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Fatigue, Sleep Problems, and Self-Efficacy Before and After Heart Transplantation: A 5 Year Follow-Up

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ABSTRACT

Introduction: Fatigue is a troublesome symptom after heart transplantation and is poorly studied in a long-term perspective. One hypothesis is that there is a strong relationship between fatigue, sleep problems, and self-efficacy, and that fatigue decreases self-efficacy. The aim of this study was to explore self-reported fatigue from the time on the waiting list to 5 years after heart transplantation and its association with self-efficacy and sleep problems.

Methods: In this multicenter, longitudinal cohort study 48 heart recipients, 12 women and 36 men with a median age of 57 years, were followed from pre-transplant to 5 years post-transplant. Three instruments were used: (1) the transplant-specific Organ Transplant Symptom and Well-Being Instrument (OTSWI), (2) the Swedish version of the Multi-Dimensional Fatigue Inventory (MFI), and (3) the Self-Efficacy for Managing Chronic Disease 6-Item Scale (SES6G).

Results: Sleep problems decreased after transplantation, but after 3–5 years, there were no differences in comparison with pre-transplant. Self-efficacy improved for the whole group from pre-transplant up to 5 years after heart transplantation. General fatigue predicted self-efficacy.

Conclusion: Fatigue plays a pivotal role in self-efficacy after heart transplantation. It reduces self-efficacy due to causing uncertainty and should constitute a primary target for future interventions.

1 | Introduction

Heart transplantation, the aim of which is increased duration and quality of life, is a well-established treatment for selected persons with end-stage heart failure [1]. Being a heart recipient is a chronic condition involving lifelong medication, lifestyle changes, and recommendations to prevent life-threatening rejection and infection. Symptom distress after heart transplantation is common and has been reported in earlier research, mainly cross-sectional studies [2, 3] with a longitudinal design [4, 5]. Symptoms hamper quality of life [6] and might also affect the heart recipient's confidence in managing everyday life, i.e., self-efficacy, making heart recipients feel less recovered [7].

Abbreviations: HRQoL, Health-Related Quality of Life; MFI, Multidimensional Fatigue Inventory; OTSWI, Organ Transplant Symptom and Well-Being Instrument; SES6G, Self-Efficacy for Managing Chronic Disease 6-Item Scale; SMATT, Self-Management After Thoracic Transplantation.

Fatigue is a prevalent and distressing symptom after heart transplantation [4, 8–10] that leads to decreased quality of life [11]. It also causes psychological distress, which is a possible barrier to self-management and is related to uncertainty and low self-efficacy [8]. Furthermore, fatigue is a predictor of poor psychological well-being after heart transplantation [5]. Adapting to life as a heart recipient with physical and psychological challenges, such as fatigue, is a time-consuming process [12]. As physical performance is an important driver of self-efficacy after heart transplantation [7], it is necessary to explore the magnitude of fatigue among heart recipients and its possible impact on their self-efficacy.

Sleep problems after solid organ transplantation have been explored, showing that 39%–52% of renal, lung, and liver recipients report poor sleep quality, which was associated with depression, anxiety, poorer quality of life, restless legs, and higher comorbidity compared to those with good sleep quality [13]. In a cross-sectional study, sleep problems were reported to be a common and distressing symptom after heart transplantation [3], and solid organ transplant recipients with persistently poor sleep quality had lower quality of life and significantly more depressive symptomatology [14]. In addition to fatigue, sleep problems were the symptom that largely explained the low psychological well-being following heart transplantation. However, sleep problems have not been thoroughly explored [13]. One effort by Dalvindt et al. [5] reported that fatigue, especially general fatigue, decreases up to 1 year after heart transplantation, but then increases, and after 5 years, heart recipients again report high general fatigue. The association between fatigue, self-efficacy, and sleep problems remains insufficiently explored. Thus, the rationale of this study is to further explore fatigue after heart transplantation.

