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Articles

Coping strategies and perceived social support among cancer patients: A cross-sectional analysis

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Abstract

Background: Cancer is a major public health problem worldwide. Being the second leading cause of death in the world, this fearsome disease is a stressful event capable to cause a time of considerable upheaval in people's lives and their loved ones. The illness condition can influence the patients' social relationships, even reducing social involvement and fostering isolation. Hence, cancer adjustment-related variables are worth studying. Specifically, the research on coping strategies is crucial since the patients' response style can act on the quality of the psychosocial outcomes.

Objective: The aim of this study was deepening the association between coping styles and perceived social support from family, friends, and significant others among a sample of 121 cancer patients.

Method: Participants were 121 cancer patients (70.2% females), aged 26 to 88 (M=61.90, *SD*=12.16). We assessed the adopted coping strategies by means of the Mini-Mental Adjustment to Cancer Scale (mini-MAC Scale), whereas the perceived social support was measured by the Multidimensional Scale of Perceived Social Support (MSPSS).

Results: We found: (1) a positive association between fighting spirit and the perception of social support from friends; (2) the hopelessness/helplessness strategy seemed negatively related with the perception of social support, regardless of the source; (3) higher levels of fatalism were connected with higher levels of perceived social support from family; (4) both anxious preoccupation and avoidance did not show any association with perceived social support.

Conclusions: Working on maladaptive coping responses might be useful for the purpose of improving the receptivity to the support from family, friends and significant others. Further research focusing on patients' coping styles is needed to promote holistic-oriented psychological treatments.

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1. Introduction

Being the second leading cause of death in the world, cancer is a universal public health problem (Siegel et al., 2020). In accordance with the World Health Organization (2020), the global incidence of cancer is expected to double reaching about 29-37 million new cancer cases by 2040.

Cancer is a medical disease that has a great impact on patient's quality of life and on existential concerns; patients may develop defensive functioning, anxiety and depressive symptoms (Di Giuseppe et al., 2020; Rahnea-Nita et al., 2019). According to Grassi (2020, p. 1) «it is quite clear then that the needs of patients with cancer do not regard only the physical aspects related to the disease and its treatment, but a wide range of emotional, interpersonal and social implications and that the consequences should be constantly monitored across the illness trajectory for both patients and family members». Indeed, the *Clinical practice guidelines in Oncology* are worked out in the context of the psycho-oncological science (Holland et al., 2007) and cancer adjustment-related variables are worth studying. For this reason, the presence of psychological services is indispensable in medical settings (Koocher & Hoffman, 2020) to improve patients' mental health and also their adhesion to clinical treatment (Lemmo et al., 2020). The overall quality of the treatment - also in terms of emotional and technical support from the structure in which the patient is being cared for - may affect the level of stress attributed to the disease (Rania et al., 2018). Besides, the clinical psychological figures in healthcare professionals expose the individuals to different pathological dynamics, which may retroactively refer to them depending on working conditions and clinical issues (Merlo et al., 2020).

Adjustment to cancer is originally defined as the cognitive and behavioral responses of an individual to a new diagnosis (Greer & Watson, 1987). Thus, two specific components to be measured are identified: the patients' cognitive appraisal and the subsequent behavioral response to a cancer diagnosis.

More recently, the complementary resources from coping theory and socio-cognitive theory are combined within the Social-Cognitive Transition Model of adjustment to cancer (Brennan, 2001). According to this model, «adjustment is an ongoing process of learning from, and adapting to, the many changes that an individual faces as a result of living with, and receiving treatment for, cancer. The degree of adjustment depends on the combined effect of coping responses, social support, and cognitive appraisal of the cancer experience» (Hack & Degner, 2004, p. 236). Therefore, the research on coping strategies when facing cancer is crucial since the patients' response style can act on the quality of the psychosocial outcomes (Zucca et al., 2010).

