Author's response to reviews

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

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Author's response to reviews: see over
May 31, 2012

Dear Editors of *BMC Family Practice*:

In this letter, we respond to the Editorial and Reviewer Comments, forwarded to us on April 25, 2012, for our manuscript “Feeling Labeled, Judged, Lectured, and Rejected by Family and Friends Over Depression: Cautionary Results for Primary Care Clinicians from a Multi-Centered, Qualitative Study.” We describe both the rationale behind manuscript changes (responses are italicized) and the manuscript changes themselves for each Editorial and Reviewer Comment (manuscript changes are underlined). We thank you for the opportunity to revise the manuscript and feel 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
Editor's comment:
'To categorize the negatively received depression-related messages that depressed patients might hear from friends and family' is an interesting and innovative aim for a paper. After minor revisions, we can accept it, I feel, it reads well.

Besides what the reviewers indicate, I see five issues:

Editor Comment 1. Increased PCP role.
The introduction states: ‘The patient-physician relationship in primary care may assume a heightened level of importance for depressed patients in primary care who experience such negative social support.’ Clinically, I could not disagree with this statement. However, as researchers, the authors have had a unique opportunity in their material to see whether the respondents actually agree with this idea: would they turn to their PCP for help in this respect, would they think that the GP could help them, etc. Perhaps these persons felt that the PCP is mostly for somatic problems? I feel this is a nursing role that some PCPs are willing to take on, but not all.

Response to Editor Comment 1. The Editor raises an important point about both patients’ and PCPs’ willingness and ability to engage in discussions about negative social support for depression. Unfortunately, our data does not allow us to test hypotheses about participants’ desires or experiences with different members of a primary care team. Furthermore, the data in our current analysis arose spontaneously in a study focused on elucidating the nature of barriers to depression symptom disclosure, and was not focused on similar investigation of barriers to negative social support disclosure. We agree with the Editor that research is necessary to investigate whether patients will engage with PCPs in these discussions about negative social support and how other members of the primary care team (nurses, nurse practitioners, care or case managers, and social workers) can collaborate most effectively in achieving this goal. Therefore, we have added statements to the Limitations section acknowledging the inability to examine this question in the current study and to the Conclusions section acknowledging the need for further research in this important area. We have also amended the Abstract Background and Conclusions sections accordingly. We have amended the text throughout the manuscript to identify any and all members of a collaborative primary care team as “clinicians,” where appropriate.

Old Limitations section, paragraph 1 on 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…”

New Limitations section, page paragraph 1 on page 18:
“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. Our recommendations for clinicians to engage patients in initial discussions of potential negative social support as part of a collaborative depression care approach must be viewed in the context of the spontaneous nature in which these recollections of negative social support arose, and our inability to expressly ascertain participants’ potential uptake of clinicians’ attempts to engage them about these negative experiences. The complementary nature…”

Old Conclusions section, paragraph 2 on page 17- paragraph 1 on page 18:
‘While members of depressed patients’ family and other social networks often offer helpful support, our analyses have uncovered ways in which members of the social networks’ statements may undermine social support that might promote earlier and more effective treatment for depression. We have categorized the types of messages that these patients may hear in such a way that PCPs can identify such messages and explore in greater depth their patients’ potential social support context in
delivering depression care [32-34]. PCPs knowledge of patients’ sources of positive and negative social support can help them enhance positive social influences and mitigate those that are unhelpful (with regard to disclosure of depressive symptoms and follow-through with treatment) or deleterious (with regard to further emotional trauma). Depression care researchers should study in greater depth reasons why members of patients’ social networks present these negative messages to patients and in what circumstances patients actually modify their help-seeking behaviors in response to negative social support.

**New Conclusions section, paragraph 2 on page 18 – paragraph 1-2 on page 19:**

“While members of depressed patients’ family and other social networks often offer helpful support, our analyses have uncovered ways in which members of the social networks’ statements may undermine social support that might promote earlier and more effective treatment for depression. We have categorized the types of messages that these patients may hear in such a way that PCPs can identify such messages and explore in greater depth, either themselves or, ideally, via effective collaborative depression care [19,20] their patients’ potential social support context in delivering depression care [43-45]. Clinicians’ knowledge of patients’ sources of positive and negative social support can help enhance positive social influences and mitigate those that are unhelpful (with regard to disclosure of depressive symptoms and follow-through with treatment) or deleterious (with regard to further emotional trauma). Depending on the organization of primary care, time allotted to visits and other local and regional factors [46-48], these discussions might be conducted by the physician, a nurse-practitioner, a practice nurse, a social worker, a navigator or a case or care manager.

