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Creating a Trans-Affirmative Assessment Practice

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Abstract

Neuropsychological assessments can have marked impacts on individuals because outcomes directly inform interventions, medication management, and accommodation services. Higher level psychological assessments have a tremendous amount of empirical backing and standardized norms; however, they often rely on gender-based norms, resulting in problems with translating findings to nonbinary examinees. Research and guidance are currently lacking on how to translate binary gender-normed assessments to be inclusive of transgender and gender diverse clients. Until more inclusive assessments are extensively studied and normed, clinicians need a process to use current materials while incorporating diversity, equity, and inclusion. The following includes recommendations for creating a trans-affirmative assessment practice, including measure selection and interpretation and how to provide gender diverse clients with a respectful and supportive assessment environment.

Keywords Assessment · Guidelines · Transgender · Trans-affirmative

Clinical Vignette

Lindsey is a 27-year-old transgender female client who contacted your practice looking for an assessment due to difficulties with social interactions and staying focused at work and home. She is hoping to better understand herself, receive a diagnosis (if applicable), and receive support and recommendations. During your initial contact with her through a phone screener, Lindsey described difficulties with understanding emotions, communicating with others, and coping with anxiety in social situations. Lindsey expressed preferences for being alone and felt like she was being judged in public places. Further, Linsey described difficulties staying on task at work, being easily distracted, and losing focus during conversations. When you inquired into her gender, Lindsey indicated she is a transgender female and transitioned when she was 22 years old. Although you have extensive experience administering neuropsychological assessments, you have never administered an assessment with a transgender client. At your practice, you use a standard battery of measures and adapt as needed based on the client's presenting concerns. Since many of the measures you use have binary gender-based norms, you are unsure of which measures and norms to use, and how Lindsey's gender identity might influence your case conceptualization. How should you proceed?

Clinical Challenge

Background

Neuropsychological, intelligence, and personality assessments are used to clarify diagnoses, determine cognitive capacity, identify challenges in functioning, assess interpersonal functioning, screen for risk, and examine the relationship between how the brain functions and the behavior it produces (Suddarth, 2021). Neuropsychological assessments often consist of a battery of standardized tests with developed norms for age, education, race, ethnicity, and gender. Similarly, personality assessments, such as the Minnesota Multiphasic Personality Inventory (MMPI), have scales that are designed to measure psychopathology and are scored and interpreted based on gender (Keo-Meier & Fitzgerald, 2017).

Transgender and gender diverse (TGD) people are individuals whose gender identity, a person's deeply felt inherent sense of their gender, does not fully align with their sex assigned at birth or who practice nonconformity to social expectations in gender expression that caters to cisgender heterosexual individuals (American Psychological Association, 2015; Hyde et al., 2019). Extensive research with diverse cultures has described gender as a nonbinary construct, which often develops in young toddlerhood. However,

an awareness that one's gender identity is not fully aligned with one's sex assigned at birth may not arise until childhood, adolescence, or adulthood, leading to the progression through stages of awareness, exploration, and identity (American Psychological Association, 2015). Among United States (U.S.) adults ages 18 and older, 0.5%, or approximately 1.3 million adults, identify as transgender. Of the U.S. adults who identify as transgender, about 38.5% are transgender women, 35.9% are transgender men, and 25.6% reported they are nonbinary (Herman et al., 2022). Recent research has shown that TGD individuals experience higher rates of mental health concerns compared to their cisgender heterosexual peers, with approximately 58% of transgender patients having at least one DSM-5 diagnosis compared to approximately 14% of cisgender patients (Hawks et al., 2019; Wanta et al., 2019). However, TGD individuals tend to seek mental health assessment and treatment less than their peers due to stigma, prejudice, and discrimination by the medical community (Hawks et al., 2019). This is especially concerning given that the general U.S. adult population prevalence for past-year suicidal ideation is 10% and for lifetime suicidal ideation is 5–15% (Nock et al., 2008), compared to TGD individuals whose prevalence for past-year suicidal ideation is nearly five times more than the general population at 48% and a soaring 82% prevalence for lifetime suicidal ideation (James et al., 2016). A disheartening cycle is created in which we know mental health outcomes are drastically improved for TGD individuals who are able to access medical care and hormone treatment (American Psychological Association, 2015), but frequently getting to that level of care requires engaging with multiple healthcare providers and/or assessment services—of which there are no normed protocols or required training, perpetuating a cycle associated with a staggering 32% prevalence rate of attempted suicide by TGD people (Clements-Nolle et al., 2006). Creating a trans-affirmative assessment environment and process may be one of the first steps to disrupting this cycle.