Cancer is a stressful event that can affect the social relationships, limiting social involvement and fostering isolation. Reduction in social contacts can cause difficulties in grasping and valuing any support from social relationships, thus lowering the odds of receiving support (Costa-Requena et al., 2015). In this regard, social support «encompasses the interpersonal relationships that develop and are accessible when an individual is faced with stressful life events» (Yağmur & Duman, 2016, p. 1).

Some research had already noted that social relationships may have important consequences for people health (Bloom et al., 2001). Further studies confirmed this association, also including improvements in adaptive coping, well-being, and survival (Hack & Degner, 2004; Howsepian & Merluzzi, 2009; Mishra & Saranath, 2019; Ozdemir & Tas Arslan, 2018; Tremolada et al., 2016; Yıldırım et al., 2017). It has been suggested that social support might play a potential role «for accelerating the recovery process of patients, increasing their adjustment to medical treatment, improving their quality of life, and extending their life» as well (Yağmur & Duman, 2016, p. 1). Indeed, the secure adult attachment is positively associated with the use of appropriate coping strategies and resilience (Craparo et al., 2018).

It is worth clarifying that some studies have distinguished between received social support and perceived social support, with the perceived social support resulting as more influential (Helgeson & Cohen, 1999). Besides, «effective coping strategies and social support may increase the self-care abilities of the patients, which may lead to them to desire more independence and need less hospital care» (Ozdemir & Tas Arslan, 2018, p. 2215).

The sources of social support can be multiple and include family, friends, and significant others. Family is often evaluated as a main resource (Ozdemir & Tas Arslan, 2018; Yağmur & Duman, 2016). However, this categorization is controversial. Some studies have suggested how the presence of spouses and partners might encourage patients to seek medical help for distressing symptoms, undergo treatment, or adhere to treatment (Jimenez-Fonseca et al., 2018). Nevertheless, other findings have highlighted the usefulness of social support in improving cancer adaptation, regardless of the specific source, as long as the patients deemed it useful (Helgeson & Cohen, 1996). Tomai, Lauriola, and Caputo (2019, p. 1) underline that «social support helped patients to be more determined in fighting the disease and contrasted helpless-hopelessness and anxious preoccupations».

Both coping and social support are central to be acquainted with the patients' risk and protective factors: many studies have shown a strong association between these variables (Costa-Requena et al., 2015; Howsepian & Merluzzi, 2009; Mishra & Saranath, 2019; Ozdemir & Tas Arslan, 2018; Zucca et al., 2010). According to Ozdemir and Tas Arslan (2018), the various coping strategies can affect perceived social support since the patients' resources would influence their capability to use social support for improving their own well-being (Costa-Requena et al., 2015).

More specifically, based on several empirical evidences, the patients who perceive higher levels of social support are likely to use more fighting spirit strategy, whether it comes from family, friends, or significant others (Cicero et al., 2009; Mishra & Saranath, 2019; Yağmur & Duman, 2016). Apparently, these ones would benefit from the closeness of others and judge the cancer diagnosis as a challenge, taking an active role in their illness and treatment (Grassi et al., 2005).

According to some research, the hopelessness/helplessness strategy and the proposed criteria for demoralization – including social isolation – are mostly overlapping (Grassi et al., 2010). Hence, many studies have found negative correlations between hopelessness/helplessness and perceived social support, regardless of the source of support (Cicero et al., 2009; Costa-Requena et al., 2015; Yağmur & Duman, 2016), and lower satisfaction for this support (Akechi et al., 1998). Also, the hopelessness/helplessness strategy is often associated with depression, anxiety (Kissane et al., 2004; Ghiggia et al., 2017), and poor quality of life (Ferrero et al., 1994).

The tendency to have a stoic, passive, and resigned attitude to illness identifies the so-called fatalism style (Grassi et al., 2005; Mishra & Saranath, 2019). The scientific literature about fatalism is controversial. Indeed, some studies have shown this strategy as an adaptive response: Calderon et al. (2020) included fatalism in the Positive Attitude Scale, as well as fighting spirit. Nevertheless, other studies have highlighted a negative correlation between this coping style and perceived social support from family, friends, and significant others (Cicero et al., 2009; Costa-Requena et al., 2015; Yağmur & Duman, 2016). However, further empirical observations have revealed a positive correlation between fatalism and perceived social support from friends (Howsepian & Merluzzi, 2009), and significant others (Mishra & Saranath, 2019).