This qualitative report serves to open the door to several potential areas for further research. Depression care researchers should study in greater depth reasons why members of patients’ social networks present these negative messages to patients and in what circumstances patients actually modify their help-seeking behaviors in response to negative social support. Future research should also investigate the feasibility and effects of inquiry into family support in the context of primary care. Clinician training and implementation strategies for collaborative depression care in primary care settings [43,49] should also emphasize “First, do no harm” by alerting clinicians to the possibility that providers, no matter how well-intentioned, could deliver similar negative support messages as those delivered by patients’ family and friends [44, 45, 50].”

**Old Abstract, pages 3-4:**

**Background**

“Discussing depression with family and friends may help patients seek out and engage in depression care. However, patients’ social networks can also undermine depression treatment and recovery. We sought to identify and categorize depression-related messages that patients hear from friends and family that patients perceive as unhelpful or detrimental. Our goal was to alert primary care practitioners (PCPs) to the potential negative impacts of depressed patients’ social networks, in an effort to improve depression care in primary care settings.”

**Conclusions**

“The richness of our results reflects the complexity of communication within depression sufferers’ social networks around this stigmatized issue. To leverage patients’ social support networks effectively in depression care, PCPs should be aware of both the potentially beneficial and detrimental aspects of social support. Specifically, PCPs should consider using open-ended queries into patients’ experiences with discussing depression with family and friends. An open-ended approach may avoid future emotional trauma or stigmatization and assist patients in overcoming self-imposed barriers to depression discussion, symptom disclosure, and treatment adherence.”

**New Abstract, pages 3-4:**

**Background**
“Family and friends may help patients seek out and engage in depression care. However, patients’ social networks can also undermine depression treatment and recovery. In an effort to improve depression care in primary care settings, we sought to identify, categorize, and alert primary care clinicians to depression-related messages that patients hear from friends and family that patients perceive as unhelpful or detrimental.”

Conclusions
“The richness of our results reflects the complexity of communication within depression sufferers’ social networks around this stigmatized issue. To leverage patients’ social support networks effectively in depression care, primary care clinicians should be aware of both the potentially beneficial and detrimental aspects of social support. Specifically, clinicians should consider using open-ended queries into patients’ experiences with discussing depression with family and friends as an initial step in the process. An open-ended approach may avoid future emotional trauma or stigmatization and assist patients in overcoming self-imposed barriers to depression discussion, symptom disclosure, treatment adherence and follow-up care.”

Editor Comment 2. Medicalisation.
In the primary care literature, there is much discussion about the value and imprecision of the diagnosis of depression (as there is no objective diagnostic criterion such as a blood test), and the subsequent 'medicalisation of distress', leading to over-diagnosis and over-prescription of antidepressants, drugs that may not have much merit over usual care in a relatively mild caseload (Fournier, JAMA. 2010 Jan 6;303(1):47-53; Hermens M, BMC Med. 2007 Dec 7;5:36). This perspective is now lacking in the paper.

Response to Editor Comment 2.
We agree that the diagnosis of depression is nuanced. The goal of the parent study from which this data was analyzed was to investigate ways in which to increase patients’ disclosure of symptoms that could be indicative of depression to primary care providers, as an initial step in identifying and assisting patients with potential depression. The work of this parent study is predicated on the understanding that depression is under-recognized, both under-treated and over-treated, and disproportionately prevalent in primary care settings. But, informed treatment decisions cannot be made if patients don’t disclose their symptoms – disclosure of symptoms was the focus of this study. Revisions in the text in the Background and Methods section clarify that we suggest that PCPs take a deeper examination of and attend to depressed patients’ social contexts in delivering depression care, be that care psychological, support, or pharmacological – and to increase the chances that meaningful patient-centered and evidence-based deliberations occur about further evaluation and treatment. Furthermore, we have acknowledged in the Limitations section that the narratives arose spontaneously and that we could not confirm the depression diagnosis in our participants. We thank the reviewer for these important references (Fournier, JAMA. 2010 Jan 6;303(1):47-53; Hermens M, BMC Med. 2007 Dec 7;5:36).

