

PEER REVIEW HISTORY

BMJ Open publishes all reviews undertaken for accepted manuscripts. Reviewers are asked to complete a checklist review form and are provided with free text boxes to elaborate on their assessment. These free text comments are reproduced below.

ARTICLE DETAILS

TITLE (PROVISIONAL)	Applying the Theoretical Domains Framework to Identify Determinants to Mental Health Care Use Among African Americans with Type 2 Diabetes: A Qualitative Study
AUTHORS	Hawkins, Jaclynn; Sengupta, Srijani; Kloss, Katherine A.; Schwenzer, Claudia; Smith, Fonda; Jones, Lenette; Mitchell, Jamie; Nwankwo, Robin; Piatt, Gretchen A.

VERSION 1 - REVIEW

REVIEWER NAME	<i>McVoy, Molly</i>
REVIEWER AFFILIATION	University Hospitals of Cleveland
REVIEWER CONFLICT OF INTEREST	Na
DATE REVIEW RETURNED	21-Jul-2023

GENERAL COMMENTS	<p>This article on barriers to health care among African Americans with T2D is important and appropriate. I have some suggestions</p> <p>Intro: “Despite this, only 25-50% of those with diabetes and depression actually receive a depression diagnosis and proper treatment (12).” - I think you must mean depressive symptoms? Be careful throughout when you are referring to depressive symptoms or diagnosed MDD Although researchers and practitioners are uniquely positioned to promote mental healthcare for Black men and women - What researchers/practitioners are “uniquely” positioned – researchers/practitioners seems pretty broad, need to be specific about what is unique Theoretical Domains Framework (TDF) – explain what this is briefly in the intro</p> <p>Methods: comment on consent of participants – noted they consented to be called, but not about consent for the study/interview This section seems out of nowhere: Patient and Public Involvement: This study was initiated because the researchers had previously noted obstacles that prevented African American people with Type 2 diabetes from utilizing mental health care. The interviews conducted in this study increased the researchers’ clarity on the specific barriers and facilitators the participants faced such that future studies can work to improve mental health care utilization in this population.</p> <p>Ethics The study was approved by The University of Michigan Human Subjects Internal Review Board. Participants provided verbal consent before the interviews began. – should move up to earlier in methods</p> <p>Results: Domain #1: Knowledge – difficult to get to the quotes/racism as related to a “knowledge domain” – needs more context “Participants also described experiences of systemic racism in the healthcare systems as factors that increase a Black individual’s risk for developing depression. One participant stated: “[We] are unable to live the lifestyle that they want to because of barriers due to systemic racism and community just not supporting. Being unsupported...by the family members, all the institutions in the community: the church, the educational system, yeah, the whole gamut.”[PID103] In general, a one liner about each domain that would then provide context about how the details follow with it would be helpful</p>
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REVIEWER NAME	<i>Dorey, Tracey</i>
REVIEWER AFFILIATION	City University of London
REVIEWER CONFLICT OF INTEREST	Na
DATE REVIEW RETURNED	26-Jul-2023

