.492
	Vocational School	0.688 (0.22498, 2.13) 0.5097	1.4815 (0.4658, 4.011) 0.465
	College	1.312 (0.47150, 3.82) 0.6072	0.5970 (0.1908, 1.579) 0.328
	University	Reference category	Reference category
	Overall Test of Effect	0.427	0.496
Household income (per month)	Less than 450 EUR	Reference	
	451–750 EUR	0.659 (0.286, 1.540) 0.326	0.733 (0.2427, 2.329) 0.583
	751–1100 EUR	0.625 (0.263, 1.491) 0.283	0.493 (0.1363, 1.709) 0.261
	1101–1700 EUR	0.605 (0.250, 1.463) 0.260	0.521 (0.1439, 1.808) 0.300
	More than 1700 EUR	0.255 (0.068, 0.783) 0.246	0.278 (0.0396, 1.261) 0.126
	I cannot/do not want to say	0.521 (0.216, 1.256) 0.143	0.550 (0.1647, 1.836) 0.320
	Overall Test of Effect	0.290	0.652
Residence	Large city	Reference	Reference
	Large town	1.228 (0.6259, 2.355) 0.542	0.7706 (0.2665, 1.981) 0.604
	Other Town	1.021 (0.5070, 1.992) 0.953	1.0090 (0.3923, 2.432) 0.984
	Small Town/Village (up to 2 000 inhabitants)	0.885 (0.3904, 1.869) 0.757	0.6512 (0.1806, 1.876) 0.461
	Overall Test of Effect	0.882	0.845
Relationship status	Married	Reference	Reference
	Have a partner – unmarried	1.081 (0.5047, 2.206) 0.834	1.2315 (0.4141 3.3339) 0.690
	Single	0.808 (0.3115, 1.859) 0.636	0.5239 (0.0799 2.0078) 0.407
	Divorced	2.733 (1.4255, 5.213) 0.002*	3.3182 (1.3967 7.9627) 0.0063*
	Widow	0.683 (0.1570, 2.081) 0.550	0.5239 (0.0283 2.8127) 0.542
	Overall Test of Effect	0.016*	0.0237*
No. of persons the IPV survivor lives together with (including children)	1	Reference	Reference
	2	1.9810 (0.8248, 5.530) 0.152	2.4129 (0.62621 15.8646) 0.260
	3	1.1722 (0.4138, 3.596) 0.769	1.7708 (0.36974 12.6179) 0.502
	4	1.2444 (0.3919, 4.067) 0.708	1.0462 (0.12259, 8.9275) 0.965
	More than 4	3.3684 (0.9534, 11.987) 0.055	8.5000 (1.69416 62.5870) 0.014*
	No one else (no children or they are older than 18 years)	1.5072 (0.5639 ,4.481) 0.430	2.4286 (0.56654 16.6348) 0.278
	Overall Test of Effect	0.316	0.117

Discussion

In the context of Lithuania, this is the first ever representative study on the prevalence and acceptability of psychological and/or economic IPV, as well as of utilisation of mental health services by its survivors. The study confirms that almost one in two women in Lithuania experience psychological and/or economic IPV, with females being significantly more likely to experience this form of domestic violence than males. This is in line with global tendencies concerning the prevalence of psychological IPV (4–6,10–13). Almost all explicative variables included in the current analysis were significantly associated with experiencing psychological and/or economic IPV, i.e., age, place of residence, education and income level. Also, IPV experience was significantly associated with the relationship status: almost one third of the women who experienced psychological and/or economic IPV were divorced.

I think you should discuss the data obtained in relation to the first research question a little more

The results show that the vast majority of survivors of psychological and/or economic IPV find this type of behaviour by intimate partners unacceptable; yet only a minority of them sought any type of help. It

has been previously highlighted in research that survivors of IPV often tend to conceal the fact of the abuse they experience. This may be due to a number of possible reasons, for example, fear, shame, self-blaming, societal and internalised stigma, victim-blaming attitudes, the context of minority stress such as discrimination, financial and/or emotional dependency on the abuser, or the fact that they might not even be consciously recognising the behaviour of their intimate partner as abuse at all (17,30,35–37).

The current study also yields some new and unique results highlighting that only around one in ten survivors of psychological and/or economic IPV in Lithuania receive mental health services. The study showed no significant difference in using mental health services between survivors of just one type of IPV or both psychological and economic IPV. This might be due to the fact that economic IPV is in fact a dimension of psychological IPV and a type of coercive control; thus, the impact of the abuse among women with these experiences may be similar (9,20).

Nevertheless, this finding is unexpected and alarming because according to literature across the world, women with experiences of IPV, especially psychological IPV and coercive control, including economic IPV, are more likely than others to have mental health conditions, such as depression, anxiety or post-traumatic stress disorder (4,20,21). Hence, the current study highlights that even though the prevalence of experiencing IPV is high and so is the expected rate of mental health problems among these women, only a small fraction of them seek and receive mental health care services in Lithuania. There may be several possible reasons for this phenomenon.