Old Background section, paragraph 1 on page 6:
“…If PCPs are aware of the potential negative effects of such messages, PCPs can consciously work to de-toxify these messages and thus, potentially, improve the likelihood that patients will seek and follow through with depression treatment.”

New Background section, paragraph 1 on page 6:
“…If clinicians are aware of the potential negative effects of such messages, they can consciously work collaboratively [19, 20] to de-toxify these messages and thus, potentially, improve the likelihood that patients will receive appropriate care [21, 22].”

Old Methods section, paragraph 3 on page 6:
“…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…”

*New Methods section, paragraph 1 on page 7:*

“…The data obtained for the present study were 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 depressive symptoms, allowing the patient and the clinical team to make informed collaborative decisions about appropriate treatment [21, 22]. As…”

**Editor Comment 3.** US.

It is also written from a US perspective. Some reflection on health care settings elsewhere and how depressed persons there may see social support and the role of their PCP may help the international reader interpret the findings.

**Response to Editor Comment 3.**

Our data do not permit international comparisons, and there are no corresponding studies from other countries. This represents an area for future research, and we did not want to speculate based on inferences about other contexts. We have statements indicating the culture-specificity of our findings and that our recommendations would need to be amended based on local and regional systems of care (with accompanying new relevant references).

*Old Conclusions section, paragraph 1 on page 18:*

“…PCPs knowledge of patients’ sources of positive and negative social support can help them enhance positive social influences and mitigate those that are unhelpful (with regard to disclosure of depressive symptoms and follow-through with treatment) or deleterious (with regard to further emotional trauma)”

*New Conclusions section, paragraph 1 on page 19:*

“…Clinicians’ knowledge of patients’ sources of positive and negative social support can help enhance positive social influences and mitigate those that are unhelpful (with regard to disclosure of depressive symptoms and follow-through with treatment) or deleterious (with regard to further emotional trauma). Depending on the organization of primary care, time allotted to visits and other local and regional factors [46-48], these discussions might be conducted by the physician, a nurse-practitioner, a practice nurse, a social worker, a navigator or a case or care manager.”

**Editor Comment 4.** Bias. Due to the nature of their depressive feelings, these subjects may have been biased in their experiences. One reviewer also refers to this. A reflection on the reality of these observations may be interesting for the reader. Is there a 'lens' effect?

**Response to Editor Comment 4.**

We agree with both the Editor and the reviewer that the interactions with family and friends relayed by our participants may have been influenced by the depressive symptoms they were experiencing at the time the interactions occurred or were relayed in the focus group. It was our intent to communicate this in our Limitations section and we amended it to more clearly state our acknowledgement of this potential bias.

*Old Limitations section, paragraph 2 on page 16 – paragraph 1 on page 17:*

“The multi-centered nature of our data gathering methodology and the sample size that we were able to obtain are strengths of this study. Furthermore, participants’ comments arose spontaneously and unprompted in the context of a study designed to deepen the understanding of barriers to communicating with primary care practitioners about depression. The sample’s racial and ethnic diversity, while a strength, might also under-represent groups for which family has been reported to play a specifically important role in depression care [28, 29]…”
New Limitations section, page 17, paragraph 2:

“The multi-centered nature of our data gathering methodology and the sample size that we were able to obtain are strengths of this study. Furthermore, participants’ comments arose spontaneously and unprompted in the context of a study designed to deepen the understanding of barriers to communicating with primary care practitioners about depression. It is possible that the interactions with family and friends reported by study participants were influenced by the depressive symptoms that participants were feeling at the time of the interaction or the later interpretation of those interactions influenced by depressive symptoms felt at the time of the focus group itself. The sample’s racial and ethnic diversity, while a strength, might also under-represent groups for which family has been reported to play a specifically important role in depression care [39, 40]…”

Editor Comment 5. Tall order?

'PCPs knowledge of patients' sources of positive and negative social support can help them enhance positive social influences and mitigate those that are unhelpful (with regard to disclosure of depressive symptoms and follow-through with treatment) or deleterious (with regard to further emotional trauma).’ This seems a tall order in busy daily practice. How can a busy GP do something like that? Is that feasible in US primary care? A nurse or care manager could do this better, I think. In a problem-solving-treatment perspective, this might be something he or she could add to a person’s 'goals' list in a collaborative care approach to depression (Unutzer; JAMA 2002 Dec 11;288(22):2836-45).

