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### ARTICLE DETAILS

<table>
<thead>
<tr>
<th>TITLE (PROVISIONAL)</th>
<th>Initial health care and coping preferences are associated with outcome one year after whiplash trauma. A multi-center 1-year follow-up study</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUTHORS</td>
<td>Myrtveit, Solbjørg; Carstensen, Tina; Kasch, Helge; Ørnbøl, Eva; Frostholm, Lisbeth</td>
</tr>
</tbody>
</table>

### VERSION 1 - REVIEW

<table>
<thead>
<tr>
<th>REVIEWER</th>
<th>Robert Ferrari</th>
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<tbody>
<tr>
<td>UNIVERSITY OF ALBERTA, CANADA</td>
<td></td>
</tr>
<tr>
<td>REVIEW RETURNED</td>
<td>19-Dec-2014</td>
</tr>
</tbody>
</table>

**GENERAL COMMENTS**

1. The paper should be read and re-written by a colleague whose first language is English.
2. Increasingly, the word "collision" is used instead of "accident". The authors may wish to make this change as well.

**Specific Comments:**

1. The authors chose not to use a standardized coping instrument, such as the Vanderbilt Pain Management Inventory. They should explain why they chose not to use a standardized and validated instrument. The authors state in the Discussion that they wanted to identify simple risk factors that can be easily noted by health personnel – without the use of extensive screening tools." However, the Pain Management Inventory is a tool easily used in clinical practice. The authors need to provide further justification for their choice.

<table>
<thead>
<tr>
<th>REVIEWER</th>
<th>Ian Harris</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNIVERSITY OF NEW SOUTH WALES, AUSTRALIA</td>
<td></td>
</tr>
<tr>
<td>REVIEW RETURNED</td>
<td>24-Jan-2015</td>
</tr>
</tbody>
</table>

**GENERAL COMMENTS**

This well written manuscript reports the findings of a prospective study comparing early preference for coping strategies with 12 month neck pain and work capacity for patients with acute neck pain after motor vehicle collisions. The study is well constructed, well described and the results and conclusions are reasonable and not overstated. The limitations are adequately addressed. I suggest that the results consistently refer to the predictor variable being PREFERENCE for (say) medications, because the reporting sometimes refers to "taking medications" as the predictor, instead of "preferring to take medications" as a coping strategy. The fact that only a half of patients completed high school seems very low for a country such as Denmark. Can this be explained?
VERSİON 1 – AUTHOR RESPONSE

Reviewer: 1
Reviewer Name: Robert Ferrari
Institution and Country: University of Alberta, Canada
Please state any competing interests or state ‘None declared’: None declared

General Comments:
1. The paper should be read and re-written by a colleague whose first language is English.

Response:
The manuscript has now been read by a lecturer and researcher of English Grammar at the Aarhus University, Denmark. Changes have been made according to his comments and corrections. As this resulted in a multitude of small changes, these are not marked in yellow in the manuscript.

Further comments by reviewer:
2. Increasingly, the word "collision" is used instead of "accident". The authors may wish to make this change as well.

Response:
The word “collision” has been changed to “accident” throughout the manuscript. Changes are marked in yellow.

Further comments by reviewer:
Specific Comments:
1. The authors chose not to use a standardized coping instrument, such as the Vanderbilt Pain Management Inventory. They should explain why they chose not to use a standardized and validated instrument. The authors state in the Discussion that they wanted to identify simple risk factors that can be easily noted by health personnel – without the use of extensive screening tools." However, the Pain Management Inventory is a tool easily used in clinical practice. The authors need to provide further justification for their choice.

Response:
We agree that being able to use a validated instrument would have been a great advantage to our study. However, we were not able to find a validated instrument that satisfactorily covered our needs. We wanted a short and easily understandable list to measure intentions to cope – before actual coping takes place. The above mentioned Vanderbilt Pain Management Inventory (VPMI) might be easy to use, but is designed to measure how patients cope with pain of a chronic nature (1). In the VPMI patients rate the frequency with which they use certain strategies when their pain reaches a moderate or higher intensity; from 1 = never do when in pain to 5 = very frequently do when in pain (1).
In our study, participants were interviewed within a median of five days post-accident (q1 = 3, q3 = 6, max 10). The pain they experience due to the accident is therefore not yet chronic, and due to the short time span the patients are likely not to have developed or started using set coping strategies. Our study aims to investigate whether beliefs about coping, or coping preferences are associated with outcome in a patient group not yet experiencing chronic pain. This cannot be investigated by using an instrument measuring coping strategies currently used for chronic pain. This is now mentioned (in yellow) on page 11 of the manuscript, under Strengths and limitations:

*Further, this study investigates preferences for coping, or intentions to cope, before coping efforts have actually taken place and before pain has become chronic. Instruments measuring coping
Currently in use for chronic pain, like the VPMI (1), can therefore not be used."

Reviewer: 2
Reviewer Name Ian Harris
Institution and Country UNSW Australia
Please state any competing interests or state 'None declared': None declared

Comments by reviewer:
This well written manuscript reports the findings of a prospective study comparing early preference for coping strategies with 12 month neck pain and work capacity for patients with acute neck pain after motor vehicle collisions. The study is well constructed, well described and the results and conclusions are reasonable and not overstated. The limitations are adequately addressed.

I suggest that the results consistently refer to the predictor variable being PREFERENCE for (say) medications, because the reporting sometimes refers to “taking medications” as the predictor, instead of “preferring to take medications” as a coping strategy.

Response:
The manuscript has been re-read and changes have been made to insure that the predictors are referred to as preferences. The changes are marked in yellow.

Further comments by reviewer:
The fact that only a half of patients completed high school seems very low for a country such as Denmark. Can this be explained?

Response:
In this sample, as shown in previous research (2, see table 1), around 50% have completed primary school only, while 50% have completed higher formal education (like high school, college or university). We agree that 50% is a high number for having completed compulsory schooling only, however, among these individuals, 30.3% report to be unskilled workers, while 40.8% are skilled workers. This information has now been added to the results section on page 7.

In the attached letter to the editor, we supply a table showing how the formal schooling variable (mainly use in this study) relates to a question on education.

Thank you!

References:

Initial healthcare and coping preferences are associated with outcome 1 year after whiplash trauma: a multicentre 1-year follow-up study

Solbjørg Makalani Myrtveit, Tina Carstensen, Helge Kasch, Eva Ørnbøl and Lisbeth Frostholm

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Correction


The number of regression analyses conducted is incorrectly stated on the second paragraph of page 3; 20 regression analyses were conducted, not 10. The paragraph should read “As multiple regression analyses were conducted, Bonferroni’s method of taking multiple testing into account was used; the required p value of 0.05 was divided by the number of regression analyses (20). Our results thus had to present a p value below 0.0025 to be significant at the 0.05 level.” This correction does not change any of the results or conclusions of the study, but the sentence below table 2: “‡Significant also after Bonferroni correction (p<0.005)” should read “‡Significant also after Bonferroni correction (p<0.0025)”.

Also, in table 2 the typographical signifier “†” should be replaced with “‡” for the columns containing the p values. Specifically, the p value for the association between coping preference “sickness absence” and “reduced capability to work”, the association between coping preference “take medications” and “neck pain”, and the association between coping preference “take medications and “reduced capability to work” should be followed by “‡” to indicate that they were significant also after bonferroni correction (p<0.0025).