The research question in the present study was how self-reported fatigue evolves from pre-transplant to 5 years after transplantation in association with self-efficacy and sleep problems. The aim was to explore associations between self-reported fatigue, self-efficacy, and sleep problems from the time on the waiting list to 5 years after heart transplantation.

1.1 | Methods

The STrengthening the Reporting of OBservational studies in Epidemiology (STROBE) checklist for cohort studies was used.

1.2 | Design

This Swedish multi-center longitudinal cohort study is part of a larger multi-center project entitled Self-Management After Thoracic Transplantation (SMATT) that has been running since 2014. The overall aim of the SMATT project is to map factors of importance for recovery, self-management, and Health-Related Quality of Life (HRQoL) after thoracic transplantation.

1.3 | Study Participants and Setting

Inclusion criteria in the present study were Swedish-speaking adults (≥ 18 years) who were on the waiting list for heart transplantation at either of the two heart transplant centers in Sweden. Exclusion criteria were being hospitalized and having a poor health status due to reasons other than those considered normal under the circumstances, e.g., heart failure in the pre-transplant phase. The participants were recruited between 2014 and 2018 by registered nurses at the three main outpatient clinics that evaluate potential heart recipients prior to transplantation and perform the follow-up afterwards. Those not invited to participate in the study were evaluated and followed up at a different outpatient clinic from the three mentioned above. Demographics of the participants are presented in Table 1.

The study participants were followed from their time on the waiting list to 5 years after transplantation. The final follow-up was performed in December 2024. The number of participants decreased at every measurement point (pre-transplantation $n = 101$, at 3 months $n = 78$, at 6 months and 1 year $n = 73$, at 2 years $n = 64$, at 3 years $n = 54$, at 4 years $n = 52$, and at 5 years $n = 48$). The analyses were based on the group of 48 participants who were followed for the full 5 years to observe the change trajectory. An overview of the sample is presented in Figure 1. In some cases, the reasons for drop-out are known; one was taken off the waiting list, two died while on the waiting list, five died after transplantation, one participant was retransplanted, 17 failed to continue after the first measurement, six withdrew from the study, and three changed to another outpatient clinic. Other reasons for drop-out might be the Covid-19 pandemic, which resulted in fewer visits to outpatient clinics. Although this cannot be confirmed, it will be discussed later in the article.

1.4 | Data Collection

Data in the large SMATT project were collected using 10 self-report instruments starting pre-transplantation as the baseline and then at 3, 6 months, 1, 2, 3, 4, and 5 years after transplantation. In the present study, data were collected using three self-report questionnaires out of the 10 employed in the SMATT project. The instruments used were as follows: (1) the sleep problems dimension, which is part of the transplant specific Organ Transplant Symptom and Well-Being Instrument (OTSWI) [15], (2) the Swedish version of the multidimensional Fatigue Inventory (MFI-19) that measures fatigue [16, 17], and (3) the Self-Efficacy for Managing Chronic Disease 6-Item Scale (SES6G) that measures self-efficacy [18]. The instruments are described in Table 2.

1.5 | Statistics

The software package for statistical analysis, SPSS Statistics 28, was used for analyzing data [19]. Data were not normally distributed, and the statistical calculations were made on nominal and ordinal data, thus non-parametric analysis. Medians and percentiles (p_{25}, p_{75}) were used for summarizing nominal data. Analyses of ordinal data in dependent groups (OTSWI, MFI, and SES6G) and differences over time were made using the Wilcoxon signed rank test. The Mann–Whitney test was applied to analyze ordinal data in independent groups and explore possible differences regarding sex and age. An independent *t*-test was conducted for age differences between men and women. Age was dichotomized to younger or older than 50 years. Spearman's

TABLE 1 | Demographics of the included heart recipients ($n = 48$).