Response to Editor Comment 5.

We thank the Editor for the reference provided and have incorporated it into the manuscript. We agree with the editor that a collaborative approach to depression in primary care is a promising correlate to our findings and recommendations and have amended to the Background and Discussion sections to make this position more clear. As described in Response to Editor Comment 1, we have also amended the text throughout to identify any and all members of a collaborative primary care team as “clinicians,” where appropriate. Unfortunately, the ground-breaking work by Unutzer, Katon and others on collaborative care in depression is not yet the standard of care in the US. Primary care visits are allotted more time in the US than in other countries and health systems, and nurses assume a more prominent role in other countries, so we can understand your concerns. Hopefully, our statements in the Limitations and Conclusions sections (see the modifications previously specified for these sections in Response to Editor Comment 1) will energize readers to consider their own contexts and promote collaborative care, but also avoid pretending that such systems are universal and making assertions without sufficient data.

Old Background section, paragraph 1 on page 6:

“…The patient-physician relationship in primary care may assume a heightened level of importance for depressed patients in primary care who experience such negative social support. If unaware of negative messages from friends and family, PCPs may unwittingly reinforce such messages. If PCPs are aware of the potential negative effects of such messages, PCPs can consciously work to de-toxify these messages and thus, potentially, improve the likelihood that patients will seek and follow through with depression treatment…”

New Background section, paragraph 1 on page 6:

“…The relationships between patients and primary care clinicians (PCPs, nurses, and/or care managers) may assume a heightened level of importance for depressed patients in primary care who experience such negative social support. If unaware of negative messages from friends and family,
clinicians may unwittingly reinforce such messages. If clinicians are aware of the potential negative effects of such messages, they can consciously work collaboratively [19, 20] to de-toxify these messages and thus, potentially, improve the likelihood that patients will receive appropriate care [21, 22]…”

**Old Discussion section, paragraph 2 on page 15 – paragraph 1 on page 16:**

“There are two clear messages that arise from our analysis. First, it is evident… By inquiring about the potential for such a negative interaction, PCPs can know better when and how to advise patients’ about enlisting the support of their families and friends in depression. “

“…While it would be overzealous to suggest that PCPs can change the social norms to which patients are exposed, with awareness, PCPs can create a space in which these norms are not further reinforced, and with greater trust, patients may feel that they have at least one venue in which it is safe and permissible to discuss their depressive symptoms. By serving as one of many potential normative counter-weights, PCPs can position themselves to help patients interpret and respond to their often unforgiving social environments [27]. We suggest beginning…”

**New Discussion section, paragraph 3 on page 15 – paragraph 1 on page 17:**

“There are two messages that arise from our results for primary care clinician teams to consider when providing care for depressed patients. First, it is evident … By making initial inquiries about the potential for such a negative interaction, clinicians can know better when and how to advise both patients and other members of the care team about enlisting the support of patients’ families and friends in depression, when possible.”

“…While it may be overzealous to suggest that primary care clinicians can change the social norms to which patients are exposed, with awareness, clinicians’ words and deeds can enable patients to understand that the norms of their family or friends are not universal. With greater trust, patients may feel that they have at least one venue in which it is safe and permissible to discuss their depressive symptoms. By serving as one of many potential normative counter-weights, primary care clinicians can help patients interpret and respond to their often unforgiving social environments [16]. We suggest that clinicians begin…”
Reviewer's (1) report
Reviewer: Hein van Hout

The authors submitted a well written and impressively sized focus group study. We thank you.

I have some comments and questions:

Reviewer 1 Comment 1.
The study focuses on negative experiences of participants and ignores possible supportive ones. This seems unbalanced e.g. positive resources are as important to know if treating or advising a patient.

Response to Reviewer 1 Comment 1.
We appreciate the Reviewer’s perspective. It was not our intent to imply that there are only negative experiences that depressed patients have with their families. Quite the opposite, we acknowledge that there is quite a bit of evidence that social support has a beneficial effect in depression and depression care. These negative experiences arose spontaneously in a study not designed to elicit them. We were struck by this observation and in reading the literature, were impressed by the lack of similar observations. Therefore, our goal is not to discount the positive effects of social support in depression and depression care. Instead, we aim to complement. We have amended the Background to clarify this position and correlate to similar statements in the Discussion of the original manuscript.

