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Uncovering the components of therapeutic empathy through thematic analysis of existing definitions

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ABSTRACT

Objectives: To identify the components of therapeutic empathy based on a review of existing definitions.
Methods: A search for therapeutic empathy definitions was conducted in two stages. First, a list of empathy definitions from within healthcare contexts was compiled using existing systematic reviews and a database of empathy definitions. The components of those definitions were identified through thematic analysis. Then, forward and backward citation searching (snowballing) of the papers from which those definitions were retrieved was conducted. These papers were randomly sampled and integrated into the analysis until saturation was reached.
Results: The searches yielded 3948 definitions of therapeutic empathy. Saturation was reached after analysing 39 individual definitions. Six interrelated components of therapeutic empathy were identified: *exploring, understanding, shared understanding, feeling, therapeutic action*, and *maintaining boundaries.*
Conclusions: This study identified six prevailing components of therapeutic empathy that distinguish it from empathy in general. The findings provide a conceptual starting point that can help the field better focus its understanding and use of activities that relate to empathy in practice.
Practice implications: Future practice, research, and education can use the components generated in this study to more consistently define therapeutic empathy, thereby offering potential to improve patient and practitioner outcomes.

1. Introduction

The term "empathy" can be traced to the German word "Einfühlung" (to feel into), which was coined in 1873 by art historian and philosopher Robert Vischer [1]. The first recorded use of the term in English of which we are aware occurred in 1895, when E.L. Hinman translated Vischer's conceptualisation of "Einfühlung" as "empathy" [2]. Hinman compared empathy to electrical capacitance, which is the ability of an object to take on and store electrical charge [2]. When empathising, instead of taking on and storing electricity, humans were described as taking on the feelings of another person.

Upon emergence of the term in healthcare settings in the 1950s, where it is often described as "therapeutic empathy" [3] or "clinical empathy" [4], "empathy" took on a slightly different meaning [1,5]. Whereas empathy *in general* often includes feeling the same, or similar, emotions as another [2,6], therapeutic or clinical empathy was described in ways that placed reduced emphasis on feeling another person's emotions [7,8]. Some definitions go further by eliminating reference to feeling emotions altogether, focusing instead exclusively on cognitive empathy, the capacity to perceive and understand the emotions of another [4]. Although "therapeutic empathy" and "clinical empathy" have been used interchangeably [9], we prefer "therapeutic empathy" because the term "clinical" is often associated with medicine [10], whereas much of the research on empathy in healthcare comes from, and applies equally to, nursing and other health professions [8,11].

More recently, empirical and conceptual work on therapeutic empathy has exploded, and there are now thousands of references to the term in PubMed, up from just hundreds two decades ago [12]. This growing body of work includes evidence now suggesting that

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therapeutic empathy can improve patient [13] and practitioner [14] outcomes. As a result, it is now considered to be a vital component of healthcare research, practice, and education [3]. This increased interest, however, has not been without controversy as there are now numerous, sometimes contradictory, definitions of the term. For example, while Finset et al. [15] state that therapeutic empathy requires a practitioner to feel the emotions of their patients, Hojat et al. [4] claim that *feeling* another's emotions is not desirable. The latter group recommends, instead, that *understanding* is key to therapeutic empathy. This and other differences have led some authors to conclude that there are "*nearly as many definitions of empathy as people working on the topic*" [16].

The variation in definitions creates a number of downstream problems. For example, it leads to differences in how "empathy" is taught [17] and what is being measured when it is evaluated [18,19, 17]. Subsequently, empirical studies of the purported benefits of therapeutic empathy are challenging to interpret, compare, and implement [13,20]. In addition, the lack of a clear definition exacerbates the conflation between connected terms such as sympathy, compassion, and person-centered care [21–23]. Worse, without conceptual clarity, the door remains open for researchers to hand pick definitions of empathy that lead to paradoxical inferences about its benefits or harms [24].

As various scholars have come to recognise these problems, attempts have been made to address the conceptual confusion [25,26]. One systematic review identified 48 definitions of empathy [25]; another identified 52 [26]. Additionally, the *Culture of Empathy* project has a database containing interviews with over 100 empathy researchers that include even more definitions [27]. Unfortunately, such extensive lists do little to clarify and, hence, provide little direction for those working on the applied aspects necessary to teach or assess therapeutic empathy. In other words, while the efforts described are useful for cataloguing definitions, they have not synthesised existing knowledge about therapeutic empathy in a manner that offers the conceptual starting point necessary to progress practice [25,27]. That is the goal of this article.