Demographics	Frequency (n) and proportions (%)
Age	
Median	57 years
Mean	54.25 years (SD 10.61 years)
Men, mean	54,86 (SD 9.02 years)
Women, mean	52.42 (SD 14.74 years)
≥ 50 years	31 (65)
≤ 49 year	17 (35)
Sex	
Women	12 (25)
Men	36 (75)
Indications for transplantation	
Dilated cardiomyopathy (different forms)	17 (35)
Hereditary conditions	21 (44)
Congenital heart disease	3 (6)
Ischemic heart disease	6 (13)
Eisenmenger	1 (2)
Mechanical assist device and time in the intensive care unit (ICU)	
Mechanical circulatory support (MCS)	8 (17)
Mean time in the ICU	7.65 days
Median time in the ICU	5.00 days
Min–max	2–29 days
Rejections	
Individuals with one or more self-reported rejections	6 (18)
Self-reported immunosuppressive medications at three-month follow-up after heart transplantation	
Cyclosporin	0
Tacrolimus	40
Mycophenolate mofetil (MMF)	38
Azathioprine	0
Steroids	34
Other	12

rho was employed to analyze correlations between self-efficacy and different dimensions of fatigue as well as sleep problems. Linear regression analysis was conducted to assess self-efficacy predictors. Relevant, p values < 0.05 (two-tailed) were considered significant.

1.6 | Ethical Considerations

Before giving their written consent, all participants were informed about the study both verbally and in writing. The study was approved by the Regional Ethics Board (2014/124) and the Swedish Ethical Review Authority (2019/02769) granted supplementary approval, informed consent was obtained from all individuals included in the study. The study adheres to the Helsinki declaration regarding medical research involving humans [20] and Swedish research ethics legislation [21].

2 | Results

Demographics and relevant information about the participants are presented in Table 1. The group consisted of 48 participants, of whom 75% were men and 25% women. Men were significantly

