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Building therapeutic alliances with patients in treatment for low back pain: A focus group study

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Abstract

Background and Purpose: Low back pain is a multidimensional disorder and a biopsychosocial management approach is recommended. However, recent data indicates that physiotherapists mainly focus on biomechanical aspects in treatment and struggle with addressing psychosocial barriers for recovery. We wanted to explore how physiotherapists express their experiences of building therapeutic alliances within a biopsychosocial perspective of low back pain.

Methods: Qualitative focus-group interviews were performed with five physiotherapists on two occasions with 6 months in between. Data were analyzed within a hermeneutical perspective with decontextualization and recontextualization, and identification of themes.

Results: Four main themes were identified from the analyses: (1) *An ideal standard*: Presence, empathy and applying the biopsychosocial perspective is central for building therapeutic alliance. (2) *Time-consuming*: Active listening and personally adapted treatment is important and time-consuming. (3) *Challenging area*: Advanced clinical reasoning is needed to understand and modify complex barriers for recovery. Clinical experience is sometimes necessary to integrate the psychological and social domains into physiotherapy management. (4) *The art of balancing*: Important to apply sensitive communication to help patients gain new insight. Some heavy psychosocial demands on patients may be outside physiotherapists' professional competence.

Discussion: The physiotherapists in this focus group study expressed a shared view that therapeutic alliance should build upon person-centering, motivational communication, and facilitation of lifestyle adjustments within a biopsychosocial perspective of low back pain. Complex clinical reasoning necessary as the optimal cause-corrective treatment strategies were often not obvious. Time and tools to uncover and modify relevant psychological obstacles for recovery were perceived challenging and partly dependent on clinical experience. Addressment of psychosocial obstacles for recovery should be included in basic as well as postgraduate curriculums for physiotherapists. Collaborative practice support

strategies like peer guidance and better platforms for interprofessional collaboration and decision support could contribute to improve practice in the psychosocial domain.

KEYWORDS
back care, client centered practice, communication, physiotherapy

1 | INTRODUCTION

Low back pain is a main cause of disability globally, and the consequences and maintaining factors are complex, demanding a multidimensional management approach (Dutmer et al., 2019; Foster et al., 2018). The biopsychosocial model consider interaction between various health determinants and provide a basis for comprehensive care (Johnson et al., 2018). Within this model, management should include measures of possibly modifiable contributing factors like pain self-efficacy, depression, anxiety, sleep quality, social functioning and work absenteeism (Tagliaferri et al., 2020). However, integration of the psychosocial domain in low back pain physiotherapy management is not optimal (Husted et al., 2020; Schaumberg, 2020). Physiotherapists have reported a lack of confidence to apply psychosocial strategies in their practice (Driver, Lovell, & Oprescu, 2019) and barely include psychosocially oriented illness perceptions in history taking (Roussel et al., 2016). In line with this, a qualitative survey indicated that self-management support provided to patients by physiotherapists are affected by a lack of tools and mainly related to biomechanical factors (Hutting et al., 2020). Patients, however, want integration of psychosocial perspectives (Chou et al., 2018).

A critical review has also indicated a lack of research on how the biopsychosocial model is conceptualized in physiotherapy (Mescouto et al., 2020). Social aspects seem to be frequently neglected while the psychological dimension tend to be reduced to cognitive-behavioral factors. The complexity of low back pain calls for a wider clinical perspective. Recently, a contemporary framework for the biopsychosocial model in musculoskeletal physiotherapy has been presented, based on an evolutionary concept analysis (Daluiso-King & Hebron, 2020). Communication was found to scaffold the framework, supporting the exploration of a person's lifeworld through the therapeutic alliance. Increased knowledge is needed on how to increase the capacity of therapists to develop soft skills for enhancing therapeutic alliance in clinical musculoskeletal practice (Babatunde et al., 2017; Sondena et al., 2020). On this background we aimed to explore a group of physiotherapists' shared experience of building therapeutic alliance for low back pain.

Study question:

How do physiotherapists experience the process of building therapeutic alliances with patients in biopsychosocially oriented treatment of longstanding low back pain?