Finally, both anxious preoccupation and avoidance responses are presented as negatively correlated with perceived social support (Costa-Requena et al., 2015; Yağmur & Duman, 2016; Zucca et al., 2010). Specifically, according to some research, anxiety and various worries about the oncological illness are associated with excessive demand for reassurance (Mishra & Saranath, 2019), whereby received help is never perceived as satisfactory. Instead, the cognitive denial underlying the avoidance strategy (*ibidem*) would make any form of social support annoying and useless. These coping styles are also associated with an increase in anxious-depressive symptoms (Costanzo et al., 2006; Ghiggia et al., 2017).

1.1 The current study

The aim of this study was to deepen our understanding of the association between coping strategies and perceived social support using a sample of oncological patients. Based on reference literature, we expected that the patients who adopt fighting spirit and fatalism would show higher perceived social support levels, whereas the patients who use hopelessness/helplessness, anxious preoccupation, and avoidance would reveal lower perceived social support levels, regardless of the specific support source.

2. Method

2.1 Participants

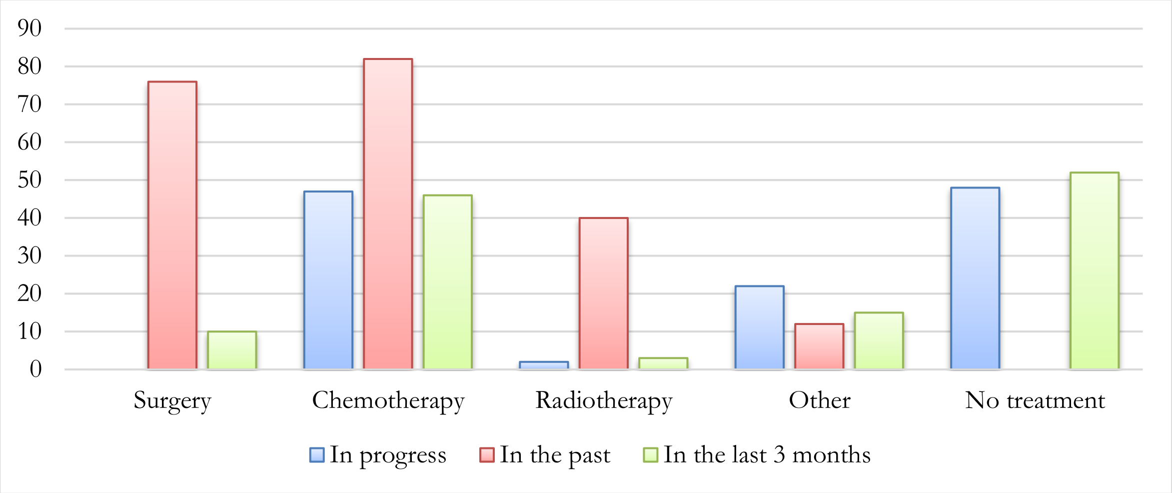
One hundred and thirty-eight patients were reached. Among them, 13 refused to participate, and 4 abandoned the procedure. Therefore, the final number of participants was 121. They were 36 male (29.8%) and 85 females (70.2%), aged from 26 to 88 years (M=61.90, *SD*=12.16). Most of them reported having a partner (married or in a relationship) (68.6%), and 84.8% reported having children (M=2.46, *SD*=1.03) (table 1).

