RESPONSE TO REFEREES' COMMENTS

We would like to thank the referees for their very useful comments which have strengthened this paper. As instructed by the editor, we have concentrated on addressing concerns about how we have defined 'gender' and emphasising the novel aspects of our study (the 'talking to a stranger' theme).

REFEREE 1
We appreciate the positive comments about the quality of writing in the paper and our previous work on this topic.

The referee discusses three issues with the paper which we have tried to rectify.

1) The need to incorporate more existing qualitative literature into the paper to provide a context for our findings.
As suggested, we have incorporated the findings of many more qualitative studies into the 'background' and 'discussion' sections of our paper (e.g. Gask et al., 2003; Kangas, 2001; Karp, 1994; Karp, 1996; Lewis, 1995; Peden, 1994; Pollock, 2007; Pollock & Grime, 2002; Rogers et al., 2001; Schreiber, 1996). We have found this very useful in setting the scene for our study. For example, we are able to make the point about the lack of a gendered approach in previous literature more forcefully.

2) The need for a clearer focus linking gender and our data.
In order to address this point, we have added a section in the 'background' part of the paper to emphasise that we are talking a gender comparative approach to the data, which looks for commonalities between men and women, and diversity among men and among women, rather than solely focusing on gender differences (see page 7).

We have also reorganised the 'results' section of the paper to clarify which of our findings demonstrate similarities between men and women, and which show gender differences. We hope that this provides a clearer link between gender and our data.

3) The need to develop emergent themes
We have included more data in the paper in order to illustrate the points we are making. In particular, we have expanded the most novel aspect of our study (talking to a stranger: pages 15-17). We have also examined this theme in relation to the existing literature in the discussion section (pages 21-22).

REFEREE 2
We are pleased that this referee feels that our study has the potential to make an important contribution to the field. We appreciate the very detailed comments and have considered carefully her minor suggestions on word choice and sentence structure. We reply to her substantive comments here.

1) Title. We have amended the title so that it does not read like a closed research question. It now reads: "Exploring men and women's experiences of depression and engagement with health professionals: more
similarities than differences? A qualitative interview study"

2) Abstract. As suggested, we have changed our reference from 'GPs' to 'health professionals'.

We do not feel it is necessary, nor is it common practice, to provide a search strategy of the literature in this sort of article.

3) Background As suggested, we have included extra literature in this section. Please see reply to referee 1 (point 1).

We have clarified our reporting of Danielsson & Johansson's work (page 6).

4) Methods We have rewritten this section and feel that it is now much clearer (pages 7-10). We have tried to steer a middle ground, including more detail where necessary, but still attempting to heed the Journal's instructions to be 'concise'. We have removed the word 'hypotheses' from the methods section.

Study design
* We have described the qualitative methodology in more detail. Open-ended interviews (rather than focus groups) are used in all DIPEx modules because they allow individuals to tell their own story of developing an illness without interruption from others.

* We have rewritten the methods section to make it clear that analysis proceeded in two stages. The initial analysis of the data used a modified grounded theory approach. One shortcoming of grounded theory is the way it confines the interpretative window to the data, and thus the immediately present micro issues, at the expense of theoretical advances already in the literature. Consequently, the grounded theory approach used was 'modified' in that existing theoretical frameworks were incorporated into the analysis via an ongoing 'conversation' between the analysis and the literature as outlined in detail by Layder (1993). The secondary analysis described in this paper used thematic analysis. This is now clarified on page 10.

Participants / setting / table 1
We would argue that it is much easier for the reader to see background information about the respondents in a table rather than to access this information in the text. We have deleted the section in the table that this referee queried, as it was not relevant to the findings of this paper ('reported problems'). As suggested, we have changed the wording of our comment in the text about respondents being at the 'severe end of the spectrum'. Instead, on page 8, we now state that "Most (34) of the 38 respondents had experienced multiple or prolonged episodes of depression and around half (18) had been hospitalised for depression or mania".

Recruitment / selection
* People were invited to take part through GPs, psychiatrists, support groups and newsletters. They were sent patient information and had to return a reply slip if interested in taking part. The interviewer (DR) then contacted the participant to answer any further questions and arrange an interview time and place.

* The referee notes that our selection criteria - 'be feeling sufficiently well to undertake the interview' could lead to a biased sample. This is a limitation inherent in all qualitative work on people with depression and we acknowledge this in the discussion.

Data collection
* We have added information (page 8) on when (2003-04) and where (locations across the UK) the interviews were conducted, and on the length of the interviews (90 minutes to 180 minutes).

* Number of respondents. In DIPEx, the aim is to achieve a maximum variation sample and to reach data saturation in the analytic categories. In the depression module, this was achieved after interviews with 38 respondents.

Interview schedule
* For each DIPEx module, an interview schedule is developed to ensure that particular issues are explored, drawing on the available literature for each illness. In the first half of the interview, respondents are asked to tell their own story 'since they first suspected a problem'. In the depression interviews, they described in their own words how they developed and recovered from depression. In the second half of the interview, they were asked about specific topics, including interaction with health professionals (see page 8 for list of topics).
* We do not report data from the topic 'life before depression' here as our focus was on respondents'
experiences of depression and communication with health professionals.