2 | METHOD

2.1 | Design

We chose to use a hermeneutical design with an interpretative approach to investigate the experiences and perceptions of the physiotherapists. This design involves focusing on the participants' experiences and describe these experiences in the words of the participants. People's experiences are, however, always contextualized, and this requires interpretation in the situational context. In this way, the study becomes hermeneutical when the researchers makes an interpretation of the meaning of the experiences (Creswell, 2007). Thus, our study design is a hermeneutical one, promoting the participants' own voices and interpreting their voices in the context of current physiotherapy practice (Creswell, 2007; Granskär et al., 2012).

2.2 | Setting

This study was undertaken as part of an observational study involving a range of physiotherapy clinics (Nordstoga et al., 2019). The setting was a collaboration group for clinicians and researchers in musculoskeletal physiotherapy.

2.3 | Sampling and recruitment

The inclusion criteria were to be a physiotherapist, to have experience-, current clinical activity and interest for patients attending physiotherapy for low back pain. Physiotherapists in the project group for the quantitative study (Nordstoga et al., 2019) were invited to participate in this focus group study to share their experiences. The present study thus recruited from a group of physiotherapists working with patients with low back pain and having volunteered to contribute in a research project. We considered this group a potential source of rich information on building therapeutic alliances within a biopsychosocial perspective of low back pain. Thus, the sample is strategic (Marshall et al., 2006). Information about the current study were provided oral in face-to-face meetings and supplemented with a written invitation letter via emails. Five physiotherapists gave their written consent to participate in the study. The physiotherapists who did not respond to the invitation letter

were not asked to give any reason for choosing not to participate. To maintain the participants' anonymity they will be referred to as participant no. 1, no. 2, and so on.

2.4 | Data collection

We chose to use focus group interviews as our data collection method. The aim of this method is to collect descriptions about the participants' experiences with respect to interpretation of the described experiences (Tjora, 2018). Group interviews are suitable for investigating the characteristics and dynamics of groups as constitutive forces in the construction of meaning and practices (Kamberelis & Dimitriadis, 2005). The participants in our study are experienced in their field; they interact closely with the patients and are in a position to facilitate, promote or prevent new ways of interactions and patient-therapist cooperation. To allow for shared perspectives to develop and be expressed, two group interviews were conducted with the participants, the second one approximately six months after the first one. In the first group interview all five physiotherapists participated, in the second one four of the physiotherapists participated. The second group interview were performed as an elaboration and member checking of the first one. Member checking, also known as participant validation, is a technique for exploring credibility of results and maintaining validity in qualitative research (Birt et al., 2016; Candela, 2019).

The authors developed a semi-structured interview guide for interview number one. The guide built on dialog with colleagues, the authors' clinical and scientific experience and a literature review of topics related to therapeutic alliance and to physiotherapists' approaches to patients with low back pain. Before the interviews, we discussed our expectations and the themes that we were eager to explore. Examples of questions in the guide are; "What do you think it takes to be a good physiotherapist?" and "What do you expect when you get a patient with low back pain?" and "In your opinion, what is important to motivate patients and increase compliance?" The second focus group interview took its point of departure in subjects emerging from the first group interview. These are examples of subjects discussed in this interview; what are the most essential tools to build therapeutic alliances, and personal experiences of working with complex and unspecific cases. The interview guide was used as a "to-do list" helping the interviewer to cover all subjects. Thus, all subjects in the interview guide were discussed, but every single question in the guide were not necessarily posed. The participants were provided information about topics in advance of the interviews, but not the whole topic guide. The interviews were carried out by both authors, the last author being a moderator and the first being a co-moderator and taking notes. The moderator and the participants had not met prior to the first interview, and the moderator was presented as a researcher from the university. Both authors are female physiotherapists and researchers, and the participants knew the first author from the larger study, which this study is nested in. The last author is experienced within qualitative research and -data collection. The first author is experienced within low back pain clinics and research.

Before the interview started, information about the study was repeated, emphasizing the study's aim and research question as well as research ethics, including volunteerism, informed consent, and confidentiality. Both interviews lasted for about 90–120 min. The interviews took place after working hours in an office at the primary physiotherapy service administration. All topics in the topic guide were discussed during the interviews, and both interviews were audio-taped and transcribed verbatim. The transcriptions were without personally identifiable data and each participant was assigned a number.

2.5 | Data analyses

Both authors analyzed the data, first separately then collectively. During the analytical process, we aimed to be open minded, curious, and reflective about our own pre-understanding and in promoting the participants' genuine voices. Initially in the analysis process, we held a workshop with the participants discussing our preliminary findings and thoughts, getting feedback and their recognition.