To achieve clarity, one might be tempted to strive for consensus around a single definition. However, the idea that there can be a single definition presupposes that a "one size fits all" approach is feasible and desirable. It could be that different definitions, or different components of definitions, serve different purposes and require varying degrees of emphasis in different contexts [30]. To determine whether that is the case and highlight the full scope of the concept requires, a delineation of the components of therapeutic empathy with particular emphasis on the activities that can make it observable. Such an advance could enhance research, teaching, and practice by enabling investigators and users to better specify their focus.

1.1. Aim

To generate a list of components of therapeutic empathy based on existing definitions.

2. Methods

2.1. Design

A review and thematic analysis of existing therapeutic empathy definitions.

2.2. Eligibility criteria

We searched for definitions of empathy used within healthcare settings and, accordingly, included definitions of "therapeutic empathy," "clinical empathy," and "empathy in healthcare" [9]. We considered a definition to be a statement describing the nature of the construct [31]. We applied the following inclusion criteria to identify eligible definitions:

1. Authors claim to be defining "therapeutic empathy", "clinical empathy", or "empathy in healthcare."
   OR
2. Authors claim to be defining "empathy" **and** their definition is clearly intended to be applicable to the healthcare setting, indicated by use the word(s) "therapeutic", "clinical", or "healthcare" (including specific healthcare disciplines such as medicine or nursing) in their paper.

No limits were imposed on publication date or language.

2.3. Information sources and selection process

Our scoping revealed that limiting our search to "therapeutic empathy" or "clinical empathy" would be insufficient because many definitions of empathy are clearly intended to be used in the healthcare setting without those specific labels being used. As a result, we began by generating an initial list of eligible definitions from two systematic reviews of how empathy has been defined more generally [25,26], the *Culture of Empathy* project database [27], and hand searches. From these we isolated definitions that focused on healthcare settings, as noted in Section 2.2, and subjected them to thematic analysis.

To test the model that arose from that analysis, we followed Higgins et al.'s advice to engage in snowball sampling [32]. That is, we conducted forward and backward reference checks using SpiderCite [33], to determine if papers that preceded or followed those subjected to thematic analysis offered any additional insights. The results of the SpiderCite search were randomly sampled in groups of 10 using a random number generator [34] and eligible definitions were integrated into the developing analysis. Sampling and analysis continued in parallel until we reached meaning saturation (i.e., the point at which no new themes, dimensions, or nuances arose in three consecutive batches of 10 papers [35]). That approach was deemed appropriate because our aim was not to generate an exhaustive list of definitions of therapeutic empathy (for the reasons detailed in the introduction), but was to identify common components of definitions.

Throughout this process, two authors (ABW and MD) independently screened the full texts for eligible definitions, with disagreements resolved through discussion with a third author (JH) when necessary. When an author proposed multiple definitions, we used their most recent [26]. However, the same author could appear multiple times as a co-author [26].

2.4. Data extraction

A Microsoft Excel workbook was created to extract the definitions and the following characteristics: authors' names, contact information, and geographical location; publication year; the academic discipline in which the definition was situated; and whether it was oriented towards the healthcare practitioner, student, or patient perspective (determined based on authors' descriptions of the context in which the definition was used and whose point of view the definition was from). Data extraction was performed in duplicate by two authors (ABW and MD).

2.5. Data analysis

We imported the included definitions into NVivo and subjected them to thematic analysis by two authors (ABW and MD) who worked through six standard phases [36,37]. In phase one (familiarisation), both authors read the included definitions multiple times, noting their initial thoughts. During phase two (coding), both authors independently coded five definitions before reviewing and refining the codes via consensus. One author (ABW) then coded all remaining definitions and MD reviewed them. Phase three (generating initial themes) involved collating codes. During phase four (developing and reviewing themes) two authors (ABW and MD) wrote short summaries to capture the

meaning of each initial theme and shared them with a third author (JH) to further develop the ideas. Phase five (refining, defining, and naming themes), involved checking the themes against the raw data to ensure each one represented a clear and coherent pattern of meaning that was consistent with the original text. At this stage, three authors (ABW, MD, and JH) finalised the names for each theme. In the final phase (writing up), two authors (ABW and MD) selected vivid extracts of data to illustrate each theme.