Limitations

Most neuropsychological assessments rely on binary gender-based norms, and there is a lack of research and guidance on conducting these assessments with adult TGD clients (Keo-Meier & Fitzgerald, 2017; Trittschuh et al., 2018). The interpretation of assessments often does not take into consideration the unique experiences of TGD people (e.g., gender dysphoria; Keo-Meier & Fitzgerald, 2017). Additionally, gender-based norms developed along binary gender categories can result in inaccurate data and over-pathologizing, thus harming TGD clients (Keo-Meier & Fitzgerald, 2017). Further, clinician bias, social and historical contexts, and cultural climate can influence how TGD individuals are more at risk for *diagnosis* of pathology, as opposed to more at risk for actual pathology (Porter, 2023), especially in the case of personality disorders, such as borderline personality disorder, in which trauma, sexuality, and belongingness in relationships can shape interpretation (Denning et al., 2022).

Currently, no assessment instruments in neuropsychological, intelligence, or personality batteries have been normed or validated on TGD people (Hawks et al., 2019; Keo-Meier & Fitzgerald, 2017). The lack of norms can create challenges when considering comorbidities or symptom clusters that are more prevalent among TGD individuals, which can result in over- or underdiagnosing, as well as limiting the sense-making process of an individual receiving assessment feedback. For example, recent research demonstrates an increased prevalence of neurodivergence (e.g., the range of presentations across the autism spectrum) among TGD people, such that a neurodivergent presentation is more than six times more prevalent among TGD individuals than their cisgender peers (Warrier et al., 2020)—yet we have no validated norms or protocols for completing neuropsychological assessments in a non-gendered way. This often leads to the question of how to administer an assessment with gender-based norms with an adult transgender client and which set of norms to use. While the intent of this paper is to broadly provide general affirming strategies that may enhance the assessment experience for TGD clients, a detailed overview or approach towards a particular area of assessment (e.g., neuropsychological, intelligence, personality) is beyond the scope of this paper.

Assessment Guidelines

Consultation

When conducting a neuropsychological, intelligence, or personality assessment with an adult transgender client, it is important to consider all components, including the setting, intake, measure selection, administration, interpretation of results, feedback session, and writing of the report. Overall, it is recommended that clinicians administering assessments with adult transgender clients seek appropriate consultation, supervision, and training to obtain competence in performing any type of assessment with TGD clients. Clinicians can seek guidance from APA Division 44: Society for the Psychology of Sexual Orientation and Gender Diversity and the World Professional Association for Transgender Health (WPATH), as well as review the WPATH Standard of Care Version 8 and the APA

Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (American Psychological Association, 2015; Coleman et al., 2022). Furthermore, since research on TGN mental health, assessment, and intervention is rapidly evolving, it is encouraged that clinicians consistently update their knowledge by seeking trainings and/or reviewing current literature on relevant domains.

Virtual and Physical Space

Clinicians should create a "safe zone," a trans-affirmative practice that consists of care that is respectful, aware, and supportive of the identities and life experiences of transgender clients. This care should be developmentally appropriate and demonstrate cultural humility (American Psychological Association, 2015). Cultural humility involves "(a) a lifelong motivation to learn from others, (b) critical self-examination of cultural awareness, (c) interpersonal respect, (d) developing mutual partnerships that address power imbalances, and (e) an other-oriented stance open to new cultural information" (Mosher et al., 2017, p. 223). The intrapersonal factors of cultural humility focus on self-reflection on one's cultural biases and promote cultural exploration and growth, while the interpersonal factors focus on the other person and their needs in the moment (Mosher et al., 2017).