Firstly, psychological and/or economic abuse are still much less recognised as types of domestic violence compared to physical and/or sexual IPV (38). The latter tend to get recognised a lot more due to the obvious and visible physical manifestations of harm, such as bruises, broken bones, internal bleeding, and other physical consequences. Additionally, physical abuse is much more often taken seriously and investigated by the police: according to the official statistics of the country, out of almost 60,000 phone calls about domestic violence made to the Lithuanian police in 2022, only around 6,000 were registered as crimes in domestic settings and the absolute majority of these crimes concerned specifically physical violence (ref). This may be one of the potential discouraging reasons for even those survivors of psychological and/or economic IPV who consciously recognise the abuse to seek any type of help.

When considering the seeking of help and support specifically from mental health services, the reasons may be rooted in predominantly deeply negative attitudes towards mental health problems and mental

health services in Lithuanian society (32,33). As it was recently emphasised in the OECD Health Working Paper (2022): "Despite legislative reform in recent years, there remains legislation prohibiting those with a diagnosed mental health disorder from taking up specified professions, and performing certain activities. Formal and informal modes of stigmatisation continue to act as a barrier to help-seeking and treatment" (33).

Moreover, in the current study, divorcees had higher odds of using mental health services compared with other relationship statuses which might be related to the fact that it is very difficult to seek help when still in an abusive relationship. This is especially relevant in the case of economic IPV where the survivor may become extremely financially dependent on the abuser, with a highly threatened personal independence and economic security (8,9,21). Also, psychological IPV more broadly and especially coercive control may leave the survivor not only quite literally entrapped in the power and control wheel of manipulative strategies systematically used by the abuser, but also isolated, degraded, with a completely diminished self-esteem, in a state of terror and entrapment, none of which can easily contribute to help seeking (7,20,39).

Finally, some more practical reasons for not seeking or receiving mental health services may also be related to inaccessibility and potentially low quality of care within these services in the public sector, especially concerning the lack of services based in the community and in rural areas of the country (33). The inaccessibility of public mental health services may result in vast economic and social exclusion-related problems, since only those who can financially afford to use services in the private sector end up receiving the needed mental health care services, whilst the poorest and most vulnerable persons may be left behind with almost nothing.

This situation is problematic and alarming because in light of global evidence, not only physical but also mental health care services are vital to survivors of IPV and for their path to healing and therapeutic, as well as personal recovery (26,40). According to the Lancet Psychiatry Commission on IPV (2023):

> *All mental health professionals should have a good understanding of the gendered nature and dynamics of IPV, the effects of IPV on mental health, and the intersections of both IPV and mental health with other forms of oppression including racism, transphobia, ableism, and poverty. Mental health professionals should be enabled to respond appropriately through training and continuous learning, and should be able to count on organisational infrastructure and support.*(40)

In most such cases, a complex support is needed, taking into account all aspects of the human rights-based and bio-psycho-social model, as well as trauma-informed approach (19,41,42). Regardless of the fact that laws, policies and practices differ across countries and tend to evolve over time, certain fundamental aspects are relevant in all cases when working with and supporting IPV survivors across different services, including within the mental health care sector: ensuring safety, actively listening, building trust, fostering autonomy, and coordinating services through inter-sectoral collaboration (26).

Previous studies from various countries mostly covered the interlink between survivors of IPV and physical health care, especially in primary care settings (26–29,43,44). The current study emphasises and draws attention to the peculiarities of Lithuanian women experiencing specifically psychological and/or economic IPV and the crucial role that mental health care services may play for this population. Further quantitative as well as qualitative research with larger sample sizes is needed in order to better understand the predictors and other contextual factors of utilising mental health care services among survivors of IPV in Lithuania and other countries; especially among survivors of psychological and/or economic IPV.

In general, to encourage survivors of IPV to seek help and support, societal stigma related to both IPV and mental health conditions needs to be eliminated. Broader implications for public health and policy in Lithuania include the urgent need to develop more accessible mental health services in the community, foster effective evidence-based interventions to better address the needs of IPV survivors, and to develop new therapeutic approaches, including trauma-informed support.

Limitations

The study is cross-sectional which limits causal inferences, namely the direction of the associations. Due to the relatively small sample size in some parts of the analysis, more uncertainty was obtained in the estimates, due to the large CI. There is room for further research and deeper analysis with larger samples of this population. Additionally, due to the availability of only limited data on this subject having been included in the survey, only experiences of psychological and/or economic IPV were analysed. Thus, the study leaves space for further exploration of relevant associations related to physical and/or sexual IPV.

Acknowledgements and Funding

The survey was funded by the Department of Psychological and Behavioural Science at the London School of Economics and Political Science through a KEI research grant. Also, financial support in a form of doctoral fellowships was provided to some of the co-authors of this article by the FCT – Fundação para a Ciência e a Tecnologia (UI/BD/151073/2021 and UI/BD/151072/2021), and 'la Caixa' Foundation (LCF/BQ/DI20/11780013).

Authors' Contributions

The study was conceptualised by the first author Ugnė Grigaitė and most of the co-authors contributed to the study design. The survey for data collection was designed, coordinated and implemented by Paulius Yamin, Maxi Heitmayer, Ugnė Grigaitė, and Eglė Žeimė. The main statistical analysis of the collected data was conducted by Sofia Azeredo-Lopes and Ugnė Grigaitė, with support from Eglė Žeimė. The first draft of the manuscript was written by Ugnė Grigaitė and all co-authors reviewed, commented on it, and provided their contributions. All co-authors reviewed and approved the final version of the manuscript.

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