Author's response to reviews

Title: Feeling Labeled, Judged, Lectured, and Rejected by Family and Friends Over Depression: Cautionary Results for Primary Care Practitioners from a Multi-Centered, Qualitative Study.

Authors:

Erik O Fernandez y Garcia (erik.fernandez@ucdmc.ucdavis.edu)
Paul Duberstein (Paul_Duberstein@URMC.Rochester.edu)
Debora A Paterniti (dapaterniti@ucdavis.edu)
Camile S Cipri (cscipri@ucdavis.edu)
Richard L Kravitz (rlkravitz@ucdavis.edu)
Ronald M Epstein (Ronald_Epstein@URMC.Rochester.edu)

Version: 2 Date: 28 February 2012

Author's response to reviews: see over
February 27, 2012

Dear Editors of *BMC Family Practice*:

In this letter, we respond to the Editorial Requests, forwarded to us on February 17, 2012, for our manuscript “Feeling Labeled, Judged, Lectured, and Rejected by Family and Friends Over Depression: Cautionary Results for Primary Care Practitioners from a Multi-Centered, Qualitative Study.” We describe both the rationale behind manuscript changes and the manuscript changes themselves for each Editorial Request (changes italicized). We thank you for the opportunity to revise the manuscript and feel a that all of the requests have served to strengthen the submission.

Sincerely,

Erik Fernandez y Garcia, M.D., M.P.H.
Assistant Professor of Clinical Pediatrics
Department of Pediatrics

**Editorial Request 1:**
“Please state in the Methods section whether written informed consent for participation in the study was obtained from participants or, where participants are children, a parent or guardian.”

**Response to Editorial Request 1:**
We obtained written informed consent of all participants. There were no participants who were children so no informed consent of parents or guardians was necessary. We have amended the manuscript accordingly.

Old Manuscript, Methods Section, Paragraph 2, Page 7:
“After conducting 3 pilot focus groups, we held 12 more groups (4 at each study site) between February and April 2008. Study participants received a $35 stipend for participation in group discussions that lasted 75-110 minutes.”

Revised Manuscript, Methods Section, Paragraph 2, Pages 7 - 8:

“The Institutional Review Boards at the three study sites (Rochester, New York; Austin, Texas; and Sacramento, California) approved all study procedures. Participants were recruited using a variety of strategies, including the internet message board “Craigslist.com,” flyers, neighborhood canvassing, and working with community leaders and clergy. Eligibility criteria stated that potential study participants were to be English-speaking men and women, ages 25-64 years, who reported a history of depression in self or “in a close friend or relative.” While participants were purposively sampled to achieve maximum variation and representativeness by gender, age, and racial/ethnic background, we focused on working-aged adults because this group is both understudied and likely to contribute disproportionately to the economic burden of depression [17]. Focus groups were stratified by gender because prior research has identified gender differences in care-seeking experiences [18]. Focus groups were also stratified by median household income level corresponding to participant zip code, as a proxy for socioeconomic status, and was designated as “low” or “middle” based on their percentiles relative to the median. Written informed consent was obtained from all participants. Research assistants trained in the protection of human subjects, reviewed the study procedures by telephone with respondents to recruiting efforts. Potential participants were sent a hardcopy of the study procedure and consent form by mail. Once at the focus group, group moderators reviewed the study procedures and the consent form and allowed time for questions about consent and participation. Once all questions were addressed, participants gave consent by signing the informed consent form. The focus group began once all consent forms were signed and collected. After conducting 3 pilot focus groups, we held 12 more groups (4 at each study site) between February and April 2008. Study participants received a $35 stipend for participation in group discussions that lasted 75-110 minutes. Focus group discussions were digitally recorded and then transcribed verbatim by a professional transcriptionist in manner ensuring anonymity of participants in the resulting transcript.”

Editorial Request 2:

“Please confirm that the RATS guidelines for reporting the results of qualitative research have been adhered to, and insert a statement to that effect in the manuscript. Details can be found at http://www.biomedcentral.com/ifora/rats”

Response to Editorial Request 2:

Our results are reported in compliance with the RATS guidelines. We have added a statement to that effect in the Results section of the manuscript. Furthermore, we have revised the manuscript in other sections to ensure that the reporting of our procedures, analyses and interpretation also adhere to the RATS guidelines.

Old Manuscript, Methods Section, Paragraph 2 (Study Design, Page 7) to Methods Section, Paragraph 3 (Data Analysis Section, Page 7):

“The Institutional Review Boards at the three study sites (Rochester, New York; Austin, Texas; and Sacramento, California) approved all study procedures. Participants were recruited using a variety of strategies, including Craigslist, flyers, neighborhood canvassing, and working with community leaders and clergy. Study participants were English-speaking men and women, ages 25-64 years, who reported a history of depression in self or “in a close friend or relative.” We focused on working-aged adults because this group is both understudied and likely to contribute disproportionately to the economic burden of depression [17]. Focus groups were stratified by gender because prior research has identified gender differences in care-seeking experiences [18]. Focus groups were also stratified by median household income level corresponding to participant zip code, as a proxy for socioeconomic status, and was designated as “low” or “middle” based on their percentiles relative to the median. After conducting 3 pilot focus groups, we held 12 more groups (4 at each study site) between February and April 2008. Study participants received a $35 stipend for participation
in group discussions that lasted 75-110 minutes.

Data Analysis

In the first phase of analysis, focus groups were digitally recorded, then transcribed verbatim by a professional transcriptionist. After verifying the accuracy of each transcript, general themes relating to the focus group guiding questions were identified in each of the 15 transcripts by two of the authors (DAP and CSC).”

