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Mindfulness-based Narrative Therapy for Depression in Cancer Patients

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Mindfulness-based narrative therapy (MBNT) is a therapeutic intervention for the treatment of depression in cancer patients. In a previous randomized controlled trial, MBNT was found to ameliorate anxiety and depression, improve functional dimensions of quality of life, and enhance treatment adherence. In this review, we describe MBNT and its technical characteristics in the context of other psychotherapeutic interventions for depression in cancer patients. We highlight needed adjustments to other narrative approaches and recommend clinical modifications tailored to the needs of cancer patients that are intended to encompass the client's initial depressive narrative. The narrative construction is supported by emotional regulation and attachment relationships on the one hand and by individual and social linguistic capabilities on the other. Through destabilization of the depressive narrative, MBNT facilitates the emergence of new meanings using both verbal and non-verbal techniques based on mindfulness. The attitude and practice of mindfulness are integrated throughout the therapeutic process. In summary, MBNT makes use of linguistic interventions, promotes mindfulness and emotional regulation, and can be adapted specifically for use with cancer patients. Copyright © 2013 John Wiley & Sons, Ltd.

Key Practitioner Message

- In this review, we describe mindfulness-based narrative therapy (MBNT) for the treatment of depression in cancer patients.
- In a previous controlled trial, we found significant benefits of MBNT in terms of reducing depressive symptoms and improving treatment adherence and quality of life in depressed, non-metastatic cancer patients.
- Narrative construction is socially and neurobiologically derived.
- MBNT makes use of linguistic interventions, promotes mindfulness and emotional regulation, and can be adapted specifically for use with cancer patients.
- MBNT is proposed as an interesting and promising intervention, particularly for patients with somatic pathologies.

Keywords: Cancer, Oncology, Depression, Mindfulness, Narrative Therapy, Combined Treatment

INTRODUCTION

Depression in cancer patients is well documented in terms of its prevalence (Sellick & Crooks, 1999; Trask, 2004; Watson, Homewood, Haviland, & Bliss, 2005) and effects on quality of life (QOL), treatment adherence, and the emotional burden of caregivers (Trask, 2004). Combined psychological and pharmacological treatment for depression is more effective than either approach alone (de Jonghe, Kool, van Aalst, Dekker, & Peen, 2001; Glik, 2004; Hirschfeld et al., 2002; Keller, McCullough, Klein, Arnow, Dunner, et al., 2000; Keller, McCullough, Klein, Arnow, et al., 2000; Pampallona, Bollini, Tibaldi, Kupelnick, & Munizza, 2004). Numerous authors have advocated a combined approach for the treatment of depression in cancer patients (Ell et al., 2008; Rodin et al., 2007; Strong et al., 2008) and have recommended evaluating alternatives to cognitive-behavioral therapy (Newell, Sanson-Fisher, & Savolainen, 2002).

It is generally agreed that psychological interventions should be an integral part of cancer care (e.g., http://guidance.nice.org.uk/Topic/Cancer). Many psychotherapeutic approaches have been used in psycho-oncology (Watson & Kissane, 2011). Cognitive therapy has been the subject of most research. Two previous meta-analyses focusing on cognitive therapy techniques in cancer patients (Graves, 2003; Luebbert, Dahme, & Hasenbring, 2001) concluded that this approach is useful for the general population of cancer patients as well as for patients with specific types of cancer (Tatrow & Montgomery, 2006a, 2006b). However, further evidence is needed from randomized controlled trials with large samples

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(Horne & Watson, 2011; Newell et al., 2002; Tatrow & Montgomery, 2006a, 2006b).

Most empirical research on alternatives to cognitive therapy focuses on group approaches, which have important psychosocial benefits. For example, supportive-expressive group psychotherapy is helpful for women with metastatic breast cancer (Kissane et al., 2007). Supportive-expressive group psychotherapy is a long-term, unstructured, group intervention for patients with advanced disease who are having difficulty adjusting to their illness. Meaning-centered group psychotherapy has shown to be useful for patients with advanced cancer (Breitbart, 2002; Breitbart et al., 2010). This approach is based on the work of Frankl (1984) and aims to help patients find meaning in their illness experience and focus on living rather than dying (Breitbart & Heller, 2003; Greenstein & Breitbart, 2000). In addition to group approaches, individualized therapies also show promise. For example, dignity therapy (Chochinov et al., 2005) is a unique, individualized, brief psychotherapy developed to relieve distress and enhance the end-of-life experiences of terminally ill patients by providing them with an opportunity to remember and/or reflect upon things of importance to them. Dignity therapy has been found to improve patients' QOL and sense of dignity and to benefit families as well (Chochinov et al., 2011).