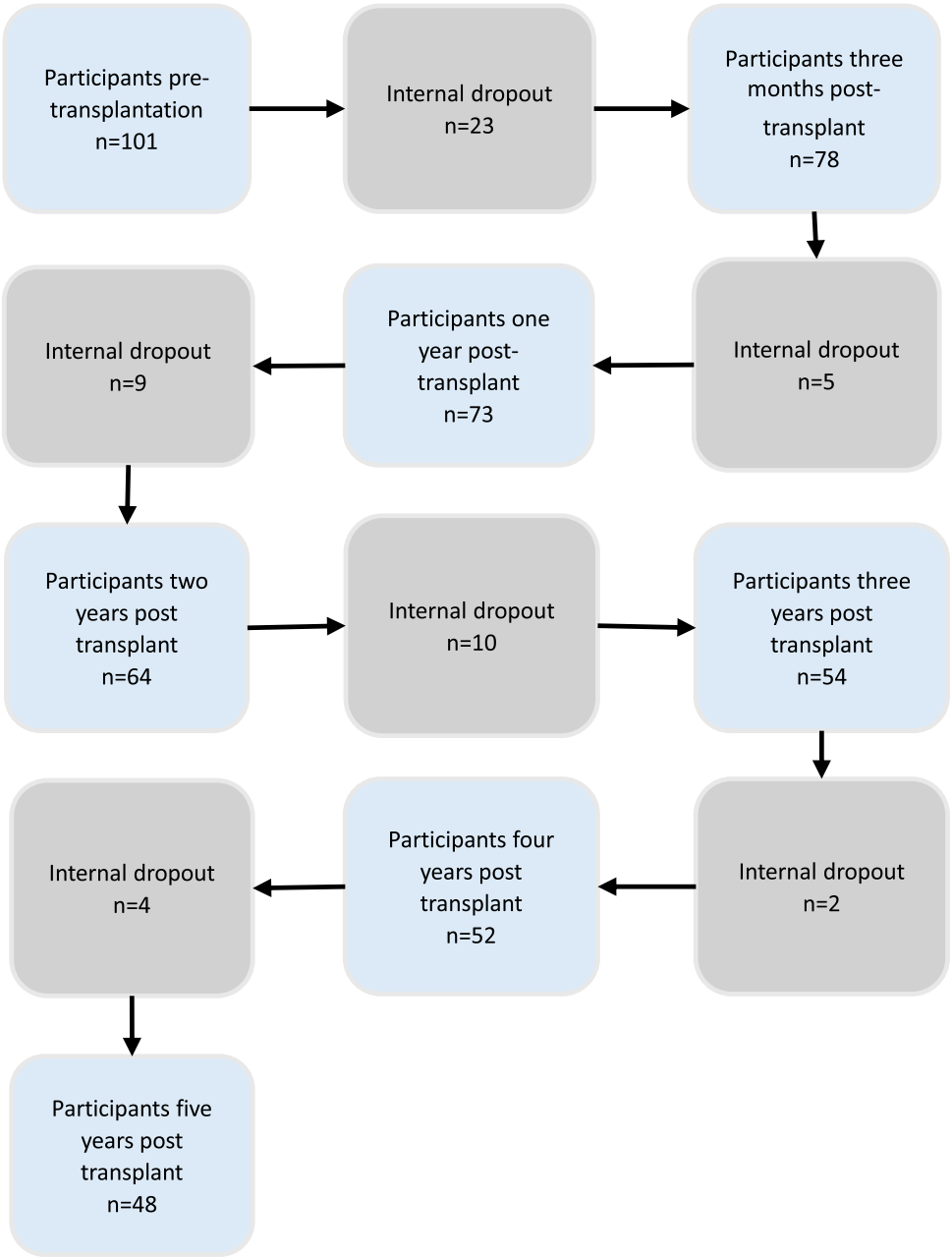

FIGURE 1 | Overview of the sample. The final group comprised 48 participants. The number of dropouts varied over the 5 years as follows: Pre heart transplantation ($n = 7$), 3 months ($n = 4$), 6 months ($n = 6$), 1 year ($n = 7$), 2 years ($n = 7$), 3 years ($n = 12$), 4 years ($n = 9$), and 5 years ($n = 0$).

older than women ($p \leq 0.001$). There were no other gender differences in sleep problems, self-efficacy, or fatigue. An overview of the sample is presented in Figure 1.

3 | Occurrence and Development of Fatigue, Sleep Problems and Self-Efficacy

3.1 | Fatigue

Those, older than 50 years reported more reduced motivation, which is a dimension of fatigue ($p = 0.044$), median 6 (p_{25} 4.5; p_{75} 10) after 6 months and 1 year ($p = 0.05$) median 6 (p_{25} 5; p_{75} 10.75) compared to younger heart recipients, median 4.5 (p_{25} 4; p_{75} 7.25) at 6 months and at 1 year median 4 (p_{25} 4; p_{75} 7.5). No other age differences were found in fatigue 2–5 years after heart transplantation.

3.2 | Sleep Problems

Sleep problems improved after 6 months ($p = 0.018$) median 3 (p_{25} 1; p_{75} 5), 1 year ($p = 0.003$) median 3 (p_{25} 2; p_{75} 5), and 2 years ($p = 0.053$) median 3 (p_{25} 1,5; p_{75} 5), compared to baseline median 5 (p_{25} 4; p_{75} 6). From 3 to 5 years after transplantation, the median was lower (3) compared to pre-transplantation (5), but the spread was greater, and there was no longer a significant

TABLE 2 | Description, measurement properties, and scales of the instruments used.