Old Background section, paragraph 3 on page 5 – paragraph 2 on page 6:
“Documenting these messages has important implications for family-centered PCPs’ approach to depression identification and treatment. Depression imposes challenges and burdens not just on the depressed individual but also on members of his or her social network [10, 11]. The burgeoning literature on “negative social support” provides a counter-balance to literature on the positive aspects of the involvement of family and friends;”

“Our primary goal in this analysis was to categorize the negatively received depression-related messages that depressed patients might hear from friends and family. Further, we sought to understand the potential impact of these messages on patients; to suggest ways in which PCPs can understand the complex nature of patients’ social support networks around depression; and suggest ways PCPs can start to build therapeutic relationships with depressed patients that may mitigate the negative effects of the social messages that patients are hearing.”

New Background section, paragraph 3 on page 5 – paragraph 2 on page 6:
“Documenting these messages has important implications for family-centered PCPs’ approach to depression identification and treatment. Depression imposes challenges and burdens not just on depressed individuals but also on members of their social network [11, 12]. Many families rise to these challenges and help patients seek and follow through with care. However, the burgeoning literature on “negative social support” provides a counter-balance to literature on the positive aspects of the involvement of family and friends; it suggests that not only can communication from relatives and friends be experienced as hurtful, undermining, dismissing or damaging [13-15], but can also result in patients experiencing even lower levels of social support [16-18]. The relationships between patients and primary care clinicians (PCPs, nurses, and/or care managers) may assume a heightened level of importance for depressed patients in primary care who experience such negative social support. If unaware of negative messages from friends and family, clinicians may unwittingly reinforce such messages. If clinicians are aware of the potential negative effects of such messages, they can consciously work collaboratively [19, 20] to de-toxify these messages and thus, potentially, improve the likelihood that patients will receive appropriate care [21, 22].
Our primary goal in this analysis was to categorize the negatively received depression-related messages that depressed patients might hear from friends and family in contrast to the generally accepted supportive messages that these social networks provide. Further, we sought to understand the potential impact of these messages on patients; to suggest ways in which clinicians can understand the complex nature of patients’ social support networks around depression; and suggest ways clinicians can start to build therapeutic relationships with depressed patients that may mitigate the negative effects of the social messages that patients are hearing.”

Reviewer 1 Comment 2.
In the design it is not clear to me how the participants were recruited and if study information might have attracted a group of persons over-selected on negative experiences?

Response to Reviewer 1 Comment 2.
We appreciate the Reviewer’s astute observation of potential bias. We do not feel that our recruitment procedures would have over-selected participant with negative social support experiences. Our recruitment materials for the parent study were distributed via community bulletin boards and organization meetings (fliers) and internet message boards (Craigslist). These materials advertised the study as one about “why people might and might not seek treatment for depression” and “your health care experiences with depression.” Therefore, no specific mention was made of the familial context of depression and these arose spontaneously. It is possible that those participants more likely to endorse medical barriers to depression treatment would also endorse familial barriers to depression treatment. However, our recruiting methods were neutral, inviting participants with experiences in both barriers and facilitators of depression treatment. Furthermore, positive experiences with family or social support were also conveyed. We did not present these findings as our goal was to present the unexpected findings of negative social support, and comparative study was beyond the scope of this current analysis. We have amended the Methods section to provide examples of our neutral recruitment language and apologize for the confusion.

Old Methods section, page 7, paragraph 2:
‘…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.”’

New Methods Section, page 7, paragraph 2:
‘…Participants’ eligibility was assessed after they responded to a variety of recruitment strategies, including the internet message board “Craigslist.com,” flyers, neighborhood canvassing, and working with community leaders and clergy. Recruitment materials included only neutral descriptions of the study, such as it being “about why people might or might not seek treatment for depression” and “about your health care experiences with depression.” 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.”’

Reviewer 1 Comment 3.
Groups were stratified on gender and household income. Did the authors found different account in these groups?

Response to Reviewer 1 Comment 3.
We did find demographic differences in the ways that patients experience depression, which was reported in an earlier paper (Epstein RM, et al.: "I didn't know what was wrong": How people with undiagnosed depression recognize, name and explain their distress. J Gen Intern Med 2010,
from these data, but we could identify no demographic patterns in negative social support.

