Author’s response to reviews

Title: Memories of paternal relations are associated with coping and defense mechanisms in breast cancer patients: an observational study

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Author’s response to reviews:

Dear Editor,

We wish to thank you and the Reviewer for helping us in further clarifying important aspects of the paper.

We revised the manuscript according to the Reviewer’s suggestion and we provide below a point by point response to her concerns.

Best regards,
on behalf of all coauthors
Major concerns (in chronological order):

Introduction

1) I very much appreciate the addition of this piece:

Criteria that differentiate between defense and coping processes include the conscious/unconscious status and the intentional/nonintentional nature of the processes. Criteria based on the dispositional or situational status of the process, and on the conceptualization of the processes as hierarchical, are demonstrated to be more a matter of overlap than of difference [6].

However, I think this might need some more explanation or examples. I'm not sure if readers will readily understand what the authors mean/ it's a little too abstract.

We clarified the meaning of our statement adding the following sentence: “For instance, while it is often theoretically emphasized the dispositional aspect of defense mechanisms in contrast to coping as strategies specific to a particular event, research indicated that both coping and defense mechanisms are influenced by personality traits as well as by the characteristics of the context [6 for a review].” (pg. 3, l. 20-23)

2) Page 7, line 3: the authors state that early parental relations can influence interaction with healthcare professionals. Please explain how/ give examples that are relevant here.

We now state: “Breast cancer patients’ attachment model but not surgeon’s identity was modestly but significantly associated with the perceived alliance with breast cancer surgeons [26]. Similarly, in a sample of breast cancer patients attending a follow-up clinic, those with positive models of self, perceived more support from nurses [27].” (pg. 5, l. 16-19)

Methods:

3) Page 8, line 18: please just mention what the actual cut-off score is

We now indicate: “Cut-off scores of the questionnaire (for mothers, a care score of 27.0 and a protection score of 13.5; for fathers, a care score of 24.0 and a protection score of 12.5) indicate whether parents were high or low on the dimensions of care and overprotection.” (pg. 7, l. 8-9)

4) Page 9, line 7: instead of just saying that the PBI is solid, the authors should mention more specifically that the PBI has adequate/good psychometric properties (i.e. reliability? validity?)
We added the psychometric characteristics of the questionnaire and we now state:

“Amongst the self-administered questionnaires assessing the dimensions of attachment, the PBI is indicated as one of the most solid [32], with good internal consistency and test-retest reliability [33], satisfactory construct and convergent validity [34], and stability over a 20 years interval [35]. Furthermore, it is independent of mood effects [34].” (pg. 7, l. 16-19)

5) Page 10, line 14: Please make sure to indicate that the reported alphas are from another study (that only becomes clear in the statistical analysis section now); and also report your own alphas for the subscales (i.e. not in the Results)

We clarified this in the Methods section and reported here our analysis on the subscales. Now it reads:

“Cronbach’s alpha for single defenses ranges between 0.36 e 0.85 (mean value of the coefficient = 0.56), while it corresponds to 0.84 for Factor1 and 0.68 for Factor2 [37]. Even if the alphas for some subscales of the REM-71 reported in Prunas et al. [34] are low, they were used because the subscales may be more informative than the two broad factors. An evaluation of reliability of subscales in this population was performed.” (pg. 8, l. 21-25)

The following sentence has been added in the Statistical Methods sub-section:

“Cronbach Coefficient Alphas of all subscales of Factor 1 in our population are greater than 0.6 indicating that subscales of Factor 1 are reliable .” (pg. 9, l. 11-13)

Methods vs. Results:

6) I think the presentation of analyses and results is still confusing.

The authors mention Wilcoxon tests and ANCOVAs in the methods, but none are reported in the results section. Instead regression analyses are mentioned (but Table 3 mentions ANCOVA). As far as I understand, the ANCOVAs were done to select variables for the regressions. Is this correct? Please state this step in the Results and mention which variables were selected!

7) Where are the results from the Wilcoxon tests? And what is the reason these tests were run anyways? They sound very similar to the ANCOVAs (?), i.e. you use cut-off scores and compare two groups on defenses/coping (Wilcoxon) and then you do the same, but adjust for other factors (ANCOVA)? -->this seems redundant;
OR did you do the Wilcoxon to select for the ANCOVAs? (that's how the table looks like, but not what is reported in the Methods; and the other question that comes along with it: why the regressions and where are they reported?)

-->overall, please better explain and justify your approach in the methods and results.

The statistical methods section was modified to clarify that univariate analyses were carried out first, to identify variables to be included in the multivariate ANCOVA regression models. We presented P-values only of the multivariate analyses in order to show results adjusted for confounders.

Now it reads: “Associations between Coping Styles and Defense Mechanisms with Parental Style (Care and Overprotection), possible confounding factors (age, BMI, menopausal status, family history, parity, education, marital status), types of treatments (mastectomy or quadrantectomy) and other cancer prognostic factors were assessed by univariate analyses (Wilcoxon-rank tests and Spearman correlations coefficient) in order to identify variables to be included in the multivariate ANCOVA regression models.

P-values from multivariate ANCOVA regression models, indicating Defense Mechanisms and Coping Styles associated with Care and Overprotection, adjusted for significant confounding factors and other cancer prognostic factors, are presented.

Residuals from full model were checked to verify normal distribution.” (pg. 9, l. 16-22)

8) I also think it is odd, that correlations are reported at the end of the Results. Given that you use both coping and defense mechanism in the ANCOVAs/regressions it would make sense to check their correlations first

Correlations are now report after descriptives and before ANCOVAs models. (pg. 11, l. 1-9)

Table numbers were changed accordingly. (pg. 28-29)

Minor points:

Page 4, line 15: symptom levels (delete 's' from symptoms)

We changed the text accordingly.

Page 5, line 15: may change to "considered a normative function of the mind"
Page 5, line 17: may change to "a rigid use"

Page 5, line 17: please explain (or delete) "the low hierarchical level of defense" this doesn't seem self-explanatory/ it's unclear what you mean (it only becomes clearer toward the end of this paragraph; so you could also think about re-ordering it)

We changed the sentence as follows:

“In general, the use of defense mechanisms is considered a function of the human mind and partly dispositional, however the flexibility in their use, their effectiveness, the hierarchical level of the defense (whether immature of mature, see below), and the situational characteristics may provide indications of pathological functioning [6].” (pg. 4, l. 9-11)