A trans-affirmative practice should promote inclusion and safety, even before a client enters the practice. For example, a trans-affirmative practice can include a value statement on its website, a commitment statement to diversity, equity, and inclusion (DEI) on paperwork mailed to clients, and can adapt intake paperwork and/or outreach materials to be more inclusive of all gender identities and expressions. To demonstrate inclusivity from the outset and avoid making assumptions or misgendering individuals, at initial contact, trans-affirmative practices should ask all new clients for their correct name, disaggregated sexual orientation, sex assigned at birth, and gender identity, and ask for correct pronouns (Basch, n.d.; Moradi & Budge, 2018). This can be accomplished by allowing clients open response options to self-describe beyond predetermined categories. For example, intake paperwork can assess gender self-identification through predetermined categories including male, female, transgender, nonbinary, and an open response to self-describe. Predetermined categories can be alphabetized to avoid the appearance of a hierarchy of identities (Moradi & Budge, 2018). Furthermore, a trans-affirmative practice can display trans-affirmative resources, brochures, visuals, and artwork in waiting areas (American Psychological Association, 2015; Moradi & Budge, 2018).

Trainings

A trans-affirmative practice should also provide trainings to clinic staff and clinicians on how to respectfully interact with TGD people (American Psychological Association, 2015). These trainings, either in the form of an onboarding orientation, as a regular staff training, or as a training manual, should incorporate knowledge of various theoretical models to better understand and support transgender clients (Keo-Meier & Fitzgerald, 2017). One such model is the Gender-Affirmative Model (GAM), which states that gender is non-binary, gender diversity varies across cultures and requires cultural sensitivity, being transgender is not a disorder, and that if pathology is present, it is more likely a response to a hostile environment (Keo-Meier & Fitzgerald, 2017). The goal of GAM is to partner with transgender people to holistically address their social, mental, and medical health needs and wellbeing in a way that respectfully affirms their gender identity (Coleman et al., 2022). Another model that aids in understanding and supporting adult TGD clients is the Gender Minority Stress Model. The Gender Minority Stress Model presents distal and proximal stress factors that have a negative impact on the health of TGD people. *Distal stress factors* include physical and sexual violence, harassment, discrimination, and prejudice, while *proximal stress factors* include expectations of rejection or violence and internalized transphobia (Hawks et al., 2019; Keo-Meier & Fitzgerald, 2017). Internalized transphobia is the internalization of societal gender norms and expectations by a TGN individual, which can result in the development of shame and self-hatred due to their lack of conformity to society's definitions of gender (Austin & Goodman, 2017; Bockting et al., 2020). Internalized transphobia can also result in self-blame for not conforming to societal expectations, as well as low self-esteem and wellbeing (Bockting et al., 2020). These experiences, in combination with everyday stressors, disproportionally compromise the mental health of TGD populations, exemplified by increased rates of depression, suicidality, and non-suicidal self-harm compared to cisgender populations (Coleman et al., 2022; Hawks et al., 2019). Similarly, the Minority Strengths Model outlines that important personal and collective strengths of minority populations combine to create resilience and positive mental and physical health. Specifically, strengths including social support and community consciousness have been linked to positive health behaviors and mental health through identity pride, self-esteem, and resilience (Perrin et al., 2020). Lastly, a trans-affirmative practice should incorporate an understanding of *gender noise*, which are the multiple daily thoughts of a transgender individual related to their gender, body, or physical safety. Extensive energy may be spent dealing with gender noise, which can negatively impact academic, professional, and life functioning. Understanding gender noise and

the energy spent coping with these thoughts can prevent a case conceptualization of inattention, lack of interpersonal interest, social anxiety, depression, and other psychological concerns (Keo-Meier & Fitzgerald, 2017).

In the clinical vignette, Lindsey presented with concerns of difficulties with social interactions and staying focused at work and home. Understanding the distal and proximal factors presented by the Gender Minority Stress Model might help explain some of Lindsey's anxiety in social situations and preferences for being alone. Further, understanding gender noise might prevent a case conceptualization of Lindsey struggling with inattention and social anxiety, when she might be spending extensive energy coping with thoughts about her gender, body, and physical safety.

