Author’s response to reviews

Title: Self-efficacy for Coping: Utility of the Cancer Behavior Inventory (Italian) for Use in Palliative Care

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Author’s response to reviews:

Dear Dr Wentlandt,

as requested we have provided to revise the manuscript addressing each reviewer comments.

Please find below a detailed point-by-point response letter describing exactly all the amendments made, specifying where these can be viewed, and highlighted in red in the manuscript.

We are grateful to the reviewers for their constructive and useful comments and suggestions.

We hope to have been able to respond appropriately and thus improve the manuscript.
Best wishes,

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Editor Comments:

BMC Palliative Care operates a policy of open peer review, which means that you will be able to see the names of the reviewers who provided the reports via the online peer review system. We encourage you to also view the reports there, via the action links on the left-hand side of the page, to see the names of the reviewers.

Reviewer reports:

Christian Schulz-Quach, M.D., MSc (Reviewer 1): Dear author team, thank you very much for this opportunity to review your manuscript on the translation and validation of an Italian version of the the Cancer Behavior Inventory within the Palliative Care setting. Please find my comments below. I hope you find them constructive and helpful in providing an amended version of your interesting study.

BACKGROUND

- page 4, Line 14: This is probably due to translation issues, but your sentence on treatment is problematic and will be perceived as challenging by many Palliative Care specialists. Treatment refers to every medical or psychosocial intervention during a patient trajectory and not just to anti-neoplastic interventions; however, if I read your sentence correctly, this is what you are referring to. Please re-phrase the sentence and make explicit what you mean by 'treatment'.

This is a good point, especially in the context of palliative care. We have clarified the references to treatment by including the type of treatment to which we were referring.

Background section, lines 14-23, page 5; lines 1-2, page 6

- page 4, Line 17: Please be careful when using the term 'Palliative patient' or 'supportive patient'; this might be misinterpreted by some readers. If I read your sentence correctly, then you are referring to patients receiving palliative or supportive care interventions. Please do not use 'palliative' or 'supportive' as adjectives in this context.
We have reworded the document to avoid the use of “palliative” and “supportive” as adjectives.

- page 4, Line 21: Which 'added challenges' are you referring to. Please be explicit and state references if you can. I might suggest the following three sources for a start, but please see those as suggestions only:


http://journals.sagepub.com/doi/abs/10.1177/0957926514564739


These publications are very interesting pieces and have been integrated into the description of challenges that are faced by persons (and health care providers) in palliative care. Thank you.

Background section, lines 19-22, page 5

- page 5: I really like how you are introducing the self-efficacy model and research! Thank you.

Thank you!

- page 6, line 4: Your description of aims for this study in inconsistent with your study title. Your title suggest that you are reporting on the translation process as well for which I can unfortunately not find any details throughout the manuscript. Please align your title and introduction section. I would highly recommend to consider reporting on your translation process and quality assurance techniques as this will be of interest to the reader and will help in understanding what you actually did apart from the statistical analyses.

This point is well-taken. We have mentioned the goal of translation in the introduction (Background section, lines 4-5, page 8) and have included more on the translation process in the method and result sections. Methods section, Translation of the Cancer Behavior Inventory-Brief/Italian paragraph, lines 5-18, page 9.

Results section, lines 20-22, page 14; lines 1-3, page 15.

METHODS:

- See my earlier comment: When starting to read your manuscript, the reader anticipates a detailed description of the bi-lingual translation process; however, this is absent from the methods section. Please discuss and revise or change the title of your submission.

We added a more detailed description of the translation procedure, with the reference used.
Methods section, Translation of the Cancer Behavior Inventory-Brief/Italian paragraph, lines 5-18, page 9.

RESULTS:

- Please report on the uptake of your study, drop-outs etc. Please consider referring to the STROBE reporting guidelines to standardise your reporting for those variables.

We reported on patient accrual and moved patient characteristics from the method section to results.

Results section, lines 15-19, page 14.

