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# An Occupational Therapy Approach to Sexuality in People with Acquired Brain Injury in a Subacute Setting

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**Abstract**
To analyze if people with acquired brain injury in sub-acute situation, as well as their relatives and/or partners, consider relevant the approach to sexuality during their Occupational Therapy intervention. This study presents a qualitative design with a phenomenological approach. Twelve participants were interviewed: eight people with acquired brain injury, two relatives and two partners who agreed to participate. The information has been collected through interviews. According to the interviews, the following categories have emerged: changes and everyday life, the taboo of sex and its relation to gender and the relevance of counselling. Participants consider sexuality as another activity of daily living, which has been modifed due to acquired brain injury. Not only does the taboo of sex condition the subject, but it is also infuenced by the individual's gender. In addition, the counselling by the professionals involved in the rehabilitation process is the main intervention claimed by the participants of this study. The participants consider sexuality as an activity of daily living. Therefore, the occupational therapist who follows the holistic conception of the people must consider sexuality in the intervention process.

**Keywords** Occupational Therapy; Sexuality; Acquired Brain Injury; Subacute Stage; Qualitative Study; Spain

## Introduction

The World Health Organization defines sexuality as "a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction" [1]. Sexuality is modified not only by intrinsic factors (biology and psychology) but also by extrinsic ones (social, economic and cultural aspects) [1] and, despite being such an intimate part of the human being, can be influenced by teaching, demography, medicine, morality, and politics [2]. Furthermore, throughout a person's life, the perception of sexuality may change and, depending on the events that occur in his/her life, it may change [3]. Therefore, when someone suffers an injury, such as an acquired brain injury (ABI), the perception and experience of sexuality may change.

The concept of "acquired brain injury" was conceived as an umbrella term by authors such as Haag, Caringal, Sokoloff, Kontos, Yoshida and Colantonio [4]. They consider it covers all those conditions at the brain level, produced or not by a traumatic event, which occurs after a person's birth. These could pose problems at a physical, sensory, cognitive, emotional and behavioral level. These problems will have a direct impact on the daily life of the sufferer [5]. The main cause of ABI is stroke, followed by traumatic brain injury (TBI), although it can also be caused by a brain tumor, infection, or anoxia [6].

Considering the prevalence of ABI and the consequences thereof, there is a strong need for quality care that addresses all aspects of the disease. It is essential to provide attention to the individual through an interdisciplinary rehabilitation team. The work of that team adapts to each case and addresses the intervention from a comprehensive approach to achieve better results [7]. This attention must also be given from the very beginning (i.e., it must begin in the acute and/or subacute stage).

This model of attention involves different personal areas and is carried out by a specialized and coordinated team to support the recovery of patients with an ABI. However, it does not encompass sexuality, which is a fundamental part of the human being and that is affected in many cases [8]. In this regard, the combination of neuropsychological, medical and physical factors, as well as changes at the relational level, will culminate in an impact on sexuality.

Furthermore, when sexuality is linked to a disability (in this case caused by an ABI), it will have more taboos, stereotypes and associated myths [9, 10]. The social imaginary can condition the conception of the sexuality of people with disabilities [11]. In many cases, these people are infantilized and labeled as asexual, or their sexuality is simply ignored when there are other types of cognitive or physical deficits [9]. People with an ABI often encounter greater barriers and difficulties when talking about their sexuality with professionals. The fact of having a previous conception of sexuality that has been affected after the injury can become a big problem for these people. Their identity as a sexual being can be altered by physical or psychological changes that will affect, in many cases, their way of relating to their environment [12].

Occupational therapy (OT) is a person-centered practice, which is conceived holistically [13]. Therefore, when occupational therapists (OTs) develop their professional practice, they should take into account all the spheres of the person. The American Occupational Therapy Association (AOTA), in the occupational therapy practice framework (2014) [14], considers sexual activity as another activity of daily living (ADL) and as part of social participation with peers and friends. Furthermore, the AOTA has a position statement that says OTs can and should address sexuality under three different facets: health promotion, remediation, and modification [15]. However, this activity is not usually fully addressed by professionals in the discipline when working with their clients [9, 16, 17]. If OTs seek the empowerment of the people and promote their independence, they must assume that sexuality is also part of their daily life.