Interviewing

During the intake, and throughout all interactions with transgender clients, it is encouraged that clinicians, as well as clinic staff, use gender inclusive language that upholds the principles of safety, dignity, and respect (Coleman et al., 2022). Clinicians should move away from saying "preferred pronouns" to just "pronouns" because the term "preferred" implies a choice about one's gender and downplays the importance of using accurate pronouns (Conover et al., 2021). Similarly, it is encouraged that clinicians use the name that the client provided at first contact as their name (Basch, n.d.). Regarding gender identity, clinicians should discuss with adult transgender clients what language or terminology they use, including how they would like to be addressed in terms of pronouns and how they self-identity their gender (Coleman et al., 2022). Reactions to the question of how one self-identifies their gender can vary because sharing pronouns can be difficult for individuals who are exploring their gender, are not out, or do not want to choose pronouns (Conover et al., 2021). Therefore, it can be helpful to start this discussion by asking the client if they are comfortable with sharing these details (Conover et al., 2021). To further promote gender-inclusivity, it can be useful for clinicians to disclose their correct name and pronouns as well. For example, a clinician might begin the conversation by asking, "My name is Dr. Smith, and my pronouns are he and him. Do you mind if I ask what pronouns you use and how you self-identify?" It is also useful to sensitively explain that many aspects of client history are important for interpreting assessment results. For adult transgender clients specifically, this includes the process of transitioning, any hormone replacement therapy, sex reassignment therapy, and the social and educational effects of their gender identity, if applicable. Clinicians should also emphasize to transgender clients to feel comfortable speaking up if the clinician says anything inaccurate or invalidating. If the client corrects the clinician, the clinician should openly appreciate the correction rather than reacting negatively to criticism. Lastly, to reduce the risk of accidentally outing a transgender client to someone who might read the final report, clinicians should collaborate with the client early in the assessment interaction process regarding risks and benefits of which name, gender, and pronouns they would like to be used in their report. These recommendations are ways to prioritize and standardize clinic procedure for discussing gender and embracing gender-inclusivity with all clients, not just transgender clients.

Conceptualization

To assist with case conceptualization, clinicians should consider utilizing the Gender Minority Stress and Resilience Scale, which assesses difficulties associated with identifying as transgender or gender diverse and resiliency factors that protect against the effects of these stressors on psychological wellbeing (Keo-Meier & Fitzgerald, 2017; Shulman et al., 2017). The stressors associated with a TGD identity assessed by this measure include gender-related discrimination, gender-related rejection, gender-related victimization, non-affirmation of gender identity, internalized transphobia, negative expectations for future events, and nondisclosure. The resiliency factors assessed include community connectedness and pride in one's identity (Shulman et al., 2017). Developing a complete understanding of a transgender client, including their strengths, can help clinicians conceptualize the presenting concerns and tailor their recommendations accordingly.

Avoiding Common Missteps

Clinicians working with adult transgender clients should also be aware of the common missteps made by mental health providers—and the associated negative impact on the therapeutic alliance—when working with TGD clients. *Education burdening* involves relying on the client to educate the clinician on transgender issues, which takes the client out of the client role. *Gender inflation* occurs when clinicians overlook other important aspects of a transgender client's life beyond gender, contributing to the objectification of one's gender, which can result in erroneous assumptions about the etiology of mental health concerns. *Gender narrowing* occurs when clinicians apply preconceived, restricted views of gender onto transgender clients, thus overlooking the diverse range of gender identities and experiences among transgender clients. On the other hand, *gender avoidance* is when clinicians lack focus, awareness, or general training on issues of gender in assessments with transgender clients and the subtle and complex ways gender can impact mental health. *Gender generalizing* involves making assumptions that all transgender individuals are the same and not listening for

or understanding the unique experiences of gender among this population. *Gender repairing* can occur when clinicians hold subtle or covert beliefs that a client's transgender identity is a problem to be "fixed" and therefore conduct an assessment in a manner that alienates or harms these clients. Similarly, *gender pathologizing* transpires when clinicians label a client's transgender identity as a mental illness to be treated or designate as responsible for the client's problems. Lastly, *gate keeping* occurs when clinicians focus on controlling a client's access to gender affirmative medical resources rather than supporting them (Mizock & Lundquist, 2016).

To create a trans-affirmative and supportive assessment experience for Lindsey, the clinician should keep these common missteps in mind and actively work to avoid them. For example, to avoid education burdening, the clinician should familiarize themselves with transgender issues but should not engage in gender generalizing and assume that Lindsey is the same as all transgender individuals. Rather, the clinician should balance listening and understanding Lindsey's unique experiences with relying on her to inform them of all transgender issues. Although it is possible that some of Lindsey's presenting concerns are related to her gender, the clinician should avoid gender inflation and any belief that her gender identity is the root of all her problems. Asking for more contextual information on screening measures is one way to avoid common missteps that might inaccurately shape early stages of the assessment formulation process.

