15

Therapy: Managing Occupational Sexual Harm in Medicine

Leslie Flynn and Amber Hastings-Truelove

INTRODUCTION

Medicine, in training and in professional practice, has long contended with a culture that has turned a blind eye to bullying, harassing and abusive behaviours by members of its profession. (1; 2) The effects of bullying and harassment in the workplace can be far reaching and can affect more than the relationship between the victim and their abuser: there can also be a 'ripple effect' which can impact other work relationships as well as domestic relationships. (3) Women, in particular, are at risk to be the victims of gendered forms of bullying or harassment. In a sample of clinician researchers, 30% of women reported having experienced sexual harassment compared with 4% of men. In one systematic review, staff, attending physicians, and senior doctors were cited most frequently as the sources of such behaviours. (4) Women were also more likely than men to describe more severe forms of harassment (e.g. subtle bribery to engage in sexual behaviour, threats to engage in sexual behaviour, or coercive advances). (5)

For a variety of reasons, physicians are notoriously bad at seeking assistance when issues arise in their own lives, especially when they perceive that those issues may have an adverse impact on how they are perceived professionally. (6; 7) Help-seeking behaviours can be impacted by a desire to not appear 'weak' to colleagues, loyalty to the team, (7) or a fear of retaliation due to power dynamics within the work environment. (6; 7) Concerns related to stigmatization (8) and confidentiality (9) can make it difficult for individuals to seek help when they are experiencing physical or mental distress. Given these barriers to care, it may be even more difficult for individuals to either report instances of harassment or abuse or seek help for symptoms that may arise as a result.

Decisions on whether to report harassment or not can become even more complicated, as terms such as sexual harassment and sexual abuse are often used interchangeably. When looking at female medical students' experiences of sexual harassment, Wear, Aultman and Borges (2007) found that most ignored 'sexual innuendo, explicit sexual banter, or crude language in general' as just part of the culture of medicine, particularly in surgery. (7) Students in this study also had

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 01:33:10, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.018

different understandings of when something should be reported. For some, it was when comments moved beyond crude to degrading; for others it was when physical contact moved from 'persistent arm, shoulder, or back touches' to what felt like sexual touching. (7) None of the women in this study had ever reported a colleague's behaviour. Rather, the researchers found that students would alter their own routines to avoid known offenders (standing further away from a 'touchy' person, signing up for shifts to avoid working with a particular individual, or removing themselves from conversations). (7)

These early experiences in medical school have an impact on professional identity formation, especially during clerkship, and creates expectations for what it is to be a 'woman doctor'. (10) Identity formation is a dynamic process achieved through socialization, which results in individuals joining the medical community of practice. (11) Babaria et al. (2015) note that while female clerkship students were able to find ways to confront and respond to inappropriate behaviour from male patients, none of the women interviewed in their study felt able to confront or report inappropriate behaviour from male attendings. In their study, a few attendings (senior medical consultants or specialists) were responsible for the behaviour, but every participant over two service rotations reported inappropriate behaviour from them. These young women recognized the power dynamics in their situations and felt that reporting would only make their situations worse. The authors noted that for female clerkship students, having numerous inappropriate interactions with male supervisors reaffirmed their identity as one of a 'sexualized token', who was less valued in the hierarchy of medicine. (10) Having these experiences early in medical training can have lasting effects on how women identify what it means to be a 'woman doctor' and may contribute to non-reporting of harassment later in their professional careers.

CULTURE OF MEDICINE

The culture of medicine is complex, and sometimes contradictory. Many of us enter this career because we see it as a calling. We enter the first day of medical school with an elevated and idealized vision of the profession which never truly leaves us, and in turn, we pass that vision on to the next generation of learners. On the one hand, holding on to that idealized notion of the profession is not a bad thing, and may in fact help us through some of those days that are harder than others. The danger to clinging to this image of our profession, however, is that we may automatically become defensive when it is challenged. When we hear of a colleague who has sexually harassed or abused a trainee or a colleague, it may challenge our own professional ideals, leading us to try to justify or excuse the behaviours to maintain our sense of professional safety.