We analysed the definitions retrieved from the initial selection process before analysing each definition identified through snowball sampling. Our analytic approach was predominantly inductive, meaning that the themes we developed were strongly linked to the data [38]. We remained mindful, however, of how our existing knowledge of the literature might influence the analysis, engaging in critical reflection throughout to ensure that our themes were grounded in the raw data.

3. Results

We retrieved 3948 papers (126 papers from our initial searches and 3822 from the SpiderCite search). Twenty-six definitions were extracted from the initial search [4,7,8,15,25,29,39–58] and a further 13 definitions were retrieved from randomly sampling six batches of 10 papers derived from the SpiderCite search [11,59–70]. This resulted in a total of 39 definitions that were included before saturation was reached (see Fig. 1) [4,7,8,11,15,25,29,39–70].

The definitions were published between 1959 and 2023 (Supplementary table S1). Most were from the United States (n = 25) [4,7,11,39,41–46,48–50,53–55,58,59,62–67,70]. The rest were from the United Kingdom (n = 6) [8,25,29,51,61,69], Norway (n = 2) [15,52], Canada (n = 1) [40], Belgium (n = 1) [47], France (n = 1) [68], Singapore (n = 1) [56], Chile (n = 1) [60], and the Netherlands (n = 1) [57]. The contexts in which the definitions were provided included medicine (n = 27) [4,7,15,25,29,41–45,48–50,52–57,59–61,63,64,67,68,70], nursing (n = 5) [8,11,46,62,66], medical education (n = 3) [40,51,65], psychotherapy (n = 2) [39,58], psychology (n = 1) [47], and physiotherapy (n = 1) [69]. The majority were oriented towards the practitioner (n = 33) [4,7,8,11,15,25,29,39,41–47,49,50,52,54,55,57–64,66–70], or student practitioner (n = 3) [40,51,65] perspective. Two definitions represented both practitioner and patient perspectives [48,56] and one specifically represented the patient perspective [53].

3.1. Components of therapeutic empathy

Six themes were identified through thematic analysis to represent the components of therapeutic empathy: *exploring, understanding, shared understanding, feeling, therapeutic action,* and *maintaining boundaries*. The definitions that contributed to the identification of each component are listed in Supplementary table S1. Fig. 2 provides a graphical representation of their prevalence. How the different components were used in the papers uncovered is summarised in Supplementary file S2.

3.1.1. Exploring

Therapeutic empathy was represented as beginning with the practitioner's observation and exploration of the patient's experiences, emotions, and expectations in 16 definitions [7,15,39–41,49,50,53,54,57,61,64,65,68–70]. For example, Benbassat and Baumal [40] state:

> *"empathy begins with gaining an insight into the patient's concerns, feelings and sources of distress…"* [40]

Exploring involves the practitioner actively seeking information about, and actively listening to, the patient's perspective. It includes having curiosity about the patient's wider social, cultural, religious, moral, and familial background. Importantly, the practitioner's exploration was presented as needing to be non-judgemental and accepting. Garden et al., [49] for example, state that therapeutic empathy is about:

> *"…genuine attention to the individual's concerns and the acceptance of those concerns. Empathy with action can mobilize the physician to actively seek out knowledge of their patients' individual experiences of illness and health and the broader contexts that influence experience…"* [49]