Measure Selection and Administration

The need for continued scale development and scale validation on TGD people remains; therefore, clinicians are encouraged to develop and validate assessment instruments that can be used with TGD clients. Due to the lack of research on conducting neuropsychological assessments with adult transgender clients and the historical disenfranchisement and disempowerment of TGD people in health care, it can be useful to collaborate with adult transgender clients throughout the decision-making process and when selecting which measures to use (American Psychological Association, 2015). Any standardized measure should be well integrated with a clinical interview and considered in the context of the client's history with gender dysphoria, gender minority stress, and gender transition status, as well as how this history might artificially inflate scores (Keo-Meier & Fitzgerald, 2017).

When selecting which measures to use, carefully review all measures in advance to see if they are gendered, how gender affects interpretation, and if less harmful measures exist (Trittschuh et al., 2018). Qualitative clinical interviews and symptom inventories developed specifically for transgender clients or that have nongender-based norms (e.g., Beck Depression Inventory, Symptom Checklist-90-Revised) are recommended over measures with binary gender-based norms (Basch, n.d.; Hawks et al., 2019; Trittschuh et al., 2018). If nongendered scoring options do not exist for a measure that a clinician is using, clinicians should score the measure using both gender norms to consider any differences between scores and emphasize the results that best align with the other information collected. However, if a measure cannot be scored twice, it may be more appropriate to score the measure using the norms for the client's recognized gender identity (Hawks et al., 2019). Clinicians should be mindful that scoring a measure with only one gender template may result in higher levels of psychopathology than the other gender for the same test data (Keo-Meier & Fitzgerald, 2017). In this case, for comparison, it may be helpful to incorporate at least one measure within each domain of interest that does not involve gender-based norms (Hawks et al., 2019). To create a trans-affirmative practice that uses a standard battery of measures, like in the clinical vignette, it may be helpful to evaluate all the measures used in that battery and list gender-based norms in a shared spreadsheet. This would circumnavigate clinicians at the same practice reinventing the wheel each time one conducts an assessment with a transgender client.

When conducting a neuropsychological assessment with Lindsey, the clinician should:

1. Carefully review all the measures in their practice's standard battery to determine if it has gender-based norms (e.g., Minnesota Multiphasic Personality Inventory), how gender might affect interpretation of results, and whether a gender is required for the online report (e.g., Weschler Adult Intelligence Scale – Fourth Edition).
2. Conduct a clinical interview with Lindsey, asking about not only her presenting concerns, but also her experiences regarding her gender identity, including her transition status, any history of gender dysphoria, and her experiences with gender minority stress. For example, the clinician might ask, "How comfortable are you with your gender identity?" or "How has transphobia and/or heterosexism or cissexism affected your life and how have you dealt with this?" The clinician should consider how Lindsey's gender identity history (e.g., internalized transphobia, gender noise) might influence her presenting concerns and whether additional measures might aid in the case conceptualization of Lindsey (e.g., a social anxiety measure developed for TGN people).
3. Finalize which measures to use, any additional measures to include, such as the Gender Minority Stress and Resilience Scale, and how measures will be scored. If nongendered scoring options do not exist for a measure

included in the practice's battery, the clinician should score the assessment using both gender norms, consider any differences in scores between both genders, and emphasize the results that more closely align with additional measures used and the clinical interview. The clinician should also consider incorporating at least one measure that does not involve gender-based norms (e.g., Beck Depression Inventory).

4. Conduct the assessment using gender-inclusive language.

Results and Feedback

To provide an accurate and ethical interpretation of assessment results, it is encouraged that clinicians administering assessments with adult transgender clients develop an understanding of cultural variables, social challenges, and potential stressors specific to the TGD population and the client specifically (e.g., gender identity; Hawks et al., 2019). At the same time, clinicians should avoid assuming the etiology of the client's distress or pathology is exclusively due to gender dysphoria, as gender-related stressors may be a secondary concern or have no correlation with their presenting symptomatology (Suddarth, 2021). When providing feedback to an adult transgender client, clinicians should consider including a detailed discussion regarding the use of normative data, their approach to interpreting the results, and limitations of interpretability (Hawks et al., 2019).