Compounding this complexity is the public's view of medical professionals. As the rhetoric throughout the COVID-19 pandemic has made explicit, physicians are

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 01:33:10, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.018

often viewed as heroes by the public. A fundamental tenet of the social contract that physicians have with the patients they serve is that physicians are meant to heal, and at the very least not to cause harm. According to Creuss and Creuss, (12) the public's expectations of the medical community include not only the assured competence of their physicians, but also that physicians adhere to standards of morality, integrity and honesty, trustworthiness, and accountability, and that they support promotion of the public good. (12) Because of this, accusations or even rumours of sexual harassment or abuse can create patterns of cognitive dissonance which perpetrators can exploit. People are trained from a young age to trust physicians, and this can include extending the benefit of the doubt to physicians accused of sexual wrongdoings.

In Canada, we are guided by the CanMEDS Framework, which identifies and describes the abilities physicians require to effectively meet the health care needs of the people they serve. Within the Professional Role, competencies for physicians demand that we 'recognize and respond to unprofessional and unethical behaviours in physicians and other colleagues in the health care professions' and that we 'participate in peer assessment and standard-setting'. (13) The framework articulates the ideal even as it recognizes that not everyone will live up to this standard and that it is up to all of us to hold individuals accountable.

A 2018 report from the National Academies of Sciences, Engineering and Medicine found that:

- Greater than 50 percent of women faculty and staff and 20–50 percent of women students encounter or experience sexually harassing conduct in academia.
- Women students in academic medicine experience more frequent gender harassment perpetrated by faculty/staff than women students in science and engineering.
- Women students/trainees encounter or experience sexual harassment perpetrated by faculty/staff and also by other students/trainees.
- Women faculty encounter or experience sexual harassment perpetrated by other faculty/staff and also by students/trainees.
- Women students, trainees, and faculty in academic medical centres experience sexual harassment by patients and patients' families in addition to the harassment they experience from colleagues and those in leadership positions. (14)

These findings may come as a shock to some people working in the profession who have either never experienced harassment or have not recognized harassment when they have witnessed it. The report identified a number of characteristics within medical culture that create higher levels of risk for sexual harassment to occur. These include:

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 01:33:10, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.018

- Male-dominated environment, with men in positions of power and authority.
- Organizational tolerance for sexually harassing behavior (e.g. failing to take complaints seriously, failing to sanction perpetrators, or failing to protect complainants from retaliation).
- Hierarchical and dependent relationships between faculty and their trainees (e.g. students, postdoctoral fellows, residents).
- Isolating environments (e.g. labs, field sites, and hospitals) in which faculty and trainees spend considerable time. (14)

Within this culture, it can be an incredibly daunting prospect for a victim of sexual harassment to come forward. There may be shame associated with being the victim of harassment, or fear of retaliation from the abuser or from the organization. Hart (2019) found that participants 'were less likely to recommend a woman for promotion if she self-reported sexual harassment relative to otherwise identical women who experienced nonsexual harassment or whose sexual harassment was reported by a coworker' (15, p. 534). She also found that women who self-reported sexual harassment were perceived as less moral, warm, and socially skilled than the woman whose coworker reported her sexual harassment. (15)

CONSEQUENCES OF SEXUAL HARASSMENT

Individuals who have experienced a traumatic event such as sexual harassment, particularly from one's colleague/supervisor/peer, are likely to have a psychological and/or behavioural response. The possible responses vary. They range from the most common responses, known as distress reactions, through to risky health behaviours and frequently psychiatric disorders (16).