Reviewer 1 Comment 4.
Can the authors provide an example of disconfirming data (p9)?

Response to Reviewer 1 Comment 4.
We apologize for the confusion. Disconfirming data were sought to modify initial hypotheses about the links between themes. For example, a certain coded type of narrative was initially thought to represent “feeling labeled.” Subsequently, a given quote or set of quotes were identified that only partially fit within the category. Therefore, the coded text in question would have to be considered to demonstrate more than one theme. Alternately, the hypothesis about the linkages between themes was modified to either become more inclusive of both types of narrative or the hypothesis was redefined entirely as to whether or not any of the quotes embodied “feeling labeled.”

Reviewer 1 Comment 5.
What is the rationale to group the themes ´labeled´ with ´judged´ and ´lectured´ with ´rejected´ in the discussion?

Response to Reviewer 1 Comment 5.
We apologize for this confusion. The goal for our Discussion was to place the results in the context of actionable items for primary care practitioners. We felt that the themes fit nicely into two overarching actionable messages to primary care practitioners on which they can act. The first message was that interactions with family over depression can cause emotional pain and this was expressed in the Feeling Labeled and Feeling Judged themes. The second message was that interactions with family over depression can cause inhibition of further or future communication over depression-themed topics and this was expressed in the Feeling Lectured and Feeling Rejected themes. Because the messages represent prescriptions for practice rather than categorization of the data, we did not feel it is appropriate to include them in the Results section. We have amended the Discussion to more clearly explain the format that we pursued.

Old Discussion section, page 15, paragraph 2:
“There are two clear messages that arise from our analysis. First, it is evident from the poignancy of our participants’ recollections that these negative interactions with relatives and friends…”

New Discussion section, page 15, paragraph 3:
“There are two messages that arise from our results for primary care clinician teams to consider when providing care for depressed patients. First, it is evident from the poignancy of our participants’ recollections that these negative interactions with relatives and friends…”

Reviewer 1 Comment 6.
The discussion could be elaborated on the attitude of the PCP which in some cases will be comparable to that of their own family. In addition what can we expect in terms of treatment effect if PCPs apply their suggestions?

Response to Reviewer 1 Comment 6.
We agree with the Reviewer that there should be a mention of the potential treatment effect that can be expected by implementing our suggestions. There is good evidence that a collaborative care approach to depression care is more effective than usual care. Collaborative care techniques include attending to patients’ own goals for treatment, goals which could include mitigating the effects of negative social support on depression symptoms and care. Unfortunately, outside of the literature noting the good effect of collaborative care in general as an approach to primary care-based depression care,
there is very little evidence on which to propose an effect specifically isolated to attending to negative social support. Therefore, the Reviewer has identified a fertile area for future research. We also agree with the Reviewer that even well-intentioned PCPs may harbor similar views, and thus react in like negative manner, as patients’ family and friends. We recognize that avoiding this outcome requires proactive efforts. We have amended the manuscript in the Conclusion section to address both of these points.

**Old Conclusion section, paragraph 2 on page 17 – paragraph 1 on page 18:**

“While members of depressed patients’ family and other social networks often offer helpful support, our analyses have uncovered ways in which members of the social networks’ statements may undermine social support that might promote earlier and more effective treatment for depression. We have categorized the types of messages that these patients may hear in such a way that PCPs can identify such messages and explore in greater depth their patients’ potential social support context in delivering depression care [32-34]. PCPs knowledge of patients’ sources of positive and negative social support can help them enhance positive social influences and mitigate those that are unhelpful (with regard to disclosure of depressive symptoms and follow-through with treatment) or deleterious (with regard to further emotional trauma). Depression care researchers should study in greater depth reasons why members of patients’ social networks present these negative messages to patients and in what circumstances patients actually modify their help-seeking behaviors in response to negative social support. “

**New Conclusion section, paragraph 2 on page 18 – paragraph 1-2 on page 19:**

“While members of depressed patients’ family and other social networks often offer helpful support, our analyses have uncovered ways in which members of the social networks’ statements may undermine social support that might promote earlier and more effective treatment for depression. We have categorized the types of messages that these patients may hear in such a way that PCPs can identify such messages and explore in greater depth, either themselves or, ideally, via effective collaborative depression care [19,20] their patients’ potential social support context in delivering depression care [43-45]. Clinicians’ knowledge of patients’ sources of positive and negative social support can help enhance positive social influences and mitigate those that are unhelpful (with regard to disclosure of depressive symptoms and follow-through with treatment) or deleterious (with regard to further emotional trauma). Depending on the organization of primary care, time allotted to visits and other local and regional factors [46-48], these discussions might be conducted by the physician, a nurse-practitioner, a practice nurse, a social worker, a navigator or a case or care manager.

