Writing a rejoinder

Presented by:
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Remember the Context

- The panel has a heavy workload of grants to process

- Your goal: to make it easy for your spokesperson to defend your grant
General Rules

• Don’t be defensive

• Shine: make your work look polished, innovative and show mastery!
We acknowledge reviewer comment that the study addresses a national health priority area, namely cancer; will be the first intervention study internationally to target the psychological wellbeing of men with advanced prostate cancer; that the study is well designed and formulated and rigorous; and that our research team is extremely impressive.

We thank the assessor for their considered assessment. The current lack of evidence to guide psychological intervention for men with advanced prostate cancer is a critical knowledge gap. We are uniquely well placed nationally and internationally to address this gap; and in doing so will contribute more broadly to the national benefit by informing health services planning and delivery in men's health and chronic disease management.
Defend Where Needed

**Will the sample size be sufficient to address this aim?**

We have based our analysis on the power to detect within-between interactions in fixed effects ANOVA with 2 groups and 4 assessments (assuming $\alpha = .05$, correlations between assessment points = .6 and an effect size of $f = .25$). On this basis, a sample size of just 30, which our proposed sample exceeds, will give just over 95% power to detect an effect. Although this estimate (based on fixed effects) is an upper limit on the power of a similar design that includes random effects, our intended sample size of 130 will provide sufficient power for mixed modelling to detect meaningful moderation effects.
The best evidence for suggesting that our sample size will be appropriate for the mediating effects we seek comes from a simulation study by Fritz and MacKinnon (2007), who compared power/sample size requirements of a range of different approaches to the analysis of mediation. First, the bias corrected bootstrap approach (as in other statistical areas) is the best approach in terms of optimal power and this is the approach we will be using (see App. p. 7). Second, with respect to sample sizes for 80% power (assuming α= .05) their Table 3 shows a sample size of 71, when the effects of the IV on the Mediator and the Mediator on the DV are of medium magnitude (i.e., .39 in Cohen’s terms), respectively. We make this decision on the basis of our own pilot data for the present application (see p. 3); and indeed our final expected sample size of 130 tallies with Monte Carlo simulations run for previous grant submissions.
Would it be worthwhile to ask participants to provide some quantitative and/or qualitative feedback on the intervention; how helpful were particular aspects; and what could be changed or improved?

We thank this reviewer for raising this important point. As a part of our standard practice in all our trials we do assess the helpfulness of different components of the intervention to assist with future translation. In our pilot study (Chambers et al, 2011 In Press) we developed a short satisfaction survey that we will administer at the three months assessment after completion of the intervention. This brief survey assesses the helpfulness of each intervention component; provides the opportunity for participants to comment about their experience of the intervention and suggest improvements.
Highlight further progress

Provide information as to how these psychological problems impact on patient progress, outcome or management.

We have published a systematic review with our proposed model of adjustment that concluded stigma about lung cancer is related to poorer quality of life and higher psychological distress in patients [1]. This is supported by more recent research with lung cancer patients where there was a positive association between perceived stigma and depressive symptomatology and where perceived stigma accounted for significant unique variance in depressive symptomatology above and beyond that accounted for by relevant demographic, clinical, and psychosocial factors[2]. We have undertaken in-depth qualitative research with an Australian specialist multi-disciplinary panel of 31 lung cancer health professionals who rated stigma in lung cancer as a key priority issue affecting lung cancer outcomes and care. Stigma in lung cancer is a key priority for Cancer Australia.