<p>GENERAL COMMENTS</p>	<p>I really enjoyed reading this paper - it is an important and interesting topic. I have a few comments and areas for clarification which I hope will be useful.</p> <p>Abstract Well written and clear. It may be useful to outline briefly the seven key domains identified within the abstract?</p> <p>Introduction Again, clear and easy to read but a few considerations: The authors state: While Black people in the United States face a disproportionate burden of preventable morbidity and mortality compared to other racial and ethnic groups - please could a reference be added? The authors write: Despite the fact that type 2 diabetes management interventions have been developed to meet the needs of Black people, few have developed programming to meet the needs of those living with comorbid depression. It may be useful to expand on this a little and provide some evidence of the interventions, and clarification of the term "programming" and why this piece of work is necessary? I believe it is, but it would be helpful if the authors were clear about this in the introduction.</p> <p>Method Good level of detail of procedures. Some explanation regarding the questions and focus on women? This isn't mentioned elsewhere so am a little unsure. Some information on how key domains were identified would be helpful - was there a pre-defined process for identification?</p> <p>Results Enjoyed the use of quotes to illustrate the alignment to TDF domains. Please could the authors clarify the domains identified and whether only some were identified as key? This links with the above comment in the Method section. Eight are listed in the initial results section discussion (social/professional role and identity appears to be the difference to those discussed in the results section). Could the authors clarify whether SPRI should be discussed or removed from the list of domains? In the discussion section the authors write that ten major domains and constructs were identified - please could this be clarified?</p> <p>Discussion Please could the identified domains be listed again for clarity? It may be useful to highlight which domains informed the discussion as I found it a little bit difficult to see how the results informed the discussion. It believe they did and with some digging I can see the links but it may be easier in general for this to be made clearer?</p> <p>Limitations This links to comments made earlier regarding data being analysed even if not under the domain/construct but could the authors clarify to what extent they believe the TDF for interview/analysis was useful at encompassing the data collected. Was there much data that was left unaccounted for by the TDF and what did they do with it?</p>
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REVIEWER NAME	<i>Salvia, Meg G.</i>
REVIEWER AFFILIATION	Harvard University T H Chan School of Public Health
REVIEWER CONFLICT OF INTEREST	Na
DATE REVIEW RETURNED	01-Nov-2023

<p>GENERAL COMMENTS</p>	<p>General comments:</p> <ul style="list-style-type: none"> - An overarching comment is that it is unclear what the participants' relationship with depression is. Was having depression or having family members with depression part of the screening criteria? It isn't clear how this lived experience informs their responses to interview questions. For example, on Page 8 Line 49, how many participants had engaged in seeking prior mental health care? This, along with the results reported on Page 10 Line 48 could be included in Table 2/3. - The Introduction does a good job of exploring the interaction between T2DM and depression in this population, but that thread is lost in the Results and Discussion. It becomes less clear how participants' diabetes plays a role in the reported results. If having T2DM was a central inclusion criteria, more discussion of how the findings inform interpretation in this population would be appropriate. - Several details outlined in the COREQ checklist are absent from the current manuscript, particularly regarding participant recruitment and researchers' positionality. - Is the research question focused on the experience of Black women specifically? And the men/male participants were asked about women's experiences? If so, that should be made clearer. Also, were individuals with identities outside of the male/female binary interviewed or invited to participate? - How did the research team handle participants' conflation of stress and depression? At several points, example quotes mention the two together, yet these are not the same construct. <p>Specific comments:</p> <ul style="list-style-type: none"> - Page 4 Line 15: In this series of sentences, it would be helpful to clarify what exactly is meant by functional disability and/or how it was measured in this study. - Page 4 Line 26: Need a citation for this statement. - Page 5 Line 9: Please provide more detail about how many participants were recruited or contacted and a sense of how many declined. The detail about non-participation (as outlined in the COREQ checklist) is not present. How were these 30 selected and identified? Any other further detail about the recruitment and selection process would be helpful. - What were the inclusion and exclusion criteria? - In the Analysis section, including a discussion of how codes were identified and managed would be helpful. Were codes generated a priori based on TDF/interview questions or was an inductive approach used? - The Analysis section should include some mention of the research team's identities/background and training/domains of expertise and acknowledge how this can inform the analysis process. I do not see the personal characteristics outlined in the COREQ checklist presented in the paper. - Page 7 Line 25: More detail about the consent process needs to be provided (or explicitly linked with the content presented on page 5, line 14-17). This also connects to my earlier comment about recruitment: what were the inclusion/exclusion criteria? Were patients contacted about interest and participation and immediately interviewed, or was there a screening call followed by a separate study visit call? This process is not as clear to readers as it needs to be. - Page 7, line 31: What does "30 interviews were pulled and analyzed" mean here? Were more participants interviewed but their data not used? - Tables 2 and 3 should be combined into a single table, stratified by gender identity, or presented jointly. Were other demographic variables available? Such as marital status (which could play a role in social support), education, type of T2DM medication/management, etc. The tables as they are currently presented are pretty sparse. - Patient identifiers could include more information to orient readers to who is quoted, such as gender identity and age.
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VERSION 1 – AUTHOR RESPONSE