Distress reactions commonly experienced include anger, demoralization, fear, a sense of increased vulnerability, irritability, lowered self-esteem, self-blame, humiliation, shame and increased self-isolation. Physical manifestations are common as a result of psychological distress and exposure to sexual harassment and trauma. This may include insomnia, nightmares and somatic symptoms including, but not limited to, headache, nausea, dizziness, muscle tension and fatigue. Individuals may engage in behaviours which further put their health at risk. Behavioural responses, which are often attempts to self-soothe, may include disordered eating, or increased tobacco, alcohol or cannabis use. Psychiatric disorders occur in some individuals following a traumatic event. Post Traumatic Stress Disorder, Depression, Generalized Anxiety Disorder, Panic Disorder and suicidal thinking are all potential outcomes of a traumatic experience such as sexual harassment. (14)

Superimposed upon these very common responses to sexual harassment are the aspects that are peculiar to the situation whereby a physician is harassed by a physician. Physicians are taught from a very early stage in their education about the necessity for Professionalism. It is an identified competence which needs to be

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 01:33:10, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.018

acquired and maintained by all physicians. (13) Professionalism is taught and learned as an expression of the values held by physicians. It includes attributes such as honesty, integrity, and being trustworthy and ethical in one's actions with patients, colleagues and administrators. It is at the core of medical practice and forms an essential component of medicine's contract with society. (12; 17) The internal conflict that arises for the individual who has been sexually harassed is therefore profound. There is shock and a sense of disbelief. There is confusion about what has happened and whether they have in some way contributed to the situation. There is uncertainty about what to do, whether they should speak and to where might they safely turn. (18)

In the face of the contradiction between what is espoused in the profession and what has occurred, the individual finds themself in a tremendously vulnerable position. They are reluctant to seek care because of the established medical hierarchy and an existing power imbalance between themself and the leadership. They have concerns about whether there will be confidentiality should they report their experience, and questions about the potential consequences they will face. Will this affect their career and if so, in what way? Will there be retaliation and if so from whom? Will their peers provide support, or will they face ostracism? There is a fear that they will not be believed.

This uncertainty falls on a previously well-established foundation of reluctance that most physicians feel when needing to seek medical care, particularly mental health care. A systematic review of the literature conducted by Kay et al. (19) revealed that 71% of doctors described themselves as embarrassed when seeing another doctor. This embarrassment was reported in multiple articles as heightened if the physician was experiencing a mental health problem. Admitting to not only needing care but needing to reveal the circumstances of being traumatized because of sexual harassment by a colleague is doubly shameful.

Given that there may be multiple very serious and detrimental responses to being sexually harassed by one's colleague, it is imperative that health care providers be prepared to provide appropriate interventions. Each individual who has had this traumatic experience will be in need of support including supportive care. Most people who have experienced harassment will have symptoms. The goals of care are to reduce their levels of distress, assist them to restore their confidence and sense of competence, and minimize the possibility of ongoing, longer-term symptoms and impairment. Recognizing that some individuals will require a more formal intervention, it is critical to have access to a therapist who is experienced in, and knowledgeable about providing, health care to physicians. (20)

THERAPIST'S PERSPECTIVE

An experienced therapist will be well prepared to engage with a patient who has experienced trauma, including sexual harassment or assault. (14) However, the

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 01:33:10, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.018

presentation of a patient, who may be a medical student, resident or colleague, may be particularly challenging. The physician therapist can relate to the medical practitioner who is presenting to them as a patient and therefore they will be able to understand, and empathize with, this individual. However, if the therapist is an attending physician in the same organization in which the harassment/assault occurred, there will almost certainly be a personal response. The physician therapist is also a colleague and peer of the identified perpetrator. The initial response may be one of disbelief. This could be expected and certainly exaggerated if the identified perpetrator is well known throughout the organization and/or an organizational leader. This has been referred to as the Therapist's Dilemma. Where does one's loyalty lie? A therapist cannot provide care to a patient if they are unable to accept the veracity of the patient's experience. If that were the situation, the therapist would necessarily withdraw from the provision of care and arrange for a colleague to assume that role.