There is a variety of approaches to analyzing qualitative data, though these have some analytical elements in common, for example, the de- and re-contextualization of data. First, the authors read and re-read the interview transcripts separately, highlighting significant excerpts, statements, and quotes. Statements illuminating the participants' experiences and perceptions were classified as significant. Such elements were often identified by the participants' use of emotional or value-laden expressions, such as "a difficult group of patients" "very demanding" or "very important." This first reading and re-reading after the interviews is called *horizonalization* (Creswell, 2007). The rest of the analysis was performed in close collaboration between the two authors. We independently read the excerpts that contextualized the highlighted statements, and we independently coded them. Then, we discussed our coding until we reached a consensus on *clusters of meaning* across transcripts. Examples of such clusters of meaning; demanding, preferable, difficult, and gets tired. Finally, we wrote a composite description that presented the *essence* of the participants' experiences and the underlying *structure/themes* of their experiences (Creswell, 2007). Examples of the analytical process are shown in Table 1.

In the results section, these findings are illustrated by the most meaningful quotations from the interviews, and all participants are represented through the quotations.

2.6 | Ethical considerations

Both authors are physical therapists and researchers. We are aware that our experiences as therapists influenced our pre-understanding of important components in successful physiotherapy treatment. To avoid our pre-understanding governing our investigation we

TABLE 1 Examples from the analytical process

Horizonalization	Cluster of meaning	Essence	Theme
"It requires quite a lot of work by the therapist to build trust"	Demanding	Building trust	A normative standard
"It is nice if the patient feels understood and cared for, if you have the time"	Preferable	Takes time	Time-consuming
"It is not always easy to convince them"	Difficult	Communication	Challenging
"I have colleagues that is totally exhausted"	Gets tired	Burdensome	The art of balancing

consulted fellow researchers and previous research on the topic. Further, we aimed at transparency at all stages of the research process, describing every step of the research process and our interpretation of empiricism. Thus, we have strived to achieve dependability and confirmability (Lincoln & Cuba, 1985). All participants were assured that participation was voluntary and that they could withdraw at any moment without any consequences and they all signed an informed consent. The study was approved by the Regional Committee for Medical and Health Research Ethics (registration no. 2013/2244/REKmidt).

3 | RESULTS

Focus group interviews are well suited to investigate the construction of meaning and practices. While this is at the core of what we wanted to investigate, participating in focus group discussions also implies that it might be hard to express other opinions than the implicitly adopted norms in the group. Five physiotherapists with interest for and ongoing experience with the treatment of patients with low back pain were included. The length of the participants' clinical experience varied. The sample consist of both female and male physiotherapists, and therapists with long clinical experience and with shorter clinical experience. The participants were active in a collaboration network for low back pain physiotherapy. We found that even though the participants generally shared the same experiences, it differed somewhat in how they related their experiences. As the results show they all experienced building therapeutic alliances with patients as a standard for competent physiotherapists, simultaneously as they also found it time-consuming, challenging and as an art of balancing. In the result section we will elaborate on the similarities and differences in the participants' perceptions of their shared experiences.

3.1 | Ideal characteristics of physiotherapists

In both focus group discussions, the physiotherapists agreed that the patient-therapist relationship was essential for the outcome of the treatment. Building trust and facilitating an open dialog, in addition to being an expert on biomechanical issues, were perceived as an ideal standard characterizing a competent physiotherapist. Participant no. 1 expressed: "It is about the patient-therapist role, about how the chemistry is there, and earning the patients' trust. Creating trust requires quite a lot of work from the therapist." Participant no. 4 elaborated a little bit more on this trust building saying:

> Quote: "Presence and empathy, the feeling of being taken care of. You get a deeper breath, you feel accepted, you feel included. Good things start to happen in the body. And to have time, I believe that is half the treatment."

To fulfill this standard was perceived as exiting and interesting, but also challenging. Participant no. 5 explained:

> Quote: "It is important to early uncover if the patients are afraid, and what their worries are. Is it not coming back to work? Is it the pain as such, or is it the persistence of the pain? To clarify this a little early is our essential role here. This is what I find exiting, when you can communicate with a patient that understands that things are connected and when you do not meet someone with high resistance against reflecting around the pain. It can be challenging and exiting, I believe, to uncover their thoughts and beliefs about this."