Leaving aside the sexuality of the person when undergoing OT goes against the current philosophy of the discipline. That is to say, if the practice must be focused on the person and their wishes and vital goals, forgetting an inherent part of the human being (i.e., sexuality) constitutes a big mistake on the part of the professional [8]. Moreover, there is a situation of occupational injustice, because the full and satisfactory participation of the person in said occupation is restricted [9, 18, 19].

There are few studies related to ABI, sexuality, and the subacute setting. So, the present study offers a new perspective that can contribute to the knowledge of this topic. The objectives of this research are to analyze if people with an ABI in a subacute situation, as well as their relatives and/or partners, consider the approach relevant to sexuality during their intervention in the OT department.

## Methods

This qualitative study presents a phenomenological approach that sought to know the subjective experience of the people with whom authors have worked. It was performed in the Occupational Therapy Department of the Neurology Unit of the Physical Rehabilitation Service at the Maritime Hospital of Oza (University Hospital Complex of A Coruña) of the city of A Coruña (Galicia, Spain). The fieldwork of the research was done by two occupational therapists. All participants came to this department either as patients or as the relatives or partners of patients.

The scope of this study was carried out between February 2018 and April 2018. The participants were interviewed individually in a private room. In this case, there were 12 participants: eight patients (five women and three men), two partners (two women) and two relatives (the father and mother of different patients). The partners and relatives of these last four people did not participate in the study. All of them met the selection criteria of the study and accepted to participate freely in it after reading the participant's information sheet. Table 1 shows the selection criteria of the study and the main sociodemographic characteristics of the participants. The sample size has been conditioned by the design of qualitative research. Sampling has been intended and convenient, and the number of participants has been established upon reaching theoretical data saturation. It implies that additional data collection from new participants no longer results in new knowledge about the phenomenon being studied.

Informed consent was obtained from all individual participants included in the study. To collect the data, a semi-structured interview especially designed for the research was used. This interview was different depending on whether it was done with the person who suffered the ABI, his/her partner, or his/her relative. Some of the questions that were asked in the interviews are included in Table 2.

Besides, to know the occupational priorities of ABI sufferers, the semi-structured interview of the Canadian Occupational Performance Measure (COPM) was used. The COPM is an evidence-based outcome measure "designed to capture a client's self-perception of performance in everyday living, over time" [20]. Nevertheless, its use was merely to know the occupational priorities; therefore, it was not administered in its entirety. This tool has been chosen because it is a questionnaire of habitual use by the researchers and that sought to ensure the focus on the occupation during the development of the fieldwork. All the interviews were recorded in audio format and then transcribed, ensuring absolute personal confidentiality at all times. After that, they were analyzed and triangulated, with different categories emerging through an inductive approach. The process of analysis of qualitative data was done by the complete research group to apply a complete triangulation of data and to revise and finalize the emergent categories.

This study was approved by the Research Ethics Committee of A Coruña-Ferrol (Galicia, Spain), with the reference number 2017/587, and the current Spanish legislation has been followed to carry out the study. All procedures performed in studies involving human participants were under the ethical standards of the Research Ethics Committee of A Coruña-Ferrol and with the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards. Data protection was prioritized and anonymized to avoid identification of the participants. The study is registered in ClinicalTrials.org, with the reference NCT03911752.

## Results

### *Sociodemographic Traits of the Participants*

There were 12 participants. Within the group of people with an ABI, five men and three women with an average age of 44.25 years were included. Within the group of partners, both were women with an average age of 46.5 years. Within the group of relatives, a man and a woman, who were both parents of young men, participated with an average age of 48 years. Table 1, which has been shown previously, includes the main features of the sample.

### *Qualitative Results*

After analyzing the interviews, the inductive approach of this qualitative study allowed categories to emerge. Besides, after the COPM was administered to participants with an ABI, only one woman (U7) identified sexual activity as an occupational priority. Nevertheless, the following categories were established when participants were prompted with the follow-up questions.

### *Changes in Sexuality*

When talking about sexuality today, after the ABI, almost all participants say they have experienced some changes. These changes are mainly physical when moving during sexual intercourse, although some describe difficulties in getting excited.