This qualitative report serves to open the door to several potential areas for further research. Depression care researchers should study in greater depth reasons why members of patients’ social networks present these negative messages to patients and in what circumstances patients actually modify their help-seeking behaviors in response to negative social support. Future research should also investigate the feasibility and effects of inquiry into family support in the context of primary care. Clinician training and implementation strategies for collaborative depression care in primary care settings [43,49] should also emphasize “First, do no harm” by alerting clinicians to the possibility that providers, no matter how well-intentioned, could deliver similar negative support messages as those delivered by patients’ family and friends [44, 45, 50].“

**Level of interest:** An article whose findings are important to those with closely related research interests

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**
I have no competing interest in this paper.
Reviewer's (2) report

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.

Version: 2 Date: 24 April 2012

Reviewer: Claire Anderson

Reviewer's report:

Minor essential revisions

This is an interesting and useful study and is worthy of publication following minor revisions

Reviewer 2 Comment 1. The question posed by the authors is well defined and clear.
Response to Reviewer 2 Comment 1. Thank you.

Reviewer 2 Comment 2. The methods appropriate and very well described.
Response to Reviewer 2 Comment 2. Thank you.

Reviewer 2 Comment 3. The data appear to be sound.
Response to Reviewer 2 Comment 3. Thank you.

Reviewer 2 Comment 4. The manuscript adheres to the relevant standards for reporting and data deposition.
Response to Reviewer 2 Comment 4. Thank you.

Reviewer 2 Comment 5. The discussion is well balanced and adequately supported by the data but is not adequately linked to other studies that have examined this issue, this needs further work prior to publication.
Response to Reviewer 2 Comment 5.

We appreciate the Reviewer’s recommendation to place our findings in the context of previous research. We could find no similar prior studies that provide a rich description of narratives of negative social support in depression or depression care. However, we have amended the Discussion section of the manuscript to indicate that previous important survey work has demonstrated an association between depression symptom severity and negative social support, albeit in chronic illnesses rather than specifically in the context of depression care. We have also amended the Discussion section to indicate that previous depression specific survey studies have sought to investigate the perceived benefit of social support in depression, both for those with a history of depression that have sought such support and those with and without depressive symptoms, but not necessarily a history of social support seeking for depression. We feel that these previous studies support our decision to pursue this line of investigation and report our findings. It is our hope that this manuscript will provide future researchers with a starting point for further investigation in this area and clinicians with evidence on which to take a more complete or holistic view of the effects of social support for their depressed patients.

Old Discussion section, paragraph 3 on page 14 – paragraph 1 on page 15:
Communication within families and other social networks around a stigmatized condition like depression is complex [20]. It is not surprising that the effects of persons’ interactions with their social networks can range from beneficial to detrimental [12-14, 21]; and detrimental actions may result from motivations that range from well-intentioned to overtly malicious. The purpose of our analysis was to provide a rich description of focus group participants’ recollections of negative social interactions and their reported impact on patients’ care-seeking and well-being. Our analyses provide, for family-centered PCPs and researchers, nuanced descriptions, examples and a typology of less-than-helpful responses from family and friends that might undermine patients’ efforts to seek and follow through with treatment for depression in primary care.”

New Discussion section, page 15, paragraph 2:

“Communication within families and other social networks around a stigmatized condition like depression is complex [28]. It is not surprising that the effects of persons’ interactions with their social networks can range from beneficial to detrimental [13-15, 29, 30]; and detrimental actions may result from motivations that range from well-intentioned to overtly malicious. Survey studies in chronic medical conditions have suggested that depressive symptom severity is correlated with negative social support [31-33]. Furthermore, depression-specific survey studies have investigated the perceived advantages and disadvantages of past attempts to seeking social support for depression [17] and the differences in perceived helpfulness of social support for a hypothetical future depressive episode between respondents with and without depressive symptoms [18]. The purpose of our analysis was to augment this nascent complementary literature, by providing a rich description of focus group participants’ recollections of negative social interactions and their reported impact on patients’ care-seeking and well-being. Our analyses provide nuanced descriptions, examples and a typology of less-than-helpful responses from family and friends that might undermine patients’ efforts to seek and follow through with treatment for depression in primary care.”