The aim of this paper is to describe mindfulness-based narrative therapy (MBNT) (Rodríguez Vega & Fernández Liria, 2012), an empirically supported novel treatment for depression in cancer patients, and to identify key elements of this approach.

NARRATIVE THERAPY: DEFINITIONS AND THEORETICAL FRAMEWORK

Narrative therapy (NT) is a psychosocial form of therapeutic intervention used with individuals, families, groups, and/or organizations (Snedker Boman, 2011). NT is based on narrative theory as well as social constructivism, a philosophy holding that there is no a unique, objective reality directly accessible to human beings through their senses. Instead, reality is constructed through language and narrative description in the intersubjective field between human beings (Anderson, 1997; Berger & Luckman, 1966; Gergen & Kaye, 1992). As such, NT is not limited to any particular therapeutic school of thought and could be interpreted and applied by therapists from diverse theoretical backgrounds (Angus & McLeod, 2004). Narrative is a core therapeutic process in the sense that all therapy involves the telling of stories (Fernandez Liria & Rodriguez Vega, 2001; McLeod, 1997; Rodríguez Vega & Fernández Liria, 2012).

Currently, there is no universally agreed-upon definition of "narrative," but generally speaking, a narrative is a story about a sequence of events that occurs in time and is organized in a script. Through narratives, human beings give meaning to what happens to them (Clandinin & Connelly, 2000). Different approaches to therapeutic practice and research focus on different storytelling structures (Angus & McLeod, 2004) ranging from the socially oriented nature of narrative psychology to the "inner self" orientation of most conventional psychotherapies (Angus & McLeod, 2004). This range reflects tension within the field of narrative psychology, which employs both postmodern ideas such as the centrality of language and discourse in human affairs and concepts drawn from existential theory, such as human self-agency, empowerment, and responsibility (Avdi & Georgaca, 2007a, 2007b; Polkinghorne, 2004; Wallis, Burns, & Capdevila, 2011). The narrative metaphor implies that human psychology has an essentially narrative structure, such that human life can be seen as storied and narratives can be seen as the organizing principle for human action (Sarbin, 1986).

Self-narratives (narratives about oneself) can become problematic when they restrict cognitive and affective diversity, thereby limiting behavioral possibilities. For instance, depressive clients often organize their self-narratives around themes of loss, helplessness, and hopelessness, preventing other possible themes from being constructed (Machado & Gonçalves, 1999; Ribeiro, Bento, Salgado, Stiles, & Gonçalves, 2011). Therapy can be construed as a process of "story repair" in which problematic self-narratives are reconstructed to become more coherent, complex, and inclusive (Avdi & Georgaca, 2007a, 2007b). Accordingly, the therapist serves as a witness to the client's storytelling and a coeditor of the unfolding narrative (Anderson, 1997).

The relative paucity of studies on NT (Etchison & Kleist, 2000; Rodríguez Vega et al., 2012; Rodriguez Vega et al., 2010) may be related to its recent emergence as an empirical paradigm and its emphasis on a subjective and qualitative understanding of problems. However, the influence of narrative perspectives on practice and research in psychotherapy is growing (Gonçalves & Stiles, 2011; Meisel & Karlawish, 2011). Recent publications in this area include our clinical studies on the use of NT for the treatment of depression in cancer patients (see the succeeding texts), a clinical trial examining the utility of NT for the treatment of depressive disorders in adults (Vromans, 2007; Vromans & Schweitzer, 2011), a randomized clinical trial on the effect of NT on pain perception in cancer patients (Cepeda, Chapman, & Miranda, 2008) and other relevant, recently published empirical research (Gonçalves & Stiles, 2011; Goncalves et al., 2011; Levitt & Piazza-Bonin, 2011; Osatuke et al., 2011; Ribeiro et al., 2011; Vromans & Schweitzer, 2011; Zweig, Angus, Monette, Hollis-Walker, & Warwar, 2011).