Table 1. Patients' socio-demographic characteristics

Socio-Demographic Characteristics	N	%
Gender		
Male	36	29.8
Female	85	70.2
Educational Level		
Elementary School	35	28.9
Middle School	48	39.7
High School	32	26.4
Old System Degree	1	.8
Triennal Degree	1	.8
Specialistic Degree	2	1.7
Other	2	1.7
Marital Status		
Single	11	9.1
Fiance	2	1.7
Married	80	66.1
Cohabiting	1	.8
Divorced	3	2.5
Separated	5	4.1
Widower	19	15.7
Having Children		
Yes	101	84.2
No	19	15.8
Type Of Cancer		
Don't Know	1	.8
Breast	43	35.8
Prostate	3	2.5
Lungs	7	5.8
Liver	1	.8
Kidneys	2	1.7
Head	1	.8
Spread In Different Parts Of The Body	13	10.8
Colon	16	13.3
Other	33	27.5
Time Elapsed Since Diagnosis		
Less Than A Month	5	4.2
From 1 To 3 Months	29	24.2
From 3 To 6 Months	13	10.8
From 6 To 12 Months	16	13.3
From 1 To 2 Years	25	20.8
From 3 To 5 Years	16	13.3
More Than 5 Years	16	13.3
Presence Of Metastasis		
Yes	26	21.7
No	77	64.2
Don't Know	17	14.2

The cancer patients had undergone different types of treatment or were following them at the time of administration (Figure 1).

Figure 1. Types of treatment (absolute frequencies)



Participants declared living alone or with up to 4 adults (M=1.34, *SD*=.97) or with up to 2 children (M=.19, *SD*=.47). They estimated the amount of perceived social support from different sources (partner, children, brother/sister, mother, father, friends, and relatives) (Table 2). The number of relatives they perceived as "neighbours at the time of illness" was on average 8.67 (*SD*=11.33), while the number of friends averaged 9.77 (*SD*=21.97).

Table 2 . Patients' estimates of perceived social support

Source of perceived social support	N	*M*	*SD*
Partner	87	3.64	.85
Children	102	3.52	1.01
Brother/sister	108	2.88	1.49
Mother	45	3.33	1.30
Father	27	3.00	1.54
Friends	116	2.84	1.27
Relatives	116	2.55	1.38

2.2 Procedure and Ethical Statements

The study was conducted at the medical-oncology department of a public hospital, from September to December 2019. A specific authorization for collecting data was received by the Medical Director. The procedure was approved by the Internal Review Board of the psychological research of the University of Enna "Kore".

The administration of the battery of psychological tests was carried out in compliance with the privacy guarantee regulations according to Legislative Decree n. 196/2003, and the GDPR (EU

Regulation n.2016/679). Data were collected for research purposes only and treated in an aggregated and anonymous form.

Data were collected individually among patients who arrived at the hospital with different medical needs (e.g., carrying out periodic check-ups, talking with a doctor, or undergoing themselves to chemotherapy treatment in day hospital). After explaining the purposes of the study, all participants signed an informed consent that was placed separately from the measurement scales to preserve their anonymous status.

2.3 Instruments

The socio-demographic characteristics were detected with an ad hoc questionnaire.

Coping styles and perceived social support were measured using the following instruments:

- *Coping styles:* the *Mini-Mental Adjustment to Cancer Scale (mini-MAC Scale)* in its Italian validation (Grassi et al., 2005), which showed acceptable levels of reliability (Cronbach alpha coefficients ranging from .60 to .80). It is the 29-item short form of the *MAC-Scale* (Watson et al., 1994), including a new subscale (i.e., avoidance), and further developments of the anxious preoccupation subscale. Based on Watson et al. (1988) model, the mini-MAC scale is aimed to assess five cancer-specific coping styles: fighting spirit (e.g., "I see my illness as a challenge"), helplessness-hopelessness (e.g., "I feel like giving up"), anxious preoccupation, (e.g., "I am apprehensive"), avoidance (e.g., "Not thinking about it helps me cope"), and fatalism (e.g., "At the moment I take one day at a time"). Each item is rated on a 4-point Likert scale ranging from "Definitely does not apply to me" to "Definitely applies to me" with a higher subscale score indicating stronger use of the coping strategy. The mini-MAC Scale has demonstrated good reliability with Cronbach alpha coefficients for each domain ranging from .62 to .88.