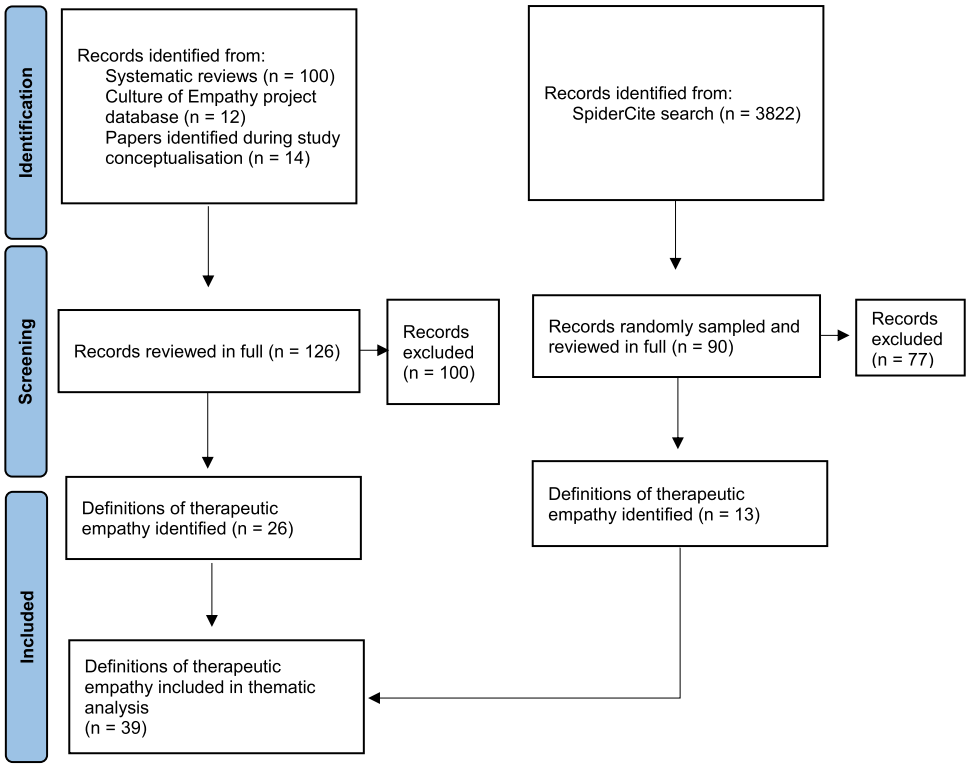

Fig. 1. Data identification and selection process.

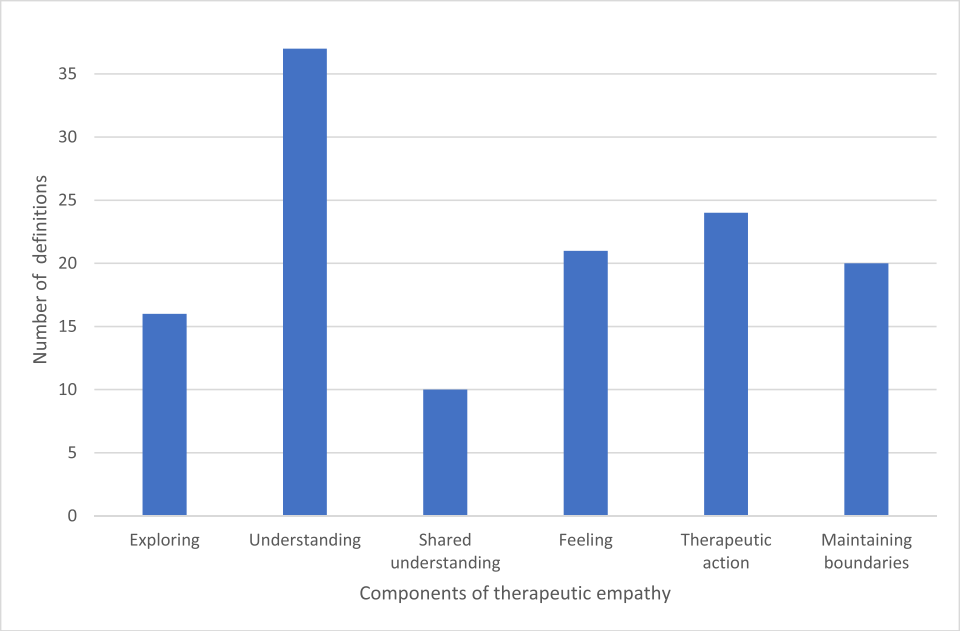

Fig. 2. The number of definitions in which components of therapeutic empathy appear.

3.1.2. Understanding

After *exploring*, definitions of therapeutic empathy indicated an expectation that the practitioner develop their own *understanding* of the patient's perspective and circumstances through cognitive processes. Almost all the definitions (n = 37) included *understanding* as a component of therapeutic empathy [4,7,8,11,15,25,29,39–63,65–69]. Hojat et al., [4] for example, assert that therapeutic empathy is:

> *"a predominantly cognitive (rather than an affective or emotional) attribute (brain mechanism) that involves an understanding (rather than feeling) of the patient's pain and suffering…" [4]*

To understand, the practitioner is required to use their imagination, logic, and reasoning to put themselves in the patient's shoes. They may draw on their own personal experiences to make sense of the patient's emotions, experiences, and expectations. Importantly, *understanding* does not require feeling or experiencing the same things as the patient. For example, Halpern [7] states that therapeutic empathy involves:

> *"…cognitive curiosity/perspective-taking… to understand the patient's experience sufficiently to be effective in treating his or her illness…" [7]*

3.1.3. Shared understanding

After the practitioner has developed their *understanding*, ten definitions of therapeutic empathy indicated the need for practitioner and patient to reach a *shared understanding* of the patient's circumstance, values, preferences, and options [4,29,43,52,58,62,66,67,69,70]. For example, Yaseen and Foster [70] contend that therapeutic empathy:

> *"…presupposes both commonality and difference as it seeks the development of a common language—a shared network of meanings, allowing one to see beyond pre-existing commonalities and create new ones." [70]*

To reach *shared understanding*, the practitioner communicates their own *understanding* of the patient's perspective back to the patient to check its accuracy and be corrected if necessary. For this reason, *shared understanding* was generally presented as being contingent on reciprocity between the patient and the practitioner [61]. For example, Mercer and Reynolds [29] contend that therapeutic empathy involves:

> *"…an ability to; (a) understand the patient's situation, perspective and feelings (and their attached meanings); (b) to communicate that understanding and check its accuracy." [29]*

3.1.4. Feeling

While many (n = 21) of the included definitions mentioned *feeling* as part of therapeutic empathy [7,11,15,25,40,41,44–48,50,51,54–58,60,61,66], very few described it as the practitioner sharing the same emotions as the patient [15]. Rather, therapeutic empathy was defined in ways that involve the practitioner *feeling* something in response to their *understanding* of the patient perspective. This *feeling* might be compassion or concern for the patient, or an altruistic desire to help. Galetz, [46] for example, states that therapeutic empathy involves an:

> *"other-oriented emotion felt for someone in need, which produces a motivational state of increasing the other's welfare." [46]*

3.1.5. Therapeutic action

Therapeutic empathy was defined as requiring therapeutic action in most (n = 24) definitions [4,7,11,15,29,40,41,43,45,47–50,53,54,56,57,59–61,63,64,67,68]. The nature of the action was often described as the caring behaviours performed by practitioners to help their patients. While this may involve establishing a care management plan or a course of treatment, it can also involve empowering the patient through education. For example, Robieux et al. [68] state that "*…giving information and teaching skills*" are important aspects of therapeutic empathy. Even simpler, a practitioner may be acting therapeutically when they actively listen or communicate understanding to the patient. In this way, *therapeutic action* is about the practitioner showing the patient that they are cared for, recognised, and understood. For instance, Rakel et al. [67] argue that:

> *"…the clinician then must be able to communicate this understanding, verbally and/or non-verbally, to the patient. This can be therapeutic in itself." [67]*

3.1.6. Maintaining boundaries

Finally, although many definitions presented therapeutic empathy as requiring the practitioner's deep engagement with the patient

perspective, 20 definitions emphasised that it also involves *maintaining boundaries* [4,7,8,25,39,40,42,44,46,47,50–52,54,57,58,61,64,67,68]. This involves a distinction between the "self" and the "other" such that the practitioner's own emotions, experiences, and expectations are recognised as separate from the patient's. In this regard, Jeffrey [61] emphasises that therapeutic empathy:

> *"…does not mean that the doctor loses sight of where the self ends and the other begins…" [61]*

Maintaining boundaries also involves emotional regulation by the practitioner. Larson and Yao [50], for example, state that "*Empathy encompasses both internal and external emotion management.*" Laughey et al. [51] imply that this is important for avoiding practitioner burnout:

> *"…empathy often involves finding a delicate balance between opposing concepts – for example, emotional giving and self-preservation." [51]*

3.2. Relationship between the components

While not all components of therapeutic empathy were present in all definitions, it was clear that the components were considered to be interrelated. *Exploring* captures the practitioner-patient interactions that can facilitate both *understanding* and *shared understanding*. For example, Jeffrey [61] states:

> *"Cognition involves attempting to understand the perspective and experience of the other person. This depends on having Curiosity, to gain understanding into the patient's concerns, feelings, and distress…" [61]*

Shared understanding can be achieved when the practitioner communicates their own *understanding* of the patients' perspective to the patient. For example, Coulehan [43] contends:

> *"In clinical medicine, empathy is the ability to understand the patient's situation, perspective, and feelings and to communicate that understanding to the patient… one cannot know without feedback… this gives the patient opportunities to correct or modulate the physician's formulation" [43]*