DISCUSSION:

- page 13, line 4: see my comments above. Your description of aim is not consistent with the title. You would be able to make a very strong argument for your translated measure if the translation process was more transparent. For an example, you could say something along the lines of "CBI-B was translated following the proposed guidelines for cultural adaption by Guillemin et al. (Guillemin et al., 1993). An overview of the translation process is shown in Figure 1. In order to study the health care needs of people with diverse cultural backgrounds, research instruments must be reliable and valid in each culture studied. (Gjersing, 2010; Munet-Vilaró F., 1990). If quantitative measures are used in research, it is necessary to translate these measures into the language of culture being studied. Without verification of translation adequacy, differences found while using the target language version in the target population, might be due to errors in translation, rather than being true differences between countries (Maneesriwongul & Dixon, 2004)." Again, please see this wording as a suggestion only.


We have mentioned the goal of translation in the introduction and have included more on the translation process in the method section with the reference used.

Background section, lines 4-5, page 8.

Methods section, Translation of the Cancer Behavior Inventory-Brief/Italian paragraph, lines 5-18, page 9.

We included more data of translation process on Results section, lines 20-22, page 14; lines 1-3, page 15.

We added some comments in Discussion section, lines 15-21, page 17.

- page 15, line 1-6: I agree with your important description of limitations. In light of those, I would urge you to reconsider your discussion above and tone down the conclusions you draw from your study, which was intended to provide evidence of a successful translation and validation process. Please focus a bit more on these aspects in your discussion so that the reader has a more rounded impression of your manuscript. For an example, what problems did you encounter during your translation process? Did you encounter any difficulties with change of meaning of words after translation etc?

We revised the discussion focusing a bit more on the translation and cultural adaptation of the questionnaire.

Discussion section, lines 15-21, page 17

I hope my comments will be helpful in further developing your manuscript. Please see them as constructive feedback with the intention to help you improve your already well written manuscript even further.

Maxwell Thomas Vergo, M.D. (Reviewer 2): This manuscript looks to assess the validity of a modified CBI-B tool in an Italian population to measure self-efficacy in coping. The authors argue that this is important as it is important to have 'active agents' who are engaged in their care plan, particularly palliative care patients. They also assess associations between the CBI-B/I and other measures of QOL, adjustment, concerns, anxiety/depression, and performance status.

I hope my review will help the authors strengthen their manuscript.

Background:

1. First reference citation starts with #10. Re-number starting with #1.

The references have been reworked to conform to the journal’s format.
2. First paragraph-- authors should consider briefly reviewing what literature exists linking QOL with coping self-efficacy. Seems this manuscript is not trying to forge new relationships here, but rather assuring the same associations that exist with the other versions of the CBI-B continue to exist with the CBI-B/I. Therefore, the readers need to know what is already known. They would then expect the manuscript to include measures that were included in previous studies.

Based on this point and #5, we have completely reworked the introduction taking into account the reviewer’s recommendations regarding reference to other measures, prior research on self-efficacy, and the overall order of the presentation of the introduction.

Background Section, pages 4-8

3. 'palliative and supportive' patients is not description enough -- very broad. I like the definition in inclusion criteria-- those who have incurable cancer who may or may not be getting therapies for life extension or palliation of symptoms.

We have included a clearer definition of palliative and supportive care in the opening paragraph.

Background section, lines 7-8, page 4

4. Reference #25: better references exist for this claim. I found the following which the authors should consider including.

Psychotherapy for depression among advanced, incurable cancer patients: A systematic review and meta-analysis. Okuyama T, Akechi T, Mackenzie L, Furukawa TA.


These references were quite helpful. We chose to include the Okuyama et al. article because of the comprehensive nature of the publication.

Background section, line 19, page 5

5. I found the first page of the Background a bit confusing. I would suggest at least starting with Page 2, line 1 and moving on from there. Not sure the first page is really needed since this manuscript is not trying to prove new associations but confirm past associations with an italian version of the CBI-B/I.

We have reworked the entire introduction based on this feedback. We agree that the organization of the introduction is greatly improved by the changes.
Background Section, pages 4-8

6. Page 2, 2nd paragraph: Simplify or split up second sentence -- hard to follow.

We did reword this sentence.

Background Section, lines 9-20, page 4

7. Page 2, 3rd paragraph: this seems to indicate coping self-efficacy is not well studied in palliative care populations. Is that true? If so, then the focus of the manuscript should move from validity to exploring the construct of this measure in this population. It is my impression there is a fair amount of data about coping self-efficacy in advanced cancer patients, so I don't think that is where this manuscript is heading.