Much more likely is that the physician therapist may have initial responses of shock, disappointment, and disillusionment. This treating physician shares the same cultural heritage referred to above with respect to the profession. There is almost certainly an existing pride and loyalty to the profession which has now come into question. Where are the standards that the therapist has come to rely upon, as guidance for professional behaviour, being upheld? Who is responsible for ensuring that these standards are in place as policies and also being respected in terms of process? How will the duty of confidentiality influence the therapeutic process? How will the engagement in therapy influence the therapist's relationship with their organization and its leadership? These questions and more will be challenges that the therapist will need to reflect upon and consider very carefully as they enter into a therapeutic relationship with the individual seeking care. These issues have the potential to put the therapist into substantial personal conflict. Their commitment must be primarily to the patient if they have accepted the responsibility of providing care. They therefore must recognize the potential impact on their collegial relationships within the organization and be prepared to navigate that reality.

Responsibilities

One aspect that the therapist should consider is any legal responsibilities they may have within the jurisdiction in which they practise. The laws relating to duty to disclose vary from country to country, and even between geographic regions within countries. In Ontario, Canada, the College of Physicians and Surgeons of Ontario mandates a duty to report when a physician has committed a sexual boundary violation with a patient. There is clear policy detailing appropriate and inappropriate behaviour for physicians towards their patients. (21) However, there are no such clear policy protections for professional boundary violations between physicians.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 01:33:10, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.018

As discussed in detail in the chapter on medical regulation (chapter 13), many countries lack clear legal obligations or guidelines for how to handle physician sexual boundary violation with colleagues, and therefore, issues of whether to report or not are relegated to the far murkier category of ethical obligations. Both the Canadian Medical Protective Association (CMPA) and the Canadian Medical Association Code of Ethics and Professionalism include provisions for an ethical responsibility to report unprofessional behaviour by colleagues. (22; 23) In both documents, the suggestion is to report unprofessional behaviour to an 'appropriate authority' such as the chief of the department.

When the physician therapist discovers this unprofessional behaviour about a colleague within the context of a therapeutic relationship, that guidance becomes far less clear. The physician therapist may find themselves questioning where their ethical obligation lies in this case: with the profession or with the patient? Reporting the offender may feel like the ethically responsible thing to do for the safety of the profession, but doing so against the wishes of the patient risks irrevocably damaging the therapeutic relationship. It is important to understand that patients seeking treatment for sexual harassment, assault or trauma are on a path towards healing, and that while they may not wish to disclose or report initially, they may want to at some point in the future. Building a strong therapeutic relationship based on trust will allow discussions about reporting to be part of an ongoing conversation.

APPROACH TO THERAPY

Recovery from trauma is not an easy journey. In this case, the trauma itself is exacerbated by the violation being executed by one's own colleague. Therefore, therapy must be approached first and foremost from a position of establishing an environment of safety. It is critical to remember that those who have suffered from being sexually harassed are very vulnerable. The creation of a safe therapeutic environment with a therapist who is trusted and engaged holds greater promise for recovery. It is important, therefore, that the therapist understands the science of safety and the need to establish trust and the social engagement system. This is knowledge that is encompassed within the polyvagal theory and is beneficial knowledge for therapists who are embarking on this type of therapy. (24)

The polyvagal theory was first described by Stephen Porges in 1994 (25) and has contributed substantially to our understanding of the biology of safety and danger, as well as the complex connection between our brain, mind and body. Over the past two decades trauma therapy has been based increasingly on an understanding of neuroscience. It therefore holds the possibility for multiple approaches to therapy. It is critical to understand that 'there is no one "treatment of choice" for trauma' (26, p. 214). There are multiple approaches to therapy with the potential to ameliorate the patient's symptoms and assist them to increasingly regain their ability to self-regulate.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 01:33:10, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.018

Although there is currently a penchant for what are described as evidence-based therapies, addressing the complexity of the impact of trauma necessitates the recognition that one size will not fit all. Research that has been conducted in neurobiology and psychotherapy has shown that the brain can change and adapt to facilitate recovery from trauma. Therefore, being sensitive to the needs of this individual patient and having multiple modalities at hand will inform the therapeutic trajectory for this patient.