Though everybody agreed that building a therapeutic alliance with the patients is essential for the outcome of the treatment we found some variations in how they emphasized this and how the psychosocial domain was implemented into practice. Such a variation can be illustrated by the words of participant no. 5: "It is something with the patient-therapist relation, it increases the effect. What it means remains to be defined. There are limits as to how much you need. Some are very fond of talking." What participant no. 5 is expressing here we understand as an ambivalence about what a therapeutic alliance really should entail, and even maybe a little restraint concerning the open dialog as "some are very fond of talking." This restraint may indicate an uncertainty in one's own capacity to address psychological aspects of low back pain.

3.2 | Time-consuming

Fulfilling the normative standard of a competent physiotherapist was unanimously expressed as time-consuming. On the one hand, the participants highlighted the importance of time and that they as

independent therapists were able to prioritize time for the individual patients. On the other hand, they also work at a tight schedule. How they balanced this tightrope of their time schedule appeared to vary. While some of the participants highlighted advantages of being a self-employed person, others emphasized disadvantages of such organization of work. Participants no. 5 and no. 3 seems to belong to the first group, proclaiming that: "What we have that is unique is the time. I believe that time is our great resource and strength. In many cases the anamnesis that took too long time is the most important part" (no. 5). "You can't be sure of getting all information the first day. But maybe next time, when they have gone home and thought about what you said the first time" (no. 3). Discussing how to conduct an anamnesis in patient assessment and how long time to spend on this engaged the participants. Participant no. 4 describe a dilemma that several of the participants confirmed that they recognized:

> Quote: "The pros with the long anamneses are that the patients feel very heard and taken care of. So, provided you have the time it is really smart. But it is a bit scary asking those questions, because it can turn out that they say "Well, it started in 1970." Sometimes it is OK to be a bit specific, like for instance: "Why are you here today?" I believe it is depending on how much you ask. 90% of the population have something that we can talk about, right. Sometimes it can be useful to include a lot of other stuff, but then you have quite another package. And other times I only have this hour and then the next patient is coming, so now we must stick to this."

This dilemma between prioritizing to initiate a time-consuming anamnesis, which they know might be "really smart," and being "a bit specific" due to a tight schedule and the next patient is a dilemma of their everyday practice. Another element, which we also find interesting, is the "scary" part of asking "those questions" which might lead to "quite another package." As we understand it this "other package" is a package that might include unexpected psychological, social or environmental aspects of living with low back pain. Thus, it might be better to stick to the more familiar biomechanical aspects of the issue, which might not be as time-consuming. Participant no. 3 expressed some perceptions that reflects the time squeeze of the participants' everyday practice: «It is good that they buy what we sell. I do not bother to spend my time if they do not do the exercises that I have given them."

3.3 | Challenging area

The need for patience, flexibility and broad competence in order to target the cause of low back pain was agreed on in this group of physiotherapists: One of the challenges the participants experienced was the complexity of low back pain which sometimes led to uncertainty about how to best help the patients. Discussing how to best target the cause of back pain participant no. 1 said:

> Quote: "On one side it is a somewhat difficult patient group because many have had their complaints for many years. And then you can choose to go in and target it symptomatically or you can try to go to the cause in a way." (no. 1)

Participant no. 5 expressed it this way: «Working with these patients can be demanding. It can be hard not having a quick fix, and instead use other tools that can be unfamiliar for the patients." Again, there was some variation in which treatment tools and therapist skills our informants emphasized. Communication was shared as important. While some focused on empathetic listening and communication about patients' beliefs and thought, others were more focused on selling in the program: This difference in focus are illuminated in the following quotes:

> Quote: "I believe it is very important how we communicate our thoughts. We must avoid overwhelming the patient with information, especially the patient that is afraid to begin with. It increases the pain picture." (no. 4)

> Quote: "Communication and selling in the program can be challenging. Making them believe in what is a bit diffuse for us. Yes, a salesperson in some way." (no. 3)

As we understand it the participants here agree on the importance of communication and information, but also discuss practical approaches and challenges. Such challenges are "how much information is optimal?" and "to what time?" and how to motivate a patient about an exercise program if you are still not positive about the main cause of the patient's low back pain. Participant no. 4 expressed: "I do not find it difficult to convince (the patient) about the connections if I know what the connections are." Our interpretation is that the essence in this quote are reflected by the words "If I know what the connections are." Triggering factors for low back pain may be complex, and to feel confident enough to navigate through the biopsychosocial spectrum requires some clinical experience as a physiotherapist. Discussing these challenges, participant no. 2 sums up:

> Quote: "I believe that you need a bit of experience as a physiotherapist. Having worked with the mechanical factors at first and got to know and seen that you can ease symptoms and the like and be safe in that. I believe that it takes a whole lot to become a good therapist on the complex. It takes more time." (no. 2)

We found that even though the participants perceived the challenges a little bit different they all agreed on the importance of communication, the need for advanced clinical reasoning given the complexity of low back pain and therefore; a need for clinical experience as a physiotherapist.

3.4 | The art of balancing your practice

There was agreement in the group that in order to obtain treatment success and to avoid burn-out for the therapist there is a fine balance between a narrow biomechanical focus and going too far into the psychosocial domain. This balancing can be interesting but also demanding. Participants no. 3 and no. 5 expressed this:

> Quote: "Challenges are fun, but it is hard to assess a back in many cases. Sometimes you only find something vague and cannot put your finger on something structural." (no. 3).

> Quote: "This demanding complex patient is not always easy to sort out. But it is fun when you have interventions that help." (no. 5).

While all aspects of the biopsychosocial models were agreed upon as relevant in anamnesis and taken into consideration, our participants perceived a risk of exceeding their competence as a physiotherapist as well as their emotional capacity in some cases.

> Quote: "I do know colleagues that are completely exhausted because they are psychologists and pedagogics, and it is marriage counseling and they become exhausted. Maybe it started with a simple low back pain, and then all these other factors came up. Listening to one after the other can be burdensome. You can become worn out after the day if there are many of that type. I could not be a psychologist." (no. 4)

> Quote (response to quote above): "Me neither. You get worn out if it is a lot of the heavy stuff." (no. 1)

The positive and stimulating experiences of the clinical reasoning process and of helping patients gain new insights, and thereby long-term improvement, was also expressed:

> It is something about getting inside, and to reflect on what can I do here. It may be something important here. (no. 5)

In summary, while the "time-consuming" and "challenging area" themes were more connected to practical organization of the physiotherapists' work, the "normative standard" and "the art of balancing" themes were more overarching and connected to ethical principles and the therapists' perspective on low back pain and its appropriate management. We found agreement in the group that longstanding low back pain was a multidimensional phenomenon and that patient-centered care aiming on behavioral change was a normative standard. However, the group dialog brought up some nuances in the participants' preferred approaches to obtain such a therapeutic alliance.

4 | DISCUSSION

In this focus group study, we explored the experience of physiotherapists of building therapeutic alliances with patients within a biopsychosocial understanding of low back pain. We found four main themes: An ideal standard, time-consuming, challenging area, and the art of balancing your practice. The therapists shared a multidimensional perspective on low back pain, though some tension appeared connected to how and whether to address the psychological aspects of low back pain. Person-centering and communication with active listening were collectively described as main tools in building therapeutic alliances with the patients. The art of balancing as a professional between helping patients towards new insights by applying time and unfamiliar tools, and on the other side the importance of professional limits was also expressed via the group dialog. The therapists shared a closeness to the complexity of low back pain and an enthusiasm above being able to uncover connections in close cooperation with the patients, but also a humility above the reality that sometimes the connections were too complex to fully comprehend.

Communication scaffolds the contemporary conceptual framework of the biopsychosocial model in musculoskeletal physiotherapy and supports explorations of the patients' lifeworld through the therapeutic alliance (Daluiso-King & Hebron, 2020). The biomedical theme included the sub-theme education, where information transfer was central. For information to be meaningful, it should be integrated into the individual patients' complexly interrelated social, psychological and biomedical context. This is in correspondence with the findings in the present study. Our participants agreed on the importance as well as the challenges of communication and emphasized different aspects of communication. Some of our participants described embracing the complexity of exploring these interrelationships in close cooperation with the patients. Others were more reluctant and emphasized the importance of staying within professional borders. This relates to the master themes of communication and individualized care which were intricately linked to the process of building a therapeutic alliance, according to the framework (Daluiso-King & Hebron, 2020). This is also in correspondence with patients' own experience of personally adapted education as a meaningful aspect of the therapeutic alliance (Unsgaard-Tondel & Soderstrom, 2021).