As previously mentioned, to reduce the risk of accidentally outing a transgender client to someone who might read the report, clinicians should ask the client what name, gender, and pronouns they would like to be used in their report (Hawks et al., 2019). As a standard practice, and to demonstrate gender-inclusivity of all clients, all assessment reports, regardless of the clients' gender identity, should include a header that identifies the client's pronouns. It is also recommended that clinicians and supervisors include their own pronouns beneath the report signature line. Within the report, it is important to discuss the limitations of interpretability of the results for transparency (Hawks et al., 2019). Specifically, if applicable, clinicians should indicate that the measures used were not normed with the transgender population, the results were generated using both gender templates, the rationale for relying more heavily on one gender template over the other, and that the data should be interpreted with caution (Keo-Meier & Fitzgerald, 2017; Hawks et al., 2019).

When discussing the results with Lindsey and writing the report, the clinician should:

1. Inform Lindsey of the results, as well as whether the measures used had gendered norms, how the scoring method chosen (e.g., scored a measure twice using both gender norms and emphasized the results that most closely aligned with the clinical interview) may have influenced the results (e.g., over-pathologized), and the limits of interpretability (e.g., perhaps not 100% accurate).
2. Make the feedback session a collaborative process where Lindsey has a say in what name, gender, and pronouns are included in the report. Additionally, Lindsey should be given the opportunity to make edits to the report before it is finalized, especially if she does not want certain information included (e.g., transition process).

Table 1 Recommendations for Trans-Affirmative Assessment Practices

Assessment Component	Recommendation
Consultation	Continually seek consultation or supervision to gain/maintain ongoing competencies for conducting neuropsychological, intelligence, or personality assessments with transgender clients
Virtual and Physical Space	Publish a statement of commitment to DEI on the practice's website, outreach material, and new client paperwork Ask all new clients at initial contact for their *correct* name, gender identity, and pronouns through open response options and the ability to self-describe
Trainings	Provide trainings to all clinic staff and clinicians on how to respectfully interact with transgender clients by incorporating various theoretical models to aid in understanding and conceptualizing transgender clients Familiarize all clinic staff and clinicians with common missteps to avoid when working with transgender clients Ensure all clinic staff and clinicians maintain the use of gender-inclusive language throughout all assessment interactions
Measure Selection	Prioritize measures that were either developed for transgender people or use nongender-based norms. If not possible due to the practice's standard battery, score the measure with both gender norms and emphasize the results that best align with the other information collected
Results and Feedback	Interpret overall results with consideration of social challenges and potential stressors specific to the client's transition, without assuming the etiology of their distress is exclusively due to gender dysphoria or gender-related stressors In both the feedback session and final report document, include a detailed discussion of how the results were interpreted, any limitations with interpretability, and highlight the client's strengths and resiliency

3. Include the name, gender, and pronouns Lindsey requested in the final report, and include a header that identifies Lindsey's pronouns and list the clinician's pronouns beneath their signature line.

When following these recommendations, a trans-affirmative practice should promote inclusion and safety for all clients throughout all time points. A summary of guidelines for how this can be accomplished can be found in Table 1.

Key Considerations

- Many neuropsychological, intelligence, and personality assessments rely on gender-based norms developed along binary gender categories, and current research is lacking on conducting these assessments with transgender clients.
- Appropriate consultation and supervision should be sought to obtain competence in performing any type of assessment with transgender and gender diverse clients.
- Clinicians and staff should create a safe, trans-affirmative practice that is respectful and supportive of transgender clients and that uses gender-inclusive language and the name and pronouns identified by the client.
- Clinicians are encouraged to develop and validate assessment instruments that can be used with transgender and gender diverse people. Otherwise, measures should be carefully reviewed *in advance* to see if gender-based norms are used and how gender affects interpretation, and measures that do not involve gender-based norms should be included for comparison.
- Clinicians should involve transgender clients in all stages of the assessment, including a discussion on which gender norms were selected, how the results were interpreted, and the limitations of interpretability.

Authors' Contributions M.W. gathered and synthesized previous research and wrote the manuscript. N.G. supervised the project at all stages and extensively edited the manuscript.

Data Availability No datasets were generated or analyzed during the current study.

Declarations

Ethics Approval and Consent to Participate Not applicable.

Consent for Publication Not applicable.

Competing Interests On behalf of all authors, the corresponding author states that there is no conflict of interest.

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