- *Perceived social support:* the *Multidimensional Scale of Perceived Social Support* (MSPSS; Zimet et al., 1988). It is composed of three subscales: family (e.g., "My family really tries to help me"; "I get the moral help and support I need from my family"), friends (e.g., "My friends are really trying to help me"; "I can count on my friends when things go wrong), and significant others (e.g., "There is a particular person who is close to me when I need"; "There is a particular person in my life who is interested in my feelings"), (the reliability of total score was .88). The MSPSS is comprised of 12 items based on a 7-points Likert scale from 1 (very much disagree) to 7 (very much agree). As a result, the maximum achievable score is 84. Scores from 69 to 84 reflect high perceived social support, scores from 49 to 68 reflect moderate perceived social support, and scores from 12 to 48 reflect low perceived social support. De Maria and collaborators (2018) worked out the Italian validation of the instrument in the healthcare sector, demonstrating reliability and validity levels (Cronbach alpha coefficients were equal to or greater than .89) in reference to chronic diseases and specific internal consistency in studies with cancer patients (Bozo et al., 2013; Cicero et al., 2009; Han et al., 2013).

2.4 Inclusion and exclusion criteria

The inclusion criteria were specified as follows: age over 18 years; patients with a cancer diagnosis; patients without any form of mental retardation; signed informed consent.

The exclusion criteria were specified as follows: age under 18; patients with no discernment; patients with cancer not yet officially diagnosed; patients who refused to sign informed consent.

2.5 Data analyses

A series of standard multiple regression analyses were performed to study the association between perceived social support levels (from family, friends, and significant others) and adopted coping strategies (fighting spirit, hopelessness/helplessness, anxious preoccupation, fatalism, and avoidance).

Data analyses were conducted using IBM SPSS Statistics 25.0.

3. Results

3.1 Descriptive Statistics

The descriptive statistics of coping and perceived social support variables are reported in table 3.

Table 3. Descriptive statistics

	M	*SD*
Fighting spirit (mini-MAC)	13.07	2.63
Hopelessness/Helplessness (mini-MAC)	12.31	5.07
Fatalism (mini-MAC)	17.16	2.96
Anxious Preoccupation (mini-MAC)	18.26	6.56
Avoidance (mini-MAC)	12.05	3.47
PSS from Family (MSPSS)	26.25	2.66
PSS from Friends (MSPSS)	20.26	7.96
PSS from Significant Other (MSPSS)	25.89	3.30

3.2 Fighting Spirit

We investigated if people playing a dynamic and active role in illness management would perceive greater levels of social support. Inserting the fighting spirit as a predictive variable and perceived social support from family, friends, and significant others as three distinct dependent variables, regression analyses showed a statistically significant result: specifically, we found a positive significant association between fighting spirit levels and perceived social support from friends (β=.24, t=2.43, p<.05, partial eta squared=.221). However, this coping style was unrelated with both family and significant other perceived social support in this group of patients. Relationships between fighting spirit and perceived social support are shown in table 4.

3.3 Hopelessness/Helplessness

We explored the association between hopelessness/helplessness and the different sources of perceived social support. Inserting the hopelessness/helplessness as a predictive variable, data analyses highlighted a statistically significant outcome: explicitly, we found that this coping strategy showed associations with all levels of perceived social support, regardless of the source of support. Specifically, higher levels of hopelessness/helplessness were associated with lower levels of perceived social support from family (β=-.48, t=-4.43, p<.001, partial eta squared=-.381), friends (β=-.26, t=-2.24, p<.05, partial eta squared =-.205), and significant others (β=-.36, t=-3.06, p<.001, partial eta squared=-.274). Findings referring the relationships between hopelessness/helplessness and perceived social support are displayed in table 4.