Trauma therapy includes approaches to the development of relaxation skills including a focus on breathing. Focused breathing exercises can change both the brain and physical symptoms in the body. Trauma therapy also includes body-based approaches: grounding techniques; movement-based techniques, such as yoga; through to Somatic Experiencing; (27) Somatic Therapy; (28) mindfulness; and meditation practices.

Trauma therapy also incorporates cognitive strategies including Cognitive Behavioral Therapy, Prolonged Exposure, Eye Movement Desensitization and Reprocessing, and Internal Family Systems therapy. This list is not exhaustive but reflects the complexity of the patient who has had a traumatic experience and the multiple ways that the therapist may approach the treatment. The treatment will be determined by the presenting status of the patient and influenced by their personal journey through the therapeutic process.

Finally, in terms of the approach to therapy it is essential that the therapist is cognizant of the inevitability that this patient will be experiencing an underlying sense of shame. This experience is a common phenomenon for victims of trauma and most often exacerbated when one is traumatized by someone to whom the victim was close or dependent upon (26). For this reason, the therapist must understand that the very first phase of therapy that is required, which is the establishment of a relationship of safety and trust, may be a slow process which requires time and patience. Rothschild, an expert trauma therapist, identifies that the 'alleviation of shame' and 'self-forgiveness for not being able to prevent or stop what occurred' are two of the key issues in trauma therapy (28). In all cases, well-informed therapy is likely to include a focus on self-compassion.

Quite clearly it is evident that the scenario is complex and extremely challenging for the physician who finds themself in the situation of having been assaulted. It poses a problem which may seem to be insurmountable. With a skilled and experienced therapist who has a wide range of tools in their armamentarium, a goal of stability, with the associated ability to cope and self-regulate, is possible.

CONCLUSION

The pervasive culture of bullying, harassment, and abuse within the medical profession has far-reaching consequences for individuals, as well as the culture of the profession. The fear of retaliation, stigma, and career repercussions often

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 01:33:10, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.018

silences victims, perpetuating a cycle of harm. To address this problem, it is essential to create a culture of respect and accountability within medical institutions. This includes offering intelligent, personalized mental health support services to victims and survivors. Additionally, it is crucial to foster a supportive and inclusive environment where individuals feel able to speak up and seek help without fear. By prioritizing the wellbeing of health care providers and promoting a culture of respect, we can create a healthier and more equitable medical profession.