Understanding, in turn, can elicit *feelings* (for example, of compassion or concern) that motivate *therapeutic action*. For example, Benbassat and Baumal [40] assert that:

> *"Empathy begins with gaining an insight … This insight is followed by engagement,* i.e.*, identification with these feelings. In turn, this produces compassion … Compassion leads to a desire to remove the cause of distress or at least to alleviate it." [40]*

Additionally, *maintaining boundaries* overlaps with each of the components, in that the boundaries between the "self" and the "other" must be maintained throughout the patient-practitioner encounter. For example, Rogers [28] states that therapeutic empathy:

> *"…is to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain hitherto as if one were the person, but without ever losing the 'as if' condition." [28]*

Moreover, because each of the components relies on the interaction between (at least) two people (the patient and the practitioner), many of them require feedback loops to qualify as being part of therapeutic empathy. For example, *exploring* may need to be revisited to arrive at a *shared understanding* and to negotiate agreed upon *therapeutic actions*. Mercer and Reynolds [29] allude to this when they describe the practitioner acting *"…with the patient in a helpful (therapeutic) way."*

Fig. 3 captures the six common components and the relations between them, based on the relations described in the included definitions.

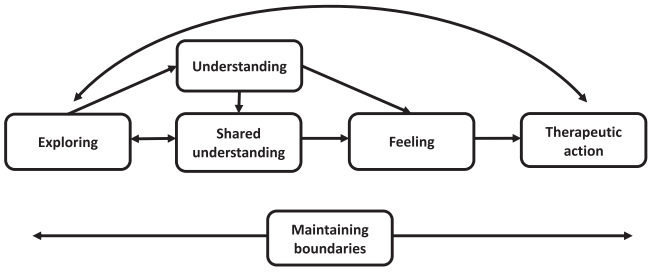

Fig. 3. A model of therapeutic empathy.

4. Discussion and conclusion

4.1. Summary of findings

Most papers on therapeutic empathy state that there is no consensus on its definition and few have made efforts to extract its defining components [8,25,45,71,72]. Those that have made the latter effort, as discussed in Section 4.2, have focused on general forms of empathy, creating the risk that key features of empathy in therapeutic contexts are missed or lack emph. Consistent with that concern, our synthesis revealed six components that are commonly present, to greater or lesser extents, when empathy is defined in relation to clinical care. Therapeutic empathy includes: *exploring* and *understanding* the patient's perspective, reaching a *shared understanding, feeling* in response to *understanding,* and taking *therapeutic action,* while *maintaining boundaries.*

4.2. Comparison with other evidence

The previous review of 52 definitions of general empathy, alluded to above, synthesised work from the fields of neuroscience, philosophy, psychology, and nursing. It resulted in the identification of four common themes: understanding, feeling, sharing, and self-other differentiation [26]. Understanding, feeling, and self-other differentiation align well with what we have called *understanding*, *feeling*, and *maintaining boundaries*; these components, therefore, may relate to both therapeutic empathy and empathy in general. "Sharing" was not identified in our review largely, we believe, because it involves taking on another's experiences and feelings, creating a distinct divide between the way empathy is defined generally and how it is defined in healthcare contexts. Instead, we identified the theme "*shared understanding*" which appears to be specific to therapeutic empathy. Additional components not included in the previous review, but which appear to be specific to the concept of therapeutic empathy, were *exploring* and *therapeutic action.* These components suggest that empathy scholars consider therapeutic empathy to be a more active and interactive concept than empathy in general. They also highlight that concepts like empathy must be considered in relation to the context in which they are used.

Our findings also reinforce that medicine has changed from the historical belief that doctors should strive to remain detached from their patients, to avoid becoming emotionally involved [73]. This belief was rooted in fears that over-identifying with patients' emotions would prevent objectivity [4,71]. Instead, our findings suggest that emotional engagement is a core component of therapeutic empathy, with over half of the definitions including *feeling* (n = 21). Importantly, however, our findings support previous authors who have asserted that therapeutic empathy does not require feeling the *same* emotions as the patient [7,8]. Rather, our findings suggest that therapeutic empathy involves the practitioner feeling something in response to the patient's situation.