Reviewer: 1

Dr. Molly McVoy, University Hospitals of Cleveland

Comments to the Author:

This article on barriers to health care among African Americans with T2D is important and appropriate. I have some suggestions

Intro:

Point 1: “Despite this, only 25-50% of those with diabetes and depression actually receive a depression diagnosis and proper treatment (12).”

- I think you must mean depressive symptoms? Be careful throughout when you are referring to depressive symptoms or diagnosed MDD

Response 1: Thank you for bringing this to our attention. “Depression” was changed to “depressive symptoms” in this sentence and a few others to ensure the correct term was being used.

Point 2: Although researchers and practitioners are uniquely positioned to promote mental healthcare for Black men and women

- What researchers/practitioners are “uniquely” positioned – researchers/practitioners seems pretty broad, need to be specific about what is unique

Response 2: Thank you, we have removed this sentence.

Point 3: Theoretical Domains Framework (TDF) – explain what this is briefly in the intro

Response 3: A sentence describing TDF has been included.

Methods:

Point 4: comment on consent of participants – noted they consented to be called, but not about consent for the study/interview

Response 4: The participants provided verbal consent to be part of the study prior to the interviews. This was clarified in the procedure section.

Point 5: This section seems out of nowhere:

Patient and Public Involvement: This study was initiated because the researchers had previously noted obstacles that prevented African American people with Type 2 diabetes from utilizing mental health care. The interviews conducted in this study increased the researchers' clarity on the specific barriers and facilitators the participants faced such that future studies can work to improve mental health care utilization in this population.

Response 5: This section was included per [BMJ Open guidelines](#).

Point 6: Ethics The study was approved by The University of Michigan Human Subjects Internal Review Board. Participants provided verbal consent before the interviews began. – should move up to earlier in methods

Response 6: This was moved up in methods in the Study Design section.

Results:

Point 7: Domain #1: Knowledge – difficult to get to the quotes/racism as related to a “knowledge domain” – needs more context

“Participants also described experiences of systemic racism in the healthcare systems as factors that increase a Black individual's risk for developing depression. One participant stated: “[We] are unable

to live the lifestyle that they want to because of barriers due to systemic racism and community just not supporting. Being unsupported....by the family members, all the institutions in the community: the church, the educational system, yeah, the whole gamut.”[PID103]
In general, a one liner about each domain that would then provide context about how the details follow with it would be helpful

Response 7: A brief description of each domain has been added to each domain in the results section and additional detail has been provided to explain how the findings relate to the domain.

Reviewer: 2

Dr. Tracey Dorey, City University of London

Comments to the Author:

I really enjoyed reading this paper - it is an important and interesting topic. I have a few comments and areas for clarification which I hope will be useful.

Abstract

Point 1: Well written and clear. It may be useful to outline briefly the seven key domains identified within the abstract?

Response 1: The results section of the abstract was amended to include which study theme matches with which domain.

Introduction

Again, clear and easy to read but a few considerations:

Point 2: The authors state: While Black people in the United States face a disproportionate burden of preventable morbidity and mortality compared to other racial and ethnic groups - please could a reference be added?

Response 2: This sentence was removed and the introduction was reorganized to improve clarity.

Point 3: The authors write: Despite the fact that type 2 diabetes management interventions have been developed to meet the needs of Black people, few have developed programming to meet the needs of those living with comorbid depression. It may be useful to expand on this a little and provide some evidence of the interventions, and clarification of the term "programming" and why this piece of work is necessary? I believe it is, but it would be helpful if the authors were clear about this in the introduction.