REFERENCES

1. Arnold LF, Zargham SR, Gordon CE, McKinley WI, Bruenderman EH, Weaver JL, et al. Sexual harassment during residency training: a cross-sectional analysis. The American surgeon. 2020;86(1):65–72.
2. Frank E, Brogan D, Schiffman M. Prevalence and correlates of harassment among US women physicians. Archives of internal medicine. 1998;158(4):352–8.
3. Lewis SE, Orford J. Women's experiences of workplace bullying: changes in social relationships. Journal of community & applied social psychology. 2005;15(1):29–47.
4. Fnais N, Soobiah C, Chen MH, Lillie E, Perrier L, Tashkhandi M, et al. Harassment and discrimination in medical training: a systematic review and meta-analysis. Academic medicine. 2014;89(5):817–27.
5. Jagsi R, Griffith KA, Jones R, Perumalswami CR, Ubel P, Stewart A. Sexual harassment and discrimination experiences of academic medical faculty. JAMA. 2016;315(19):2120.
6. Sanfey HMMF, Fromson JMD, Mellinger JMDF, Rakinic JMDF, Williams MP, Williams BP. Surgeons in difficulty: an exploration of differences in assistance-seeking behaviors between male and female surgeons. Journal of the American College of Surgeons. 2015;221(2):621–7.
7. Wear D, Aultman JM, Borges NJ. Retheorizing sexual harassment in medical education: women students' perceptions at five U.S. medical schools. Teaching and learning in medicine. 2007;19(1):20–9.
8. Adams EFM, Lee AJ, Pritchard CW, White RJE. What stops us from healing the healers: a survey of help-seeking behaviour, stigmatisation and depression within the medical profession. International journal of social psychiatry. 2010;56(4):359–70.
9. Bianchi EF, Bhattacharyya MR, Meakin R. Exploring senior doctors' beliefs and attitudes regarding mental illness within the medical profession: a qualitative study. BMJ open. 2016;6(9):e012598-e.
10. Babaria P, Abedin S, Berg D, Nunez-Smith M. 'I'm too used to it': a longitudinal qualitative study of third year female medical students' experiences of gendered encounters in medical education. Social science & medicine. 2012;74(7):1013–20.
11. Cruess RL, Cruess SR, Boudreau JD, Snell L, Steinert Y. A schematic representation of the professional identity formation and socialization of medical students and residents: a guide for medical educators. Academic medicine. 2015;90(6):718–25.
12. Cruess RL, Cruess SR. Expectations and obligations: professionalism and medicine's social contract with society. Perspectives in biology and medicine. 2008;51(4):579–98.
13. Professional Role: Royal College of Physicians and Surgeons of Canada; 2015 (available from www.royalcollege.ca/rcsite/canmeds/framework/canmeds-role-professional-e).

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 01:33:10, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.018

14. Johnson PA, Widnall SE, Benya FF. Sexual harassment of women: climate, culture, and consequences in academic sciences, engineering, and medicine: The National Academies Press; 2018.
15. Hart CG. The penalties for self-reporting sexual harassment. Gender & society. 2019;33 (4):534–59.
16. Brower KJ, Riba MB. Physician mental health and well-being: research and practice: Springer International Publishing; 2017.
17. Cruess RL, Cruess SR, Steinert Y. Teaching medical professionalism: Cambridge University Press; 2009.
18. Stone L, Phillips C, Douglas KA. Sexual assault and harassment of doctors, by doctors: a qualitative study. Medical education. 2019;53(8):833–43.
19. Kay M, Mitchell G, Clavarino A, Doust J. Doctors as patients: a systematic review of doctors' health access and the barriers they experience. British journal of general practice. 2008;58(552):501–8.
20. Myers MF, Gabbard GO. The physician as patient: a clinical handbook for mental health professionals (1st ed.): American Psychiatric Pub.; 2008.
21. Boundary Violations: College of Physicians and Surgeons of Ontario (updated December 2019; available from www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Boundary-Violations).
22. Reporting Another Physician: Canadian Medical Protective Association; 2016 (updated 2016; available from www.cmpa-acpm.ca/en/advice-publications/browse-articles/2010/reporting-another-physician).
23. Canadian Medical Association Code of Ethics and Professionalism 2018 (updated 2018; available from https://policybase.cma.ca/link/policy13937#_ga=2.10110005.1643337144.1646247258-2062090102.1646247258).
24. Dana D. Polyvagal flip chart: understanding the science of safety (1st ed.): W. W. Norton; 2020.
25. Porges SW. The polyvagal theory: neurophysiological foundations of emotions, attachment, communication, and self-regulation. Norton Series on Interpersonal Neurobiology: W. W. Norton; 2011.
26. Van der Kolk BA. The body keeps the score: brain, mind, and body in the healing of trauma: Viking; 2014.
27. Levine PA. Healing trauma: a pioneering program for restoring the wisdom of your body: Sounds True; 2008.
28. Rothschild B. 8 keys to safe trauma recovery: take-charge strategies to empower your healing (1st ed.): W.W. Norton; 2010.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 01:33:10, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.018