> (U1) Now… I am a little more limited in this leg or this arm… there is… how to say it? Postures that you used to do that now… I mean… you would get tired more… or you could not stand…
> (U4) Yes, I get more tired because I'm not 100%. But maybe I try to do it better. What is hardest for me now is to focus [to get excited]. When she and I are alone… it is harder for me… how to say it… to have an erection, to get excited, and we play more than before. Now we play first and then it is what it is [coitus]. Before it was not like that […] now maybe I like more than I liked before because we give more excitement, more game. We do more heating [preliminary].

### *Sexuality, Partnership and Affection in Everyday Life*

Most of the participant interviews established links with sexuality and the couple, as well as with daily affection. Besides, changes in sexuality were identified after the ABI, which generates concerns in most of them.

> (U7) Well important because I tell you that it is a communication with my partner and that it unites us more, and all of that is important.
> (U4) For me, sexuality is important because otherwise then it goes off and on we go, for me it's all. For me the affection, the love day by day, stand up for your partner and say ghuapa. Or good days and let her tell you what you are going to do today, I will do this, I will go to such a place. Everyday life, that's all

In all the discourses, sexuality was linked to the partnership. That is to say, all of them emphasize the importance of this sexuality as another sign of affection towards their partner when it exists, and they identify everyday affection, communication or respect, as well as intercourse, sexual games and preliminaries, which are part of a person's sexuality. When this couple is casual (i.e., the result of a single encounter), they also consider sexuality but do not speak in any discourse of individual sexuality.

> (P2) I…, for me, personally, it's…, I don't know… the day by day, the caresses, the behavior, the attitude. Then apart, of course, sex, but, for me, primordial, is the above. The day by day, the love, the communication. Daily living. I would not limit it to what sex is, but always with my partner.
> (U4) For me it's love, the love each day, get up next to your partner and say "beautiful" or "good morning!" It is everyday life, it is everything.

For the participants, sexuality has a close relationship with the couple in their daily life. This means that most of them identify it as another ADL and consider it equivalent to others, such as dressing or feeding. Furthermore, the perception of change in roles from partner or lover to caregiver was addressed by participants.

> (U7) Yes, yes, without a doubt, it is another activity more, because it is another part of my life. And it seems important in my life…
> (P1) My partner has struggled between life and death, and you appear thinking about, are we going to have sex? It seems a little frivolous.

***Fear and Doubts***

Moreover, most participants highlight that they fear the fact of having sex again, because they do not know if it would be good for them. Also, others say that their partners may be afraid of hurting them in the current situation after the ABI.

> (U5) I have that doubt about how my body will be or how my body and I would react having sex.
> (U6) I don't know if it's good for me or if… I'm a little afraid of whether it can hurt me. I'm also afraid because of mobility and because I don't feel the same.

Apart from that, almost all the informants commented that they had doubts on the subject and mention that many of these already arose when they were in the hospital.

> (U4) (When asked if he had doubts about sexuality when the ABI had just occurred) *Yes, yes, of course. You always have doubts: if you will do it well if you will do it wrong, how it will be, how it will not be, if she will like it, if she will not like it… But… nobody talks to you or asks about this…*
> (P1) Now I have passed that moment of doubts, which you do not know… but I think that things are going well… But it is good to know that there are people you can go to. Because of course, it is an issue that… my partner has struggled between life and death, and you appear thinking about are we going to have sex? It seems a little frivolous.

### *The Taboo of Sex and Its Relation to Gender*

Most informants highlight the influence that the taboo of sexuality exerts on them when talking about this topic. They talk about the importance of the culture that governs the life of each person and the education they have received on it. Besides, in the interviews of most of the participants, there was a certain degree of modesty when talking about sexuality, such as laughter, euphemisms for words such as sex and/or sexuality or very simple answers when the most concrete questions are asked (especially in the interviews of U6 and U8).

> (U1) Yes, there will be many people who will embarrass him, not myself, for example, but… (laughs). I see it as something supernatural and supernormal so I don't understand why she/he blushes because of that, I do not understand… but well… of course… that is already in the culture of each person…
> (U8) (When asked if he considers sexuality as another ADL) My level of priorities has changed. I no longer need… I give more importance to other things that maybe do not have it but…
> (P1) It is good to know that there are people to whom you can ask for help. Because of course, it is a topic that… my partner has fought between life and death, and you appear thinking about "are we going to have sex? It seems a little frivolous.
> (P2) (When asked if he had doubts about this issue at some point) No, not at all, not at all. I already tell you, until now, this issue had not crossed my mind.