Outcome studies based on randomized, controlled trials are the "gold standard" of clinical effectiveness research (Margison et al., 2000). Our group carried out a clinical study comparing the efficacy of MBNT plus antidepressants (combined therapy) versus antidepressants alone (standard treatment) in patients diagnosed with major depression and non-metastatic breast, lung, or colon cancer (Rodriguez Vega et al., 2010). We found that combined treatment was associated with greater treatment compliance and improvement in functional dimensions of QOL at 12 and 24 weeks post-treatment. We also conducted a qualitative study by using focal discussion groups of patients to examine the meaning of these quantitative results in-depth (Rodríguez Vega et al., 2012). Our interest was in understanding the subjective meaning of QOL dimensions and evaluating the contribution of psychotherapy to the process of adjusting to illness. Patients in combined treatment found MBNT helpful and were more likely than patients in standard treatment to report positive changes consistent with post-traumatic growth, such as increased social intimacy and a new found ability to re-evaluate the meaning of situations. The methodology and results of the aforementioned studies are described in detail elsewhere (Rodriguez Vega et al., 2010; Rodríguez Vega et al., 2012). With these findings, we believe that MBNT could be a useful approach for the treatment of depression in cancer patients. However, as yet, no studies have been conducted to directly compare the efficacy of MBNT versus other types of therapy.

MINDFULNESS-BASED NARRATIVE THERAPY IN CANCER PATIENTS

Our choice of NT over other therapeutic methods for the treatment of cancer patients is motivated by the fact that it is custom built for each patient, such that the patient's narrative of his or her own personal experience guides the intervention and the therapist and patient co-construct new meanings for despair, suffering, or disablement narratives. The narrative perspective allows the therapist to match strategies to specific individuals and their distress, that is, to move from a therapy-centric orientation to a patient-centric approach. In contrast to cognitive therapy (Horne & Watson, 2011), MBNT emphasizes acceptance rather than change strategies, offers no training in changing thinking patterns, re-examines knowledge that is taken for granted, and promotes metacognitive awareness (seeing thoughts as just thoughts rather than reflections of reality). In contrast to other meaning-making interventions, MBNT is not limited to existential issues (Breitbart et al., 2010).

Our view of NT is broader compared with other authors. We consider narrative construction to depend not only on social or linguistic construction as emphasized by traditional narrative theory (Clandinin & Connelly, 2000) but also on a construction based on interpersonal neurobiology (Siegel, 1999). We believe that personal experience can be studied in a manner that maintains the notion of human agency and subjectivity while attending to the interactional, social, and cultural embeddedness of narrative production (Avdi & Georgaca, 2007a, 2007b; Crossley, 2000).

The major goal of NT is the creation of alternative stories that are different from the main narrative, which contains the problem. In this sense, psychotherapy is about meaning transformation. Patients display and make meaning of their lives through the stories they tell andc retell to their therapists (Gonçalves & Stiles, 2011). New narratives can arise through both top–down (from narration to emotions and physical sensations) and bottom–up (from bodily sensations to meaning and the story) information-processing channels (Ogden, 2006). As described by Ogden, "top–down cortically mediated techniques typically use cognition to regulate affect and sensorimotor experience, focusing on meaning-making and understanding. The entry point is the story, and the formulation of a coherent narrative is of prime importance. In the bottom–up approaches, the body sensations and movements are the entry points and changes in sensoriomotor experience are used to support self regulation" (Ogden, Minton, & Pain,). Bottom–up interventions are critical when working with patients with somatic illnesses such as cancer because bodily sensations frequently are one of the most important complaints and the body is the locus of some of the most traumatic experiences of the illness (Scaer, 2001).

Narrative therapy must adapt to fit the variable and changing needs of cancer patients, which has important clinical implications for therapeutic practice. When faced with a rigid and inflexible initial narrative from a patient (e.g., "I am depressed because I am a weak person"), the therapist could initiate standard verbal NT interventions such as externalizing conversation (White, 2007) to promote de-identification regarding depression. In other words, the goal is to disconnect the problem from the patient's identity (to "externalize") such that the patient does not have depression, but rather, depression has taken hold of the patient (Snedker Boman, 2011). The notion that depression is an inner state is challenged. In theoretical and linguistic practice, this means that a divide is inserted between the client and the depression. The therapist can also use other techniques including naming and remembering (Snedker Boman, 2011) and include family and other relevant people as external witnesses who reflect upon and share the patient's experience.