3.4 Fatalism

The association between fatalism and perceived social support was also inspected. Based on data drawn from the examined group of cancer patients, participants with passive, and resigned attitude to illness showed higher levels of perceived social support from family. Indeed, inserting fatalism as a predictive variable and perceived social support from family as a dependent variable, the performed regression analysis revealed a positive statistically significant association: β=.20, t=2.24, p<.05, partial eta squared=.205. Conversely, fatalism did not appear related to both friends and significant others perceived social support. Complete results referring relationships between fatalism and perceived social support are shown in table 4.

3.5 Anxious preoccupation

Further, we explored the association between anxious preoccupation and perceived social support. Our findings revealed that this coping strategy was unrelated with any of the examined perceived social support sources. The performed regression analyses with our group of patients did not show any statistically significant result. Therefore, this way of adjustment to cancer did not seem associated with the perception of social support. Findings referring the relationship between anxious preoccupation and perceived social support are displayed in table 4.

3.6 Avoidance

Finally, we investigated the association between avoidance and perceived social support. Based on our findings, avoidance did not seem associated with any of the evaluated kinds of perceived social support. Indeed, the applied data analyses did not show any statistically significant result with this sample of participants. Thus, the perception of social support did not seem related to this specific way of adjustment to cancer. Outcomes about relationships between avoidance and perceived social support are displayed in table 4.

Table 4. Relationships between coping styles and perceived social support

Variables	*β*	*t*	Sig.	Partial η^2
	Fighting spirit			
Family	.163	1.742	.084	.160
Friends	.244	2.426	.017	.221
Significant Others	.093	.919	.360	.085
	Hopelessness/Helplessness			
Family	-.479	-4.426	.000	-.381
Friends	-.260	-2.243	.027	-.205
Significant Others	-.358	-3.057	.003	-.274
	Fatalism			
Family	.198	2.242	.027	.205
Friends	-.058	-.617	.539	-.057
Significant Others	.152	1.595	.114	.147
	Anxious Preoccupation			
Family	.213	1.945	.054	.178
Friends	.084	.718	.474	.067
Significant Others	.151	1.270	.207	.118
	Avoidance			
Family	-.112	-1.217	.226	-.113
Friends	.106	1.074	.285	.100
Significant Others	-.024	-.237	.813	-.022

4. Discussion

Cancer is a medical disease that has a great impact on patients' and their loved one's psychological wellbeing (Di Giuseppe et al., 2020; Rahnea-Nita et al., 2019). The perceived social support from different source may improve the use of adaptive coping strategies and survival (Hack & Degner, 2004; Howsepian & Merluzzi, 2009; Mishra & Saranath, 2019; Ozdemir & Tas Arslan, 2018; Tremolada et al., 2016; Yıldırım et al., 2017). The present study was addressed to investigate how the coping strategies in facing stressful situations and traumatic experiences connected to cancer diagnosis would be associated with the perceived social support derived from different sources.

Based on previous studies (Costa-Requena et al., 2015; Howsepian & Merluzzi, 2009; Mishra & Saranath, 2019; Ozdemir & Tas Arslan, 2018; Zucca et al., 2010), we hypothesized a significant association between coping styles – in terms of fighting spirit, fatalism, hopelessness/helplessness, anxious preoccupation, and avoidance – and perceived social support, regardless of the specific support sources. Interestingly, partially contrasting our initial hypotheses, we detected that the sources of perceived social support may often matter.

In line with both our initial hypothesis and some research (Cicero et al., 2009; Mishra & Saranath, 2019; Yağmur & Duman, 2016), we found that the patients who use fighting spirit for adjusting to cancer may perceive higher social support levels. However, in our sample, friends seemed the most relevant source of perceived social support, whereas the perceived support derived from both family and significant other did not seem connected to fighting spirit. In other words, fighting spirit did not seem to value the support received from the family and from the significant others. As a viable interpretation, the patients who appraise the cancer diagnosis as a challenge as well as maintaining a more active attitude (Grassi et al., 2005) would avoid to decrease their social contacts, thus gaining a better chance of receiving social support. Under such condition, the perceived social support from family and significant others might be perceived as foregone.