Measurement area	Description of the instrument	Measurement properties and scale
Symptom distress and transplant specific well-being (OTSWI)	This transplant-specific instrument consists of eight factors that measure well-being, symptom distress, and the extent to which individuals experience 20 specific symptoms. The eight factors comprise: sleep problems, joint and muscle pain, foot pain, fatigue, cognitive functioning, basic activities of daily life, mood, and financial situation, each of which consists of two to three items. In the present study, the sleep problems dimension was used, which contains three questions.	A five-point Likert scale ranging from 0 (not at all) to 4 (very much). The lowest possible score is 0, and the highest is 80. There is no cutoff, but a high score indicates symptom distress, and a low score represents good well-being. The eight factors account for 86% of the variance with satisfactory internal convergent validity and good item-scale discriminatory validity.
The Self-Efficacy for Managing Chronic Disease 6-Item (SES6G)	The SES6G consists of six items measuring self-efficacy covering different domains common in chronic conditions, i.e., symptom control, role function, emotional functioning, and communicating with physicians. SES6G is considered to bring a low burden to the responders and is thus useful in clinical practice and research.	A 10-point scale ranging from "not at all confident" (1 point) to "totally confident" (10 points). A mean score is calculated based on at least four of the six items, meaning that two can be missing. The mean score is then interpreted and ranges from 1 to 10, with higher values indicating a greater level of self-efficacy. The SES6G was externally validated using the German General Self-efficacy scale and Spearman´s rho correlation test and showed good convergent construct validity (0.578, $p < 0.001$). Correlations between 0.44 and 0.6 are considered good. The internal consistency was high with Cronbach´s alpha 0.930. The SES6G had low floor and moderate ceiling effects.
Multidimensional Fatigue Inventory (MFI-19)	This instrument consists of five different fatigue dimensions: general fatigue, physical fatigue, reduced motivation, reduced activity, and mental fatigue. It is a valid and reliable self-report questionnaire with a timeframe covering the previous few days. The original instrument contained 20 items, and the Swedish version revised by Hagelin et al., (2007) has one item less.	A five-point Likert scale ranging from "Yes, i.e., accurate" to "No, i.e., not accurate". Every dimension consists of three to four items, and they are given a score from 1 to 5 and then summarized to a scale ranging from 4to 20 points. There is not a cutoff for the whole instrument. However, the dimension of general fatigue has a cutoff 12. A value of 12 and above indicates high fatigue. A cutoff 18 indicates severe fatigue. Cronbach´s alpha coefficient varied between 0.67 and 0.94, while the inter-item correlation varied between 0.21 and 0.90.

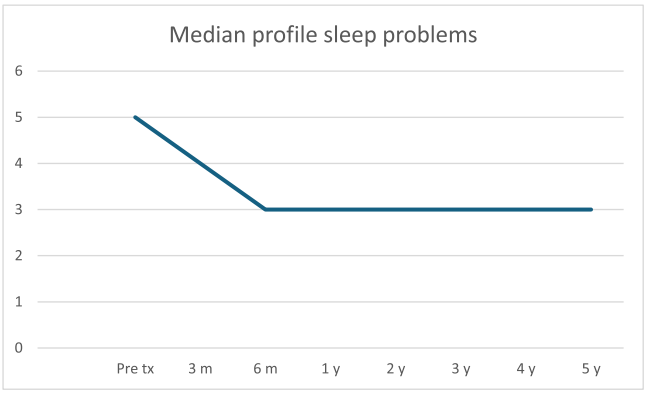

FIGURE 2 | Changes in sleep problems among 48 heart transplant recipients from pre-heart transplant (pre tx) to 5 years after heart transplantation expressed as a median score. The scores range between 0 and 8, where a higher score indicates more sleep problems. The number of missing responders varied over the 5 years as follows: Pre tx ($n = 3$), 3 months ($n = 5$), 6 months ($n = 3$), 1 year ($n = 3$), 2 years ($n = 8$), 3 years ($n = 8$), 4 years ($n = 7$), and 5 years ($n = 2$).