We integrate both an attitude and practice of mindfulness into our treatment. Mindfulness emphasizes observation of thoughts and feelings moment by moment and has been described as "a particular way of paying attention: on purpose, moment-by-moment, and without judgment" Kabat-Zinn, 1991. Mindfulness meditation is seen as a

way to experience life in a "non-judgmental" way, which involves acceptance of the current situation (including symptoms of illness) without judging and mindful presence within a given situation (including negative emotions). Patients are trained in both formal and informal mindfulness practices. Formal practices involve set periods of meditation, such as sitting and focusing attention on the breath, body scan, mindful walking and stretching, and a series of soft hatha yoga exercises. Informal practices involve mindfulness in everyday life; for example, by deliberately focusing awareness on the experience of everyday activities (e.g., showering, looking through a window, and eating a piece of fruit). Mindfulness exercises train a person to remain observant, non-judgmental, and within the present moment, without getting entangled in feelings of guilt or failure, desires, memories, or anticipation of the future (Ledesma & Kumano, 2009; Musial, Bussing, Heusser, Choi, & Ostermann, 2011; Shennan, Payne, & Fenlon, 2011).

In clinical practice, a therapist may respond to a bodily centered narrative (e.g., "I feel so tired that I can't say anymore" or "I am having difficulty breathing because of pressure in my chest") by encouraging the creation of new narratives using non-verbal, bodily centered, emotional regulation techniques such as mindfulness. Working with new meanings that arise (e.g., "while I was meditating I had a feeling of connection with myself and others again" or "I can see the brightness of colors again"), the therapist facilitates narrative construction from bodily sensation towards the story. Empirical data on the efficiency of mindfulness (L. Carlson, Ursuliak, Goodey, Angen, & Speca, 2001; Mackenzie, Carlson, & Speca, 2005; Ott, Norris, & Bauer-Wu, 2006; Speca, Carlson, Goodey, & Angen, 2000) and other somatosensory techniques such as hypnosis and guided imagination (L. E. Carlson & Bult, 2008) in the treatment of depression and anxiety in cancer patients indicate that this is a particularly important approach when working with this population.

The practice of mindfulness integrates into narrative practice, as both maintain an open dialogue and share common ground, emphasize acceptance, and view reality as a construction of the observer. Observer and observed are one (Waldron, 2006). Mindfulness opens the world of the six senses (sight, hearing, smell, touch, taste, and mind), thereby expanding consciousness and allowing different paths to become visible when faced with a stressful situation. NT expands the meaning of "what is not said" or "what is not sensed" (Anderson & Goolishian, 1988). The result is an expansion of the repertoire of action (or non-action), allowing alternative narratives to emerge that do not include the usual pattern of reaction that generates suffering. From both perspectives (NT and mindfulness), the patient is encouraged to explore his or her relationship with reality (the problem). This is encouraged, for instance, in the externalization technique. Mindfulness involves considering one's own thoughts and feelings as just that: "thoughts" or "feelings" (Segal, Williams, & Teasdale, 2002). Similar to Buddhist psychology, which involves seeking the experience of "anatta" (not-self), NT views "self" as multiple-self, dynamic, and changing (Epstein, 2007). It is possible to facilitate self-reorganization in a suffering patient by integrating mindfulness and NT. As proposed by Engler, "you have to be somebody before you can be nobody" (Engler, 2003).

In summary, to help the patient integrate his or her experience into a new, coherent narrative, the therapist explores and challenges the argument and the perspective of the old narrative. The patient tells a story with a main script (e.g., biography, loss, grief, and family disputes) and places himself or herself in a certain perspective (first, second, or third person) to tell his or her story (Table 1) (Bruner, 1986).

The patient assumes a first-person perspective when he or she focuses on the relationship he or she has with himself or herself and tells stories involving biographical items or emotional dysregulation. An example from the biography reads as follows: "I rejected to take quimiotherapy. I do not want to be a burden for my family. Until I stopped drinking, I mistreated my wife and kids. I don't deserve now to be looked after by them". Another example of emotional dysregulation is as follows: "I am fine, I do not feel sad, it is just that when I am about to take quimiotheraphy, my legs buckle and my husband has to carry me on a wheelchair." Stories from a second-person perspective are based on significant interpersonal relationships. Gloria says "since my daughter died, it makes no sense for me to follow the treatment anymore." Stories from a third-person perspective are focused on social meta-narratives such as gender or the social stigma of cancer. "My uterus has been removed, I no longer serve for anything as a woman." (Table 2). The ultimate goal of the intervention is to help the patient build a healthier version of his or her narrative from the initial depressed one.