Data presentation and reporting
* We have now added further data into the paper. Each quotation is given by gender. We have reported contrasting views (respondents who wanted a close personal relationship with their GP v those who wanted to talk to a stranger) and looked for deviant cases (e.g. the one woman who emphasised getting practical results from talking therapies).

* There are 27 ‘talking about’ summaries on the depression website and each contains interactive links to clips from appropriate interviews to illustrate points. It is therefore not possible to add these to the paper. They are freely available on the website for interested readers (www.dipex.org).

Data analysis - statistical data
* We are puzzled by the reference to ‘statistical data’ as this is a qualitative paper. We merely provide background details for respondents in table 1. It would be inappropriate to attempt statistical analysis on these qualitative data.

Qualitative data
* We have expanded the section on data analysis and feel that this is now much clearer (pages 9-10).

* All of the authors were involved in debates about the interpretation of the data. We feel that an advantage of secondary qualitative analysis is that a number of researchers have independently analysed the data and reached agreement about the interpretations presented. So far, we have debated an outline and 3 drafts (including this one) of the paper.

* We hope we have clarified the two stages of analysis. The initial stage of analysis which used the full dataset of 38 respondents has so far resulted in one published journal paper (Ridge & Ziebland, 2006) and a book which will be published in 2008. The secondary analysis consists of two papers. The first (Emslie et al., 2006) concentrated solely on men with depression, and so used a subset of the data (16 male respondents). The second paper from the secondary analysis (this one) uses the full dataset of 38 respondents. Plans for the secondary analysis only developed after the data were collected.

* We have changed the wording to make it clear that we have explored our interpretation of the underlying reasoning of respondents. (page 10)

5) Ethical considerations
* Respondents did not receive payments or incentives.
* It is impossible to know if any respondents declined involvement after receiving an information pack, as they were distributed through GPs, psychiatrists, support groups and in response to information in newsletters. Only one participant decided to withdraw from the study once she had started to take part because she felt negative about the narrative she had given.
* As with all DIPEx modules, thought was given to unintended consequences. Procedures put in place for the depression module included: informing people the interview was not counselling, providing referral sheets with counselling numbers, debriefing after interview, following up respondents after interviews if the researcher felt particularly concerned. In practice, respondents frequently reported that telling their story in a supportive environment was therapeutic.

6) Results and Discussion
* As suggested, we have added an introductory paragraph giving an overview of the themes (page 10-11).
* As suggested, we have put ‘personal relationships with health professionals’ and ‘talking to stranger’ under the same over-arching theme (valued features of relationships with health professionals: pages 13-17).

7) Conclusion
* We have rephrased the point about our study representing ‘a broad range of experiences of depression’ in the way suggested by the referee (page 24).

Practical / clinical limitations
* The referee suggests that we should be cautious about prescribing GPs’ behaviour. However, we feel it is important to draw out the recommendations from our research for health professionals.

* We have clarified the data analysis process.
Further research
* We have not suggested that future qualitative research should be done on GPs' perspectives on depression as a substantial amount of literature already exists on this topic (Andersson et al., 2002; Dew et al., 2005; Maxwell, 2005; Murray et al., 2006; Rogers et al., 2001; Sigel & Leiper, 2004).

REFEREE 3
This referee raises three issues with our paper which we have tried to rectify.

1) Conceptualisation of gender
We take the referee's point about treating 'male and female as psychologically monolithic concepts'. This was never our intention, but we recognise that our assumptions about gender were implicit in the former draft of the paper. In this draft, we have tried to make our approach to gender more explicit. We have made it clear in the background section (page 7) that we do not see 'men' and 'women' as binary categories and are not interested in analyses which focus exclusively on gender difference. We have reorganized our results section to make it clear that many of our findings show similarities between men and women (as well as diversity among women and among men).

Our paper reports a secondary analysis of narrative interviews, so it was not possible to have any input into the data collection process by the time we had formulated the research questions. Therefore, we do not have any quantitative measure of psychological gender for this sample. (In our previous quantitative work, we have used this approach to explore relationships between 'masculinity', 'femininity' and health-related behaviours e.g. Emslie et al., 2002; Hunt et al., 2006). However, a previous qualitative paper (a secondary analysis using a subset of these data - 16 men) explored this topic; we used qualitative analysis to examine the variety of strategies men with depression used to reconstruct a valued sense of themselves and their own masculinities (Emslie et al., 2006).

We hope that these changes to the paper will guard against the reinforcement of gender stereotypes. Our intention in writing this article is exactly to assess whether there is any empirical evidence for gender stereotypes relating to depression (i.e. women talk, men don't). One of our conclusions is that health professionals should guard against gender stereotypes (for example, that (all) men seek help only when they are really ill, whereas (all) women consult for more trivial problems).

2) Men may be more 'atypical' than women in the sample
We accept that men who describe themselves as depressed may be 'decidedly unmasculine' from a cultural standpoint and have added this to our list of study limitations in the discussion (page 23). However, our previous work on the men in this sample found that most men incorporated values associated with hegemonic masculinity into their narratives, although a minority of men consciously distanced themselves from these culturally dominant forms of masculinity (Emslie et al., 2006).

3) Clarify the title so that the gender focus is apparent.
We have changed the title to:- "Exploring men's and women's experiences of depression and engagement with health professionals: more similarities than differences? A qualitative interview study"

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