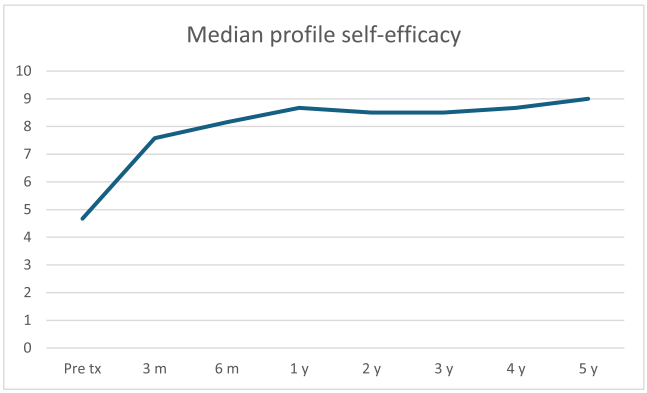

FIGURE 3 | Changes in self-efficacy among 48 heart transplant recipients from pre-heart transplant (pre tx) to 5 years after heart transplantation expressed as a median score. The scores range between 0 and 10, where a higher score indicates more self-efficacy. The number of missing responders varied over the 5 years as follows: Pre tx ($n = 3$), 3 months ($n = 5$), 6 months ($n = 3$), 1 year ($n = 3$), 2 years ($n = 8$), 3 years ($n = 8$), 4 years ($n = 7$), and 5 years ($n = 2$).

difference in sleep problems compared to pre-transplantation. The median profile of sleep problems is illustrated in Figure 2.

Differences in the increased level of sleep problems were seen in the older subgroup. One-year post-transplant sleep problems had increased among older heart recipients ($p = 0.001$) median 4 (p_{25} 3; $p7_5$ 6), compared to younger ones, median 2 (p_{25} 1; p_{75} 3).

3.3 | Self-Efficacy

Self-efficacy improved at every measurement point compared to baseline ($p < 0.001$). Comparing every measurement point with the former, there was a difference, i.e., improvement, between baseline and 3 months after transplantation ($p < 0.001$) and between 6 months and 1 year after transplantation ($p < 0.006$). Self-efficacy did not improve between 3 and 6 months after transplantation but consistently increased over time from the pre-transplantation median of 4.67 (p_{25} 3.67; p_{75} 6.84) to 5 years post-transplant, median 9 (p_{25} 7.1; p_{75} 9.67). The median profile of self-efficacy is presented in Figure 3.

3.4 | Correlations and Possible Fatigue Predictors

The Spearman´s rho analysis confirmed that there was a significant negative correlation between self-efficacy and the different dimensions of fatigue (Table 3), meaning that the greater the fatigue, the lower the self-efficacy. The relationship between self-efficacy and fatigue became stronger from 6 months to 3 years. The correlation between sleep problems and different dimensions of fatigue was weak during the first-year post-transplant, apart from general fatigue after 3 months. The relationship is more evident from 1 year to 4 years (Table 4).

3.5 | Predictors

Based on the strong correlations between fatigue and self-efficacy, linear regression was used to explore how well fatigue explains self-efficacy. One-year post-transplant general fatigue predicted a significant 80.6% of the variation in self-efficacy (*beta* = −0.806, 95% CI: −0.410, −0.254, $p \leq 0.001$). Two-years post-transplant general fatigue predicted a significant 70.5% of the variation in self-efficacy (*beta* = −0.705, 95% CI: −0.376, −0.187, $p \leq 0.001$). Three-years post-transplant general fatigue predicted a significant 70.4% of the variation in self-efficacy (*beta* = −0.704, 95% CI: −0.325, −0.089, $p \leq 0.001$). Four-years post-transplant general fatigue predicted a significant 54.1% of the variation in self-efficacy (*beta* = −0.541, 95% CI: −0.329, −0.156, $p \leq 0.001$). Five-years post-transplant general fatigue predicted a significant 65.5% of the variation in self-efficacy (*beta* = −0.655, 95 %CI: −0.403, −0.186, $p \leq 0.001$). In summary, fatigue explains 54%–80% of the variation in self-efficacy up to 5 years after heart transplantation.

3.6 | Discussion

The main findings in this study were

- self-efficacy improved for the whole group from pre-transplant up to 5 years after heart transplantation.
- general fatigue predicts self-efficacy, in particular, 1 year after transplantation.
- sleep problems decrease during the first years after transplantation, but after 3–5 years, there are no differences compared to pre-transplant.