Table 1. Narrative therapy: definitions

Narrative	A story about a life experience, constructed by a person or group of people, which includes events perceived by the narrator as being important (Kholer, 2008).
Argument	The organizing principle of the experience (Hermans 1995). A guide for the selection of events.
Perspective	The position of "self" when telling one's own story.

Table 2. Narrative exploration

Perspective	First person	Second person	Third person
Argument	Biography Emotions Internal dialogue	Mourning Role transition Interpersonal/family relationship Therapeutic relationship	Social significance of the illness Stigma Gender
Therapeutic resources	Biographical review and type of attachment Emotional control Acceptance Medication	Working on the therapeutic relationship Working on mourning Partner/family interventions	Being aware of social conventions associated with the illness

KEY ELEMENTS OF MINDFULNESS-BASED NARRATIVE THERAPY FOR CANCER PATIENTS

Through the therapeutic conversation, stories containing "knots" of narrative meaning are explored. Knots are areas of the narrative that have the potential for change through exploration and questioning because they are especially relevant for this particular person in this particular illness situation. The problem that the patient raises in the form of a dominant narrative (Sluzki, 1992) (e.g., "I can't sleep," "I'm afraid the cancer will come back," and "I'm scared of telling my wife about what's frightening me") is the starting point of a therapeutic conversation. With cancer patients, there are some particularly frequent tasks to which the therapist must attend:

1. From the first-person perspective:

   a. Encourage emotion regulation through work focused on the body. This may mean working with a hyper-activated patient (emotional flooding) or a hypo-activated, inhibited, or emotionally constrained patient. A goal is to restore the body as a resource for growth and emotional modulation as opposed to a place of damage or loss (Ogden, 2006). Next is an example of the clinical practice that illustrates how the therapist, starting off from the patient's initial narrative, brings somatosensorial consciousness and gradually introduces a mindfulness attitude. Laura sits on the chair, heavyhearted. "Since I was given the cancer diagnosis, I feel a pressure on the chest that doesn't allow me to breathe. They have dismissed an organic cause and I do not understand it because I put up with the diagnosis with tranquility. The only thing that I ask from you is to help me with this trouble." Therapist: . . . Laura, I am noticing that your breathing is faltering. Have you noticed that? (the therapist attends to the patient's initial complaint and initiates interventions that will increase—gradually and respecting the patient's rhythm—his or her body conscience)... What if you change your position. . .straightening up your back a bit and bringing your shoulder blades closer... do you feel any change? (the therapist encourages body consciousness through changes in posture and movement)... What if you breathe in, noticing the air entering the body, and exhale noticing the air leaving the body? (the therapist helps out to stop breathing being an automatic process and to work on conscious breathing). Can you now follow the air's trajectory as far as the abdomen and notice, just notice, observing how the navel rises with inhalation and descends with exhalation? (the therapist trains diaphragmatic breathing—the type that predominates in moments of calm—and helps the patient to maintain an observer attitude in the here and now)... focusing on this movement, without changing anything, just observing, and when the mind wanders, simply, be aware, with kindness, bring it again to the here and now... that's it...

   b. Explore the patient's biography to understand how he or she would answer the question, "Who am I?" Breitbart and colleagues (Breitbart et al., 2010) proposed that cancer modifies the response to this question. For example, the loss of autonomy associated with illness may have different implications for a patient who, through a difficult childhood, learned that depending on others is dangerous than for a patient with different life experiences. The latter person might actually find a loss of autonomy to be an agreeable experience to the extent that it fosters an intimate connection with loved ones and may be able to discover new things from the illness experience (Breitbart et al., 2010).