You are correct in assuming that we are not claiming that self-efficacy is not well-studied in palliative care. Our intention was to make the case for aligning the measurement of coping self-efficacy with new models of palliative care in which the person is view as active and agentic. Thus, one goal is to identify and refine, for use with patients who speak Italian, a well-established measure of coping self-efficacy for persons receiving palliative care and test its utility in that setting. We have modified the narrative to be more in line with this approach.

Background Section, lines 21-23, page 7; lines 1-4, page 8

8. Why are the authors looking at this coping self-efficacy tool instead of others used in this population? Are there advantages to this one? Please explain in background.

This is a good point. First, there are more general measures of self-efficacy as well as measures of self-efficacy for coping, but these measures are not specific to the cancer setting. The two measures that are focused on cancer are the SUPPH (Lev et al, 2007), which does not appear to have a stable factor structure and the SICPA which was designed specifically for the intervention reported in Telch & Telch (1986) and was neither subjected to peer review nor published. We have included this information in the introduction.

Background Section, lines 21-23, page 7; lines 1-4, page 8

Methods:

1. Who determined cognitive impairment? Study personnel or treating clinicians. Please include in methods.

We added this information.
Methods section, Validation Procedure paragraph, line 2, page 10

2. 2nd paragraph of methods should be a Table 1 with enrolled pts demographics and should be in the beginning of the Results section.

We moved this paragraph in the Results section, lines 15-19, page 14 and added the Table 1 with patients’ characteristics.

We added a sentence in the Statistical Analyses section, line 10-11, page 13

3. Consecutive enrollment-- need to know the enrollment rate (# screened, # approached, # enrolled). Also, how long did enrollment take. This helps the reader understand how biased the population may be (speaks to generalizability).

We added this information.

Results section, lines 15-19, page 14

4. Under measures, CBI-B/I should be listed first given it is the tool of interest.

We listed first.

Methods section, Translation of the Cancer Behavior Inventory-Brief/Italian paragraph, line 5-18, page 9

Results:

1. This was the first area (reference to Figure 1) where I understood the 4 factor model the authors were hypothesizing. this should be emphasized and clearer in the methods section.

We added this information.

Methods section, Translation of the Cancer Behavior Inventory-Brief/Italian paragraph, line 7-10, page 9

2. In general, tables need to have what a statistically significant p-value is defined and any abbreviations spelled out under the tables to a reader can interpret the table without having to go back to the body of the manuscript.

We defined the significance in the Statistical Analyses section, line 10-13, page 14 and all abbreviations in Table 3 and Table 4.
Discussion:

1. Second paragraph: The authors propose that improving coping may improve symptom management, but they need to emphasize the opposite is also equally valid -- patients with less symptoms, better functional status, less cancer concerns are those that are coping the best (ie. have the least amount of burden weighing them down and causing stress).

We added this consideration.

Discussion section, lines 7-11, page 18

This suggestion allowed us to realize the opportunity to add also other results related the symptom subscales (table 3). Thank you.

2. Third paragraph: 'distraction and not thinking about one's illness may, in fact, reduce emotional distress' needs another sentence or two putting those dots together for the reader.

We added some considerations, reporting the reference used.

Discussion section, lines 20-22, page 18

3. Define Fatalism a bit more; that may not be a concept known to the readers (as opposed to Fighting Spirit and Cognitive Avoidance which seem more self-explanatory).

We defined a bit more, reporting the reference used.

Discussion section, lines 6, page 19.

4. Limitations: please explain what is meant by 'nonrandom' population. there is no intervention here so I am not sure how you would randomize. Also, consecutive enrollment tries to minimize selection bias that can come with these studies (ie. clinicians select patients who are coping best and most able to consent and participate in a study). Also, should add the following biases: 1) this is only one point in time so this only speaks to associations and not causality. 2) Potential selection bias (enrollment percentage will help with quantifying the risk of this bias).

We deleted the not applicable definition of “nonrandom” sample. Patients were consecutively enrolled, as planned in the research protocol, in order to avoid or minimize the potential bias selection; therefore, we do not consider this aspect a limitation for our study.

We appreciated the suggestion inherent the cross-sectional nature of the study and added this point as a limitation of the research.
Discussion section, lines 1-3, page 20.