Some participants also talked about the differences that exist between men and women when they talk about sexuality. In many of the interviews, it is considered that, for a man, it is more complicated to talk about this topic.

> (U3) (When asked if he thinks it would be more complicated to talk about this with a man than with a woman) *[…] Yes, of course, we have that of a male, tough guy, those things you know? And that, after all, is nonsense, because, hey… an accident can leave you with many sequels and, among all of them, you might have damaged the sexual system.*
> Also, one of the participants, during the administration of the COPM, indicated that he would like to be the one to take the reins again during sexual intercourse with his wife.
> (U1) (When talking about occupational priorities) *Sex life is also important, I mean, I want to take the reins instead of being taken by the couple…*

### *The Relevance of Counseling*

The counseling was highlighted by most of the participants as the main intervention that should exist in the topic of sexuality. However, they did not know how OT could take part. All of them emphasized that the first step to talk about this subject should be given by the professional.

Sexuality counseling is highlighted as the main intervention of the professional, whether it is an OT or another one. On the one hand, they seek orientation on the subject, and on the other hand, the professional informs them of the problems or changes that may exist in this area.

> (U5) […] So I think it would be fine if sexuality were approached for guidance, yes. At least to know if something happens… here then, perhaps in therapy, they tell you "look at this, at the moment you have sex because of your accident this or this can happen, you can do this to avoid that…
> (P1) First, I think it would be important to open a space to have the possibility to talk about it, because nobody talks to us about this. It is necessary that space to detect if there is a problem, or those doubts can be solved or how…

### *Lack of Awareness of Occupational Therapy*

Almost all participants identify OT as an aid to develop and participate in their daily life as before. They do not talk about discipline at a general level, but they focus on their specific case.

> (U3) Well… a series of exercises to put me back, […], at the same level in conversations with friends, in memory, in any activity you do in your day to day, in your daily living. […] Go back to the daily routine for a future and reintegration into my job.

Moreover, most of the participants did not know how OT could help them in the field of sexuality. Some believe that it could be approached by not only advising the person but also talking with their partner about their possible doubts.

> (U7) Yes, I would like to know how you could help me with such an intimate thing. And as it is a subject that is a bit taboo because there is not much talk… Then I don't know. However, I guess the doubts I have then… if you can help me on all levels. I think it's a good idea if you can help on the subject of postures so as not to get tired, then maybe also talk a little with the couple because he sometimes is afraid of hurting me and just stays without touching me and… I do not know what else.

### *The Moment of Intervention*

The participants of this study emphasized the importance that the first step to talk about this issue is given by the professional. Some commented that they would not know whom to address, and they did not even know that the OT could help in this area.

> (U2) […] So, if you approach it in a subtle but direct way but with caution so that they know that, in addition to the daily activities, there is this part that can also be important, but that they had never contemplated it and that, likewise, it can be treated… well, it would be very good. […]
> (U7) Maybe… I think I can't do something and maybe teaching me new ways I could do it… maybe that way they could help us. I think the best thing would be to explain to us that it is to help and to talk about all the doubts we have and, then, if you want to deepen if there are more doubts continue with issues that interest us more. However, I think the most important thing is that the professional has to take the first step. Because this is easier, I think this way people feel more comfortable.

The parents who participated also emphasized the importance of the professional when it comes to intervening with their children on the topic of sexuality, as they consider that for them, as parents, it would be more difficult.

> (F1) […] he feels more comfortable talking with you because you are going to respond differently than I am going to answer him as a father, so I tell you that it is a very good idea.

## Discussion

The main objective of this study was to explore the perceptions of people with ABI in the subacute stage, as well as their partners and family members, in their assessment of the approach to sexuality during the OT intervention. More specifically, it was intended to analyze the importance of this occupation in their life, what for them was the approach to sexuality and the differences that could arise by age and gender. However, these objectives have not been fully achieved, probably because of the limitations presented by this study, which are presented later.

Sexuality is seen as an ADL by the Occupational Therapy Practice Framework [14], but its approach is usually incomplete or non-existent. The lack of training in this respect or the existence of the taboo nature of sexuality could be the reason [16]. McGrath and Lynch [21] in their study pretend to know the perspectives of OTs on the attention to sexuality in elderly people. They say they would intervene if they worked with younger people. However, most OTs do not address the sexual needs of their patients, regardless of age or the area in which they work [22].