2. From the second-person perspective:

   a. Explore the patient's meaningful relationships. Humans are relational beings who do not exist in isolation. For this reason, it is important to include the family in key moments of the therapeutic process and explicitly work with what arises in the therapeutic relationship (Kissane & Bloch, 2002).

b. Explore the meaning of mourning the loss of health, anticipation of death, and impending separation from loved ones (Worden, 2000), as well as the health-to-illness role transition, from independent to dependent, from caregiver to being cared for, and from worker to pensioner. Specific issues surrounding functional adaptations to everyday life such as walking with crutches or wearing a colostomy bag would be included here (Averill & Nunley, 1993; Schut, Stroebe, Van Den Bout, & Terheggen, 2001).

c. Use the therapeutic relation as a privileged place to explore interpersonal interaction.

3. From the third-person perspective: Explore changes in patient's values resulting from the disease. Which aspects from the world's beliefs question the illness? We refer to basic existential themes: freedom, death, the meaning of life, isolation, and changes that affect the most nuclear identity of the person, the nuclear self, or core self (Frankl, 1984). We also take into account the cultural narratives that both patient and therapist draw upon to construct their stories.

The key elements of meaning identified through this process can guide the therapist through a range of tasks, such as the following:

1. Exploring the meaning of illness in the context of the biography.
2. Exploring the meaning of existential themes including fear of death, isolation, and dependence. Any one of these themes would be subject to variations by gender and culture.
3. Exploring the patient's past or present significant interpersonal relationships.
4. Exploring the relationship with the therapist and using the opportunities and challenges inherent therein to establish and maintain the therapeutic relationship, as a gateway to relational exploration.
5. Exploring the meaning of grief and difficulties in role transition.
6. Training in techniques of emotion regulation including mindfulness, self-hypnosis, guided imagination, and other somatosensory techniques, with the aim of increasing somatic awareness and focusing on healthy resources to regulate emotions, deal with specific symptoms (e.g., pain, nausea, or anticipatory vomiting), or prepare for an invasive examination or surgical intervention.
7. Inclusion in the therapeutic process of significant people in the patient's life, with the goal of validating individual and familial emotional stress, facilitating family communication, and helping redefine relationships in anticipation of physical deterioration or death.

Thus, in each intervention, the therapist must take into account the possibility of (a) involving family members, friends, or significant others in the conversation; (b) discussing existential issues and mourning; (c) working with somatic awareness in one of its many forms; (d) achieving cognitive restructuring through clarification or confronting patterns or beliefs that maintain the narrative of depression; (e) working on the therapeutic relationship; and (f) maintaining a focus on discovering and strengthening the patient's health resources. Recently, we published a reference manual describing how the therapeutic strategy evolves throughout the stages of the therapeutic process (Rodríguez Vega & Fernández Liria, 2012).

CONCLUSION

We described an adaptation of MBNT for use with cancer patients. We propose using top–down processing of the dominant narrative brought by the patient, which is often rigid and inflexible, as well as bottom–up approaches to work with emotions expressed as bodily sensations and to encourage emotional regulation. In the process of therapy, the therapist explores the dominant argument of the narrative and perspective from which the patient tells his or her story and uses this as a guide in the choice of appropriate therapeutic resources.

As Angus and McLeod (2004) pointed out, there are different storytelling structures. The MBNT approach posits to initiate the therapeutic conversation from the narrative the patients bring to us, from a narrative that is socially orientated to another that deals with internal dialogues of self-devaluation or body sensations. In other words, we aim to meet the patient wherever he or she is. The therapy—understood as a process of repairing rigid and restrictive narratives (Gonçalves, 2011), as it happens in depression—should include or integrate the work with somatosensorial consciousness as a preferential path towards narrative amplification and the emergence of new meanings or alternative stories.

A previous randomized, controlled trial using both quantitative and qualitative analyses supported the effectiveness of our adaptation of MBNT in treating depression and improving QOL in cancer patients (Rodríguez Vega et al., 2012; Rodriguez Vega et al., 2010). However, that study was limited in that it did not compare NT with other empirically supported forms of psychotherapy, and it considered only patients with non-metastatic cancer. MBNT might be a therapeutic alternative for depression in cancer patients that merits to be evaluated with larger samples, in different stages of cancer, using a group approach and comparing it to an active control group. In addition, MBNT seems a promising intervention in other physical illnesses such as chronic pain and multiple sclerosis, in which our group is actually developing research projects. NT is socially and neurobiologically informed and,

despite a relative lack of empirical support and validation, is increasingly influential in psychotherapeutic practice and research.

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CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest.

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