Revised Manuscript, Methods Section, Paragraph 2, Pages 7 - 8:

“The Institutional Review Boards at the three study sites (Rochester, New York; Austin, Texas; and Sacramento, California) approved all study procedures. Participants were recruited using a variety of strategies, including the internet message board “Craigslist.com,” flyers, neighborhood canvassing, and working with community leaders and clergy. Eligibility criteria stated that potential study participants were to be English-speaking men and women, ages 25-64 years, who reported a history of depression in self or “in a close friend or relative.” While participants were purposively sampled to achieve maximum variation and representativeness by gender, age, and racial/ethnic background, we focused on working-aged adults because this group is both understudied and likely to contribute disproportionately to the economic burden of depression [17]. Focus groups were stratified by gender because prior research has identified gender differences in care-seeking experiences [18]. Focus groups were also stratified by median household income level corresponding to participant zip code, as a proxy for socioeconomic status, and was designated as “low” or “middle” based on their percentiles relative to the median. Written informed consent was obtained from all participants. Research assistants trained in the protection of human subjects, reviewed the study procedures by telephone with respondents to recruiting efforts. Potential participants were sent a hardcopy of the study procedure and consent form by mail. Once at the focus group, group moderators reviewed the study procedures and the consent form and allowed time for questions about consent and participation. Once all questions were addressed, participants gave consent by signing the informed consent form. The focus group began once all consent forms were signed and collected. After conducting 3 pilot focus groups, we held 12 more groups (4 at each study site) between February and April 2008. Study participants received a $35 stipend for participation in group discussions that lasted 75-110 minutes. Focus group discussions were digitally recorded and then transcribed verbatim by a professional transcriptionist in manner ensuring anonymity of participants in the resulting transcript.

Data Analysis

[Previous statement about recording and transcribing focus groups in a way that maintains anonymity of participants has been moved to paragraph above] After verifying the accuracy of each focus group transcript, general themes relating to the focus group guiding questions were identified in each of the 15 transcripts by two of the authors (DAP and CSC).”

Old Manuscript, Results Section, Paragraph 1, Page 8:

“Results

One hundred eighty-three eligible people responded to our recruitment efforts; 37 were unavailable or ineligible due to age or income. We were able to accommodate 116 (64%) into one of 15 scheduled focus groups (Table 1).“

Revised Manuscript, Results Section, Paragraph 1, Page 9:

“Results

These results are reported in adherence to the R.A.T.S. guidelines for qualitative research [19]. One hundred eighty-three eligible people responded to our recruitment efforts; 37 were unavailable or ineligible due to age or income. We were able to accommodate 116 (64%) into one of 15 scheduled focus groups (Table 1).”

Old Manuscript, Discussion Section, Paragraph 4 (Strengths and Limitations), Page 16:

“…Also, the study was not designed to corroborate or provide causal links among implied motivations of members of the participants’ social networks, their reported actions and the effects of those actions on the study participants. Lastly, data on validity of participants self-reported depression diagnoses were unavailable.”

Revised Manuscript, Discussion Section, Paragraph 4 (Strengths and Limitations), Page 17:
“…Also, the study was not designed to corroborate or provide causal links among implied motivations of members of the participants’ social networks, their reported actions and the effects of those actions on the study participants. The complementary nature of the multidisciplinary research team, made up of clinician-researchers (EFG, RLK, RE) and non-clinician mental health researchers (DP, CSC, PD), was integral to forming clinically relevant research questions and to tempering potential clinician-researcher bias in the data collection, analysis and interpretation. Furthermore, our recruitment strategy (self-selection into the potential participant study pool) and the discussions leading to informed consent minimized the potential for therapeutic misconception in participants of studies involving dual clinician-researchers. Lastly, data on validity of participants self-reported depression diagnoses were unavailable.”

Editorial Request 3:
“The current study is reported as being part of a larger study. Could you please clarify and expand on this point in your cover letter and in the manuscript.”

Response to Editorial Request 3:
The data analyzed for the current study was collected part of a larger study funded by the National Institute of Mental Health (RO1MH79387). The goal of the larger study is to develop and evaluate two clinic-based interventions to promote patient disclosure of depression to clinicians immediately after being exposed to the interventions. The interventions consisted of short targeted (gender and income) informational videos and individualized informational computer programs. The focus groups described in the current study were conducted for the purposes of developing the interventions in the larger study. We have described in the Background section of the manuscript how analysis of the focus group data for the purposes of the larger study led to the development of the current study. We have also revised the current manuscript to more clearly describe that the data collection procedures and the data described in the current study originated in the larger study. We apologize for this confusion.

Old Manuscript, Methods Section, Paragraph 1 (Study Design), Page 6:
“Study Design
As part of a larger investigation of strategies for enhancing depression care-seeking in primary care practice, we convened 15 focus group interviews of people who reported experience with depression in themselves and/or close relatives. We chose focus group methods to use interactions among participants that would capture the diversity of patient care-seeking experiences in a supportive environment [15]. The team developed guiding questions about individual, interpersonal, and organizational barriers to care-seeking that were informed by theories of health behavior change and illness cognition [16]. These study questions have been published elsewhere [7].”

Revised Manuscript, Methods Section, Paragraph 1 (Study Design), Page 6:
“Study Design
The data obtained for the present study was gathered as part of the formative research of a larger project. The focus of this larger project is to develop and evaluate office-based interventions to encourage patients to disclose depression as the initial step to receiving care and recovering. As part of the formative research, we convened 15 focus group interviews of people who reported experience with depression in themselves and/or close relatives. We chose focus group methods to use interactions among participants that would capture the diversity of patient care-seeking experiences in a supportive environment [15]. The team developed guiding questions about individual, interpersonal, and organizational barriers to care-seeking that were informed by theories of health behavior change and illness cognition [16]. These study questions have been published elsewhere [7].”