Therefore, as can be seen, emerging in the discourse of this research, people with an ABI do not have enough information about the intervention with regard to sexuality. In many cases, they do not even know how the OT can help them in that area. However, not only does the OT not offer any intervention but also no other professional does. Schmitz and Finkelstein [8] comment in their study that people with an ABI feel uncomfortable talking about sexuality with health professionals and think that the latter has the same feeling. The participants of the present investigation agree with the data of Schmitz and Finkelstein [8]. For them, professionals should take the initiative to talk about the issue. Counseling is considered the main intervention they would need. While addressing these findings, mention should be made of the Permission, Limited Information, Specific Suggestions, and Intensive Therapy (PLISSIT) model developed by Jack Annon to address sexuality issues with patients. "The model guides clinicians to support patients according to the unique needs of individual patients as well as the clinician's comfort level and expertise. Referrals can be made when a patient's needs exceed a clinician's comfort, knowledge, and time" [23]. So, this model can be a good point on which to base the intervention and communication done by any professional that develops a Personal Health Plan in the field of sexuality.

Taking into account the objective of determining relevance on the attention to sexuality in people with an ABI, they show that the best thing would be that the OT participants would want the professional to inform them from the very beginning that, in the case they have any need, they could intervene in the sexual sphere. Schmitz and Finkelstein [8] emphasized the importance of initiating the intervention in sexuality after the acute phase when the patient and the couple are stable physically and emotionally. Also, Moreno, Arango Lasprilla, Gan and McKerral [24] highlighted the importance of starting as soon as possible.

It should be mentioned that when administering the COPM, only one person suggested sexuality was important. Therefore, a change of focus in the model of attention to ABI would be relevant. If what is desired is an integral intervention, the sexual sphere should be considered as an essential and basic part of every human being. The mention of the importance given to sexuality in the COMP COPM by only one person may conflict with the fact that the participants of this research, in their speeches, consider sexuality as a cornerstone in their relationships. It has lost its traditional objective of reproduction to constitute another act of love [3]. That can be a possible explanation for the few participants that suggested they felt it was frivolous to address sexuality when other more important concerns were going on in their relatives' life due to ABI (*see quote of P1*).

Furthermore, all participants talked about the daily life of sexuality linked to acts of affection and communication within the couple. That is to say, in no case do they relate it solely and exclusively to coitus. Thus, as a result of identifying sexuality with daily gestures of affection with his/her partner, they conceived it more as an ADL. In fact, most of the interviewees would put it at the same level as other activities, such as showering, eating or dressing.

The sexuality of the participants changes after the ABI, as they recognized. The main changes are those related to the body, such as mobility during intercourse and the maintenance of certain postures during it. One of the participants had arousal problems after the ABI. However, he says that he now enjoys sex more because of the increase in frequency and erotic games with his partner. This may indicate that other erotic manifestations can gain a greater weight after an ABI, and sexuality can even be enriched after an event like this.

Despite the union between sexuality and partner, when an ABI occurs, this link can be destabilized. As participant P1 says, *"My partner has fought between life and death, and you appear thinking we are going to have sex? It seems a little frivolou*s." This discourse is related to the ideas of Brunsden, Kiemle and Mullin on the experiences of male partners of women who have suffered an ABI. The authors show that couples are forgotten in the rehabilitation process, since the care services are directed to the person with the ABI. They claim to be the silent victims of the ABI, also experiencing a change of role from lover to caregiver [25]. Therefore, it should be considered that the involvement of couples where on partner has an ABI is also a direct consequence of it; therefore, health services should provide care to this population. Additionally, this change of role can often be incompatible with the former lover [24].

Knowing the differences in discourse due to age was one of the objectives of this work. However, relevant findings were not found due to the homogeneity of the sample.