According to previous research, the sources of perceived social support are all relevant (Helgeson & Cohen, 1996) when related to hopelessness/helplessness – the most maladaptive coping response as well as the major indicator of demoralization and depressive disorders (Grassi et al., 2010). As expected, based on both scientific literature (Cicero et al., 2009; Costa-Requena et al., 2015; Yağmur & Duman, 2016) and our derived hypothesis, the obtained results suggested that the patients who have a negative view of the future, a sense of loss of control, confidence, courage, and energy to achieve their own goals (Grassi et al., 2010) perceived less social support from loved ones, whoever they were. As a possible explanation, this coping strategy would prevent the opportunity to relate to others in a profitable way, making useless any eventual supportive effort from anyone.

Most literature about the use of fatalism (Cicero et al., 2009; Costa-Requena et al., 2015; Yağmur & Duman, 2016) has acknowledged the existence of an association between this coping style and perceived social support. According to our initial hypothesis, outcomes confirmed the expected positive relationship referring to the perceived social support derived from family. Therefore, fatalism could not act as an absolute maladaptive strategy (Calderon et al., 2020). As a possible explanation, support from family would be likely perceived as capable of holding the disease within a safe context, in which one may also take refuge in faith, warded from overthinking and excessive worrying about the future.

Lastly, in contrast with our initial hypotheses, despite some studies have shown an association between both anxious preoccupation and avoidance and perceived social support (Costa-Requena et al., 2015; Yağmur & Duman, 2016; Zucca et al., 2010), our findings did not reveal any significant result around these coping styles, regardless of the source. As a practical interpretation, as suggested by Mishra and Saranath (2019), anxious preoccupation and avoidance might make useless any form of social support since the patients' attitude would not allow reaping the benefits of possibly provided physical, instrumental, and emotional closeness to others.

Overall, this study might play a role in addressing people's mental health needs, whereby psychological well-being and physical symptoms should not be thought as separate from each other. The style of adjustment to cancer could affect how patients perceive their illness, life, and social environment, outlining different ways of interpreting reality. Also, cancer is both an individual and collective experience since patients are mostly involved in social relationships, which could provide the psychological tools to deal with the disease and improve their quality of life. Our detected findings suggested the need for further investigations focusing on patients' coping styles in order to develop or improve psychological treatments oriented to a holistic approach of support. This might be helpful to deepen the care of people as a promotion of well-being in every area of their life, including the social context.

5. Limitations

First of all, the study included patients with different types of cancer. The small number of participants for each type did not allow us a cancer type-based comparison of patient related variables. Besides, the empirical generalizability of results may be limited since the administration was carried out in a single Italian hospital. Here, the participants were invited to take part to the study at different times in their clinical path. This condition may have caused unanalysed differences. Finally, the nature of the cross-sectional study did not help determine cause and effect links. Indeed, the applied data analyses could not address the temporal relationships between the measured variables for identification of potential causal factors.

6. Conclusion

This study might increase the knowledge about the association between the adopted coping strategies and the perceived social support among cancer patients. Our results suggested that the adaptive coping styles – e.g., fighting spirit – might make patients more likely to perceive social support. In a complementary manner, maladaptive ways of coping – e.g., hopelessness/helplessness – might make patients unable to take advance of any eventual help from others.

The specific relevance of the various sources of perceived social support was also inspected: friends could encourage patients to a more active and joyful life, and family could provide a safe haven. Therefore, the cancer patients who adjust to cancer in a positive way might benefit from the proximity of loved ones.

To conclude, the analysis of patients' coping styles might help to understand the level of accessibility of their resources. Increasing the adaptive ways to cope with cancer could lead to a functional personal life during the time of disease crisis. The mental health professionals who offer services in oncological department should pay attention to the use of maladaptive coping styles for the purpose of improving the patients' receptivity to support from family, friends, and significant others.

Conflict of Interest Statement

The authors declare that the research was conducted in the absence of any potential conflict of interest.

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