There has been a longstanding debate regarding the impact of empathy on practitioner burnout [4,14,71,74]. While some scholars argue that empathising is a risk factor for burnout [4,71], others suggest that therapeutic empathy can protect against practitioner burnout [14, 74]. In our research, we found that definitions of therapeutic empathy

were largely split down the middle in terms of whether (n = 20) or not (n = 19) they emphasised the importance of practitioners *maintaining boundaries* between themselves and their patients (which presumably protects against burnout). The fact that some definitions emphasise *maintaining boundaries* while others do not might help to explain some of the controversy surrounding the impact of empathy on practitioner wellbeing. It could be that those who consider *maintaining boundaries* to be a defining feature of empathy, enabling a clear differentiation between the "self" and the "other" are those who are liable to maintain the more optimistic outlook [14,74].

Finally, it is noteworthy that our findings echo the underrepresentation of patient views in healthcare research, practice, and education [75]. Only three of the definitions we identified included a patient perspective [48,53,56]. Interestingly, however, those definitions that did so emphasised *feeling* and *therapeutic action* (see Supplementary file S2) [48,53,56]. This reflects previous research showing that patients prefer emotionally engaged practitioners to practitioners who remain objective and emotionally detached [76].

4.3. Limitations

We used existing systematic reviews [25,26] and a database [27] of empathy definitions as our primary information sources. Despite our rigorous search, it is nonetheless possible that we missed definitions of therapeutic empathy that were not included in these sources despite our efforts to deliberately sample from additional definitions uncovered through the SpiderCite search. Our intention, however, was not to compile an exhaustive list of therapeutic empathy definitions but to identify common components of existing definitions. We achieved this by sampling and analysing until we reached meaning saturation.

Regardless of whether other definitions would have yielded additional components (which we believe is unlikely given our method), our analysis was constrained to the ways in which other authors have defined therapeutic empathy. Many definitions were based on the behaviours and attitudes involved in therapeutic empathy, but did not specify how these should be enacted. This is reflected in the components generated by our analysis, which frame therapeutic empathy as an active and interactive concept. While deeper understanding of how these behaviours and attitudes are expressed in practice would be beneficial, our aim was to inductively identify the components of therapeutic empathy based on previous authors' use of the term.

4.4. Recommendations for future research

Research is needed to explore the relative value of the different components of therapeutic empathy and whether it differs across contexts. That is, the field would advance conceptualisation and practice if it explored the ways in which the components of therapeutic empathy are enacted. Further research is also needed to explore patient and carer perspectives regarding the definition of therapeutic empathy and whether they differ from the practitioner perspective. Finally, we would encourage those attempting to measure therapeutic empathy and its effects to take into consideration the components generated through our analysis.

4.5. Practice implications

The findings of this study offer clarity regarding the concept of therapeutic empathy and distinguish it from empathy in general. These findings address the controversy surrounding the use of the term in clinical contexts and may encourage practitioners to reflect on the way that they enact and express empathy in practice. Practitioners, researchers, and educators can use the six components identified through our analysis to clearly specify their focus and goals, and more consistently practice, measure, and teach therapeutic empathy.

4.6. Conclusion

Our study has generated the first list of common components embedded in definitions of therapeutic empathy (i.e., empathy as it is defined in the healthcare setting). This helps overcome ambiguity surrounding the term and provides a conceptual starting point to enable better focus on this amorphous construct. Therapeutic empathy has six prevailing components: *exploring, understanding, shared understanding, feeling, therapeutic action*, and *maintaining boundaries*. By highlighting the full scope of the concept, our findings pave the way for greater consistency in the research, teaching, and practice of therapeutic empathy that can improve patient and practitioner outcomes.

Ethics declaration

This research did not involve primary data collection and therefore ethical approval was not required.

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CRediT authorship contribution statement

Jeremy Howick: Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Conceptualization. **Maya Dudko:** Writing – review & editing, Methodology, Formal analysis. **Amber Bennett-Weston:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis. **Kevin Eva:** Writing – review & editing, Writing – original draft, Methodology, Conceptualization.

Author contributions

JH, KE, and **ABW** were involved in the conceptualisation of this research. **ABW** and **MD** screened full-texts, and completed data extraction and data analysis. **JH** acted as a third senior reviewer to resolve discrepancies and supported the analysis. **ABW** and **JH** drafted the initial manuscript and **KE** and **MD** further developed it. All authors made substantial contributions to revisions of the manuscript, read and approved the final copy.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.pec.2024.108596.

Data availability statement

Data related to this research is included in this publication and as supplementary information. Please contact the corresponding author if additional information is required.

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