The authors also sought to know the differences in discourse due to gender because some participants also talked about the variances that exist between men and women when they talk about sexuality. Interesting data was found when analyzing the discourse. However, in the interviews of men, the need for an erection appears as the cornerstone of sexuality (for instance, the quotes of U4). They consider the fact that the ABI has affected this level as the main problem, since they could not enjoy sex. This data agrees with research on the influence of gender roles and stereotypes when there is some type of problem that affects the area of sexuality [4, 12, 24]. Therefore, it is obvious that changes in sexuality can be influenced by the gender of the person, but it is also revealed that there is a certain taboo related to the gender perspective, since, in general, there is the idea that men can appear weak if they ask questions about their sexuality and sexual life [12] (e.g. s*ee quote of U1, in the section "the taboo of sex and its relation to gender")*.
In the couple, the influence of gender roles can pose a problem. These may suppose, in the case of a man with an ABI, that a dominant role is expected during sexual intercourse [12]. All this agrees with the interview of the participant U1 who wants "[…] to take […] the reins instead of the couple taking them." It is important to reiterate that, if any element that constitutes the human being is altered (as in the case of an ABI), the meaning of the sexuality of that person had changed radically [12]. However, in the present study, it was not possible to show whether women, being able to be influenced by gender stereotypes, seek to maintain the typically associated roles [26]. It is also common for women to play a role as caregivers, since in fact, according to the Spanish Society of Geriatrics and Gerontology, 89% of caregivers are women [27]. However, no evidence of gender stereotypes with regard to the role of caregiver that may be played by women in couples in this research has been found.

When speaking with the participants, it becomes clear that sexuality is not only a taboo to address it from a professional point of view but also to talk about it and refer to it. This causes the interviews to be plagued with periods of silence, laughter, metaphors and euphemisms that look to replace the words "sex" or "sexuality." This is consistent with research, such as that of Pizarro Pedraza, which investigates the use of taboos and euphemisms for sexual concepts in the city of Madrid. It emphasizes the use of metaphors (mainly in men) and metonyms (mainly in women) when talking about sexuality [28].

The presence of the taboo also affects the sexual education transmitted from parents to children, which causes the phenomenon to continue generation after generation [29]. This could be reflected in the interviews of F1 and F2, who prefer that their children talk with health professionals rather than with them about sexuality.

However, it should be noted that the main sexual education received is based on hygiene, reproduction, and genitality. That is, it is because of education based on intercourse that does not comprehensively contemplate the human sexual sphere [3].

This type of sexual education can condition the way of intervening on sexuality when an ABI occurs. This can be seen in studies, such as that by Moreno, Arango Lasprilla and McKerral, where they note that, of the professionals who approach sexuality with their patients, they do so after the latter's request [24].

This lack of attention to sexuality is conditioned and influenced by the social construction that maintains that people with disabilities are not sexual beings [30]. Therefore, it is essential to understand the importance of breaking down the taboo that surrounds both sexuality and disability. This aims to work so that people with an ABI have comprehensive and holistic care during the subacute stage.

### *Limitations of the Study*

There are several limitations to this study. First, the size of the sample in the groups of relatives and couples was very small. That is, although the theoretical saturation has been reached for the complete sample of participants, in the specific group of relatives and couples, the number of interviewees has been very small, therefore, evident conclusions about these groups have not been able to be extracted

Also, concerning the results of the administration of the COPM, different factors have been able to influence conditioning them. On the one hand, the lack of experience of the researcher at the time of administering it, and on the other hand, the tool does not include sexual activity as an example in any of its sections. So, that fact could cause the participants not to know where they could place this activity. Or perhaps, they simply did not consider it an occupational priority at the time the tool was administered to them.

## Conclusion

In conclusion, it is necessary that OT, following the holistic conception of the human being, contemplates sexuality from the beginning of the intervention process. Sexuality is considered another ADL due to the daily gestures of affection, love and attraction in life as a couple. However, in this study, authors can conclude that it is not addressed by any professional during the rehabilitation process of the person who has suffered an ABI. This could be conditioned by the taboo of sexuality, and the changes that occur in sexuality can also be influenced by the gender of the person.

Furthermore, it is necessary to reinforce the university education of the OT on sexuality, and it is recommended to increase their continuous training on sexuality. In summary, a change of focus in the integral attention to individuals with an ABI is fundamental.

## Compliance with Ethical Standards

### Conflict of interest

The authors declare that they have no conflict of interest.

**Statement of Human Rights/Welfare Animals**
All procedures performed in studies involving human participants were under the ethical standards of the Research Ethics Committee of A Coruña-Ferrol and with the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards. This article does not contain any studies with animals performed by any of the authors.

**Informed Consent**
Informed consent was obtained from all individual participants included in the study.

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