The important knowledge that all fatigue dimensions improve after transplantation, but that general fatigue exceeded high fatigue levels 5 years after transplantation, is reported in Dalvindt et al. [5] and was the reason for exploring the associations between self-reported fatigue, self-efficacy, and sleep problems from the

TABLE 3 | The relationship between self-efficacy and different dimensions of fatigue and sleep problems from pre-transplantation to 5 years after heart transplantation.

Related variables/Measurement points	Correlation values							
	Pre-tx	3 months	6 months	1 year	2 years	3 years	4 years	5 years
Self-efficacy/General fatigue	**−0.438****	**−0.573****	**−0.759****	**−0.733****	**−0.739****	**−0.678****	**−0.603****	**−0.734****
Self-efficacy/Physical fatigue	−0.345	**−0.621****	**−0.693****	**−0.810****	**−0.664****	**−0.698****	**−0.570****	**−0.621****
Self-efficacy/Reduced activity	−0.352	−0.344	**−0.686****	**−0.702****	**−0.672****	**−0.607****	**−0.590****	**−0.555****
Self-efficacy/Reduced motivation	**−0.415****	**−0.461****	**−0.703****	**−0.573****	**−0.684****	**−0.559****	**−0.546****	**−0.617****
Self-efficacy/Mental fatigue	**−0.469****	−0.347	**−0.594****	**−0.682****	**−0.703****	**−0.465****	−0.320	−0.351
Self-efficacy/Sleep problems	−0.164	−0.329	−0.241	**−0.430****	−0.402	−0.367	**−0.411****	**−0.666****

Note: Strongly significant relationships, i.e., $p \leq 0.001$, are marked in bold and with **. The number of missing responders varied over the 5 years as follows: Pre heart transplantation ($n = 3$), 3 months ($n = 5$), 6 months ($n = 3$), 1 year ($n = 3$), 2 years ($n = 8$), 3 years ($n = 8$), 4 years ($n = 7$), and 5 years ($n = 2$).

TABLE 4 | The relationship between sleep problems and different dimensions of fatigue from pre-transplantation to 5 years after heart transplantation.

Related variables/Measurement points	Correlation values							
	Pre-tx	3 months	6 months	1 year	2 years	3 years	4 years	5 years
Sleep problems/General fatigue	0.314	**0.489****	0.318	**0.599****	**0.547****	**0.520****	**0.644****	0.377
Sleep problems/Physical fatigue	0.269	0.291	0.133	**0.509****	**0.532****	**0.529****	**0.454****	0.227
Sleep problems/Reduced activity	0.207	0.358	0.316	**0.535****	**0.491****	**0.565****	**0.499****	**0.410****
Sleep problems/Reduced motivation	0.082	0.202	0.255	0.340	**0.498****	**0.492****	**0.489****	**0.403****
Sleep problems/Mental fatigue	0.288	0.299	0.247	0.351	**0.527****	**0.430****	**0.514****	0.122

Note: Strongly significant relationships, i.e., $p \leq 0.001$, are marked in bold and with **. The number of missing responders varied over the 5 years as follows: Pre heart transplantation ($n = 3$), 3 months ($n = 5$), 6 months ($n = 3$), 1 year ($n = 3$), 2 years ($n = 8$), 3 years ($n = 8$), 4 years ($n = 7$), and 5 years ($n = 2$).

time on the waiting list to 5 years after heart transplantation. The context of this result is worth mentioning.

To our satisfaction and as expected, self-efficacy increased from year to year. The knowledge of how to manage everyday life should theoretically increase with experience. Unfortunately, there was a moderate to strong correlation between fatigue and self-efficacy. It became evident that fatigue predicts self-efficacy, which confirms the hypothesis previously developed by Almgren et al. that fatigue causes uncertainty, leading to decreased self-efficacy [7]. This highlights the importance of symptom management support for those burdened by fatigue due to the fact as self-efficacy is necessary for effective self-management [22].