Reviewer 2 Comment 6. The limitations of the work clearly stated?

Response to Reviewer 2 Comment 6.

We apologize for the confusion. We have significantly reformatted the Limitations section of the manuscript in response to the Editor and Reviewer 1 comments.

Old Limitations section, paragraph 2 on page 16 – paragraph 1 on page 17:

“Strengths and Limitations

The multi-centered nature of our data gathering methodology and the sample size that we were able to obtain are strengths of this study. Furthermore, participants’ comments arose spontaneously and unprompted in the context of a study designed to deepen the understanding of barriers to communicating with primary care practitioners about depression. The sample’s racial and ethnic diversity, while a strength, might also under-represent groups for which family has been reported to play a specifically important role in depression care [28, 29]. We acknowledge that the experiences of our participants may differ from those of the general population of depressed primary care patients. In addition, focus groups may foster collective thinking which can lead to reinforcement of some themes and avoidance of others even when guiding questions are utilized. For example, friends and family members frequently play a helpful role in medical care [30, 31] and the perspectives of the individuals implicated in participants’ recollections of discussions were not available. 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.”

New Limitations section, paragraph 2 on page 17 – paragraph 1 on page 18:
“Strengths and limitations
The multi-centered nature of our data gathering methodology and the sample size that we were able to obtain are strengths of this study. Furthermore, participants’ comments arose spontaneously and unprompted in the context of a study designed to deepen the understanding of barriers to communicating with primary care practitioners about depression. It is possible that the interactions with family and friends reported by study participants were influenced by the depressive symptoms that participants were feeling at the time of the interaction or the later interpretation of those interactions influenced by depressive symptoms felt at the time of the focus group itself. The sample’s racial and ethnic diversity, while a strength, might also under-represent groups for which family has been reported to play a specifically important role in depression care [39, 40]. We acknowledge that the experiences of our participants may differ from those of the general population of depressed primary care patients. In addition, focus groups may foster collective thinking which can lead to reinforcement of some themes and avoidance of others even when guiding questions are utilized. For example, friends and family members frequently play a helpful role in medical care [41, 42] and the perspectives of the individuals implicated in participants’ recollections of discussions were not available. 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. Our recommendations for clinicians to engage patients in initial discussions of potential negative social support as part of a collaborative depression care approach must be viewed in the context of the spontaneous nature in which these recollections of negative social support arose, and our inability to expressly ascertain participants’ potential uptake of clinicians’ attempts to engage them about these negative experiences. 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.”

Reviewer 2 Comment 7. The authors clearly acknowledge any work upon which they are building, both published and unpublished?
Response to Reviewer 2 Comment 7.
We appreciate the Reviewer’s recommendation to place our findings in the context of previous research. As we have described in Response to Reviewer 2 Comment 5, there is little literature in the area of negative social support in depression or depression care. We were struck by the fact that these narratives arose spontaneously in a study designed to investigate medical barriers to depression care treatment. We were equally struck by the lack of discussion on this topic in the depression and depression care literature. Our hope then, is to begin to fill in this gap in the literature via the dissemination of these results. We feel that, as the Reviewer rightly demonstrates, researchers will be able to use our results as a point of departure for future investigations in this important area of depression and depression care in primary care settings. Furthermore, primary care clinicians can utilize our results to gain a more nuanced and complete perspective on the role that social support
plays in the lives of their depressed patients than is currently available in the literature. Please see our amendments to the manuscript described in Response to Reviewer 2 Comment 5 and Response to Editor Comment 3.

**Reviewer 2 Comment 8.** The title and abstract accurately convey what has been found.  
*Response to Reviewer 2 Comment 8.* Thank you.

**Reviewer 2 Comment 9.** The writing is acceptable  
*Response to Reviewer 2 Comment 9.* Thank you.

**Level of interest:** An article of importance in its field  
**Quality of written English:** Acceptable  
**Statistical review:** No, the manuscript does not need to be seen by a statistician.  
**Declaration of competing interests:** I declare that I have no competing interest