Though applying a biopsychosocial perspective of low back pain emerged as a shared normative standard, the contents and tools towards a therapeutic alliance were varying. Some tension between participants were expressed that acknowledging the multidimensional nature of low back pain did not automatically mean that going into the psychosocial challenges was the optimal treatment strategy. This may indicate an uncertainty in one's own capacity to address psychological aspects of low back pain which will be consistent with the findings of another study (Driver, Oprescu, & Lovell, 2019). Driver and coworkers also found that though physiotherapists

incorporated an advanced biopsychosocial insight into low back pain, the extent to which psychosocial strategies and tools were applied, depended on factors like earlier treatment success with-, and confidence towards such strategies. Yet another qualitative study also found that while physiotherapists recognized the multi-dimensional nature of low back pain and the need to manage it from a biopsychosocial perspective, the clinical addressment of psychological factors was viewed as challenging due to a lack of training and guidance (Cowell et al., 2018). While some of our participants were reluctant to address complexity, others expressed an enthusiasm for reflecting on deeper connections in close cooperation with the patient. This finding may be seen in the context on earlier studies indicating a general lack of integration of the social dimension and reduction of the psychological dimension (Mescouto et al., 2020). Moreover, physiotherapists have expressed a wish for further training in psychosocial strategies in their practice (Driver, Lovell, & Oprescu, 2019). In our study, participants expressed clinical experience as a key to confidence when assessing of psychosocial factors. This view of clinical experience as crucial was shared despite a varying length of clinical experience in our focus group. Schaumberg also reported that clinicians with less than 5 years of experience asked fewer psychosocial questions than more experienced colleagues (Schaumberg, 2020).

Contributing to improvement for patients with heavy psychosocial obstacles, for example, trauma or high degree of resistance, was experienced as challenging of all participants. Still, some participants expressed self-efficacy towards contributing to correct mistaken beliefs and thereby remove possible psychological obstacles for recovery. Others mentioned applying tools that were unfamiliar for the patients as a potential barrier. Affirming the causal mechanisms in the most complex cases was mentioned as another barrier. Our participants unanimously expressed that sufficient time for anamnesis, quality communication and ensuring that their message had been understood as intended was a key to obtain therapeutic alliance. Moreover, the risk of too much information and time spent as well as the challenge with patients dominated by fear and pessimistic beliefs was acknowledged in the group. Time has also been identified as a main barrier in a previous study, where especially the support towards emotional disclosure were seen as challenging in patients with high levels of distress (Cowell et al., 2018). In our study, both the risk of going beyond your competency, and the risk of compassion fatigue were expressed as barriers for addressing possible psychological obstacles for recovery.

4.1 | Strengths and limitations

The authors have aimed at thoroughness and transparency in planning, implementation, interpretation, and reporting of the study. The participants were recruited from the collaboration group in a quantitative study and had volunteered to participate.

4.2 | Implications for physiotherapy practice

The physiotherapists in this focus group study expressed a shared view that therapeutic alliance should build upon person-centering, motivational communication, and facilitation of lifestyle adjustments within a biopsychosocial perspective of low back pain. Complex clinical reasoning and close collaboration between patient and therapist was embraced as an integral part of practice. A humility was expressed towards the fact that the optimal cause-corrective treatment strategies were often not obvious. Time and tools to uncover and modify relevant psychological obstacles for recovery were perceived challenging and partly dependent on clinical experience. Another recent study found that newly graduated physiotherapists wanted accessible and individualized mentoring (Forbes et al., 2021). This may imply that tools, techniques and procedures for addressment of psychosocial obstacles for recovery should be included in basic as well as postgraduate curriculums for physiotherapists. Collaborative practice support strategies like peer guidance after education, and better platforms for interprofessional collaboration and decision support could contribute to improve practice in the psychosocial domain.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

AUTHOR CONTRIBUTIONS

Idea and design: Monica Unsgaard-Tøndel and Sylvia Søderstrøm. *Recruitment*: Monica Unsgaard-Tøndel. *Data collection*: Sylvia Søderstrøm assisted by Monica Unsgaard-Tøndel. *Data analysis*: Sylvia Søderstrøm assisted by Monica Unsgaard-Tøndel. *Writing*: Monica Unsgaard-Tøndel and Sylvia Søderstrøm. *Approving final version*: Monica Unsgaard-Tøndel and Sylvia Søderstrøm.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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