Sleep problems are common, with between 81% and 92% of heart recipients reporting them as the most prevalent symptom [3]. In the present study, sleep problems initially improved, but after 3–5 years, returned to pre-transplant levels. The correlation between sleep problems and fatigue strengthens after 1 year, which is not surprising, as the extensive medication and psychological challenges inherent in being a heart recipient are most likely to emerge by that time. Fatigue is also a symptom sometimes

caused by insomnia, which means difficulties initiating and maintaining sleep [23]. Even though the relationship between sleep problems and fatigue is weak to moderate, sleep problems are underestimated after heart transplantation and require far more clinical attention to limit the negative health implications involved, including fatigue. As Cordoza et al. reported [13], sleep problems after heart transplantation have not been sufficiently investigated, and the present study shows that it is a symptom that requires attention, as 3–5 years after transplantation, such problems are as bad as before transplantation. Sleep problems and fatigue in combination with low psychological well-being are important symptoms of depression [24], which is common after heart transplantation [25, 26]. Thus, the fact that depression was not analyzed is a limitation.

High symptom distress after transplantation is extremely negative; hence, symptom management support and interventions targeted at distressing and problematic symptoms are especially important [27]. According to Bengoa and Yach, self-management is an essential aspect when structuring the care of chronic conditions [28], e.g., being a heart recipient. Self-efficacy is necessary to maintain effective self-management. The present study shows that the important driver of self-management, i.e., self-efficacy, decreases when burdened by fatigue. The need for a person-centered approach to identify and handle burdensome symptoms is obvious [27], and in times of limited healthcare resources, this study highlights an important symptom that requires both identification and intervention. Fatigue and sleep problems have also been identified as common symptoms among heart recipients reporting poor psychological well-being [5].

3.7 | Methodological Considerations and Study Limitations

The instruments used in the study are validated, reliable, and commonly used in the studied population, which strengthens the findings. There were no differences between men and women in any variable but age. The group of women was small; thus, it is not easy to be certain about the lack of differences. The small study population is of course a limitation, as a larger number of participants would have increased statistical significance. The data were collected during the Covid-19 pandemic, with few resources for research, and when patients were afraid to visit their follow-up clinics. In view of that situation, 48 participants followed from baseline to 5 years after heart transplantation must be considered an achievement in a Scandinavian context. Inclusion of Swedish-speaking participants systematically excluded the growing number of immigrant heart recipients, which is a limitation due to the loss of those people´s important perspectives.

4 | Conclusion

In conclusion, this study strengthens the hypothesis that fatigue is a common symptom that lowers heart recipients' self-efficacy. This underlines the importance of person-centered interventions during the first 5 years after heart transplantation to support each heart recipient's self-management during this period, together with interventions to enable them to master fatigue in a long-term perspective.

Author Contributions

Data curation: Annette Lennerling and Anna Forsberg. Formal analysis: Marita Dalvindt, Hannah Lindahl Veungen, and Anna Forsberg. Funding acquisition: Anna Forsberg. Investigation: Marita Dalvindt, Hannah Lindahl Veungen, Annika M. Kisch, Annette Lennerling, and Anna Forsberg. Methodology: Anna Forsberg and Annette Lennerling. Project administration: Marita Dalvindt, Hannah Lindahl Veungen, Anna Forsberg, and Annette Lennerling. Resources: Anna Forsberg. Software: Anna Forsberg. Supervision: Anna Forsberg and Annika M. Kisch. Validation: Anna Forsberg, Annika M. Kisch, and Maria Hjorth. Visualization: Marita Dalvindt, Anna Forsberg, and Annika M. Kisch. Writing original draft: Marita Dalvindt and Anna Forsberg. Reviewing, editing, and approval of article: Marita Dalvindt, Hannah Lindahl Veungen, Annika M. Kisch, Annette Lennerling, Maria Hjorth, and Anna Forsberg.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings are available from the corresponding author upon request.

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