Response 3: Thank you, we have changed the phrasing and added a sentence explaining why this is necessary.

Method

Good level of detail of procedures.

Point 4: Some explanation regarding the questions and focus on women? This isn't mentioned elsewhere so am a little unsure.

Response 4: Some of the questions were related to gender and participants were asked questions specific to their own gender. The table in the submission only included the questions women were asked, so the table was fixed to include both versions of the questions and an explanation was added of the gender-specific questions.

Point 5: Some information on how key domains were identified would be helpful - was there a pre-defined process for identification?

Response 5: We have added the following discussion to the methods section in order to clarify how we determined which TDF domains to include in our data collection and analysis procedures: "TDF domains were identified based on guidelines established for investigators using the TDF to identify factors that influence health behaviors in various contexts. Specifically, TDF domains for our study were based on a thorough assessment of a range of sources of information about mental health care

use in African Americans via a careful examination of evidence-based recommendations and empirical research. We identified mental health care use as our primary health behavior because a wealth of research shows that various forms on mental health interventions (i.e. individualized and group therapy) effectively treat depression and are typically the most widely used treatment option after a depression diagnosis.”

Results

Enjoyed the use of quotes to illustrate the alignment to TDF domains.

Point 6: Please could the authors clarify the domains identified and whether only some were identified as key? This links with the above comment in the Method section. Eight are listed in the initial results section discussion (social/professional role and identity appears to be the difference to those discussed in the results section). Could the authors clarify whether SPRI should be discussed or removed from the list of domains? In the discussion section the authors write that ten major domains and constructs were identified - please could this be clarified?

Response 6: There were nine study themes from seven TDF domains. The listing of domains has been corrected. There were seven key domains which were knowledge, beliefs about capabilities, beliefs about consequences, reinforcement, goals, environmental context and resources, and social influences.

Discussion

Point 7: Please could the identified domains be listed again for clarity?

It may be useful to highlight which domains informed the discussion as I found it a little bit difficult to see how the results informed the discussion. It believe they did and with some digging I can see the links but it may be easier in general for this to be made clearer?

Response 7: The study themes and key domains were listed again in the first paragraph of the discussion. Additionally, the domains we are referring to have been listed clearly in the remainder of the discussion.

Limitations

Point 8: This links to comments made earlier regarding data being analyzed even if not under the domain/construct but could the authors clarify to what extent they believe the TDF for interview/analysis was useful at encompassing the data collected. Was there much data that was left unaccounted for by the TDF and what did they do with it?

Response 8: Thank you for this thoughtful feedback. As we began to edit this section of the manuscript we realized that our interpretation of excluded codes/data as a limitation needed to be revisited. After much discussion, we revised our text in the limitations section to reflect that we only sought to identify data/codes that fell within the TDF domains/constructs. Codes/data that did not fall within a TDF domain were very limited and were excluded because they were not relevant to our study's research question. As a result, we removed mention of excluded data as a limitation. We have also expanded the discussion of our coding process and provide an explanation of how data/codes were excluded from our analysis in the analysis section of the manuscript.

Reviewer: 3

Dr. Meg G. Salvia, Harvard University T H Chan School of Public Health

Comments to the Author:

General comments:

Point 1: An overarching comment is that it is unclear what the participants' relationship with depression is. Was having depression or having family members with depression part of the screening criteria? It isn't clear how this lived experience informs their responses to interview questions. For example, on Page 8 Line 49, how many participants had engaged in seeking prior mental health care? This, along with the results reported on Page 10 Line 48 could be included in Table 2/3.

Response 1: Our study focused on African Americans with type 2 diabetes and no depression diagnosis because we sought to capture responses of a broad range of individuals with and without experience with depression and mental health care use. Given that African Americans are less likely

to receive proper diagnosis and treatment of depression, we aimed to better understand barriers and facilitators to mental health care use to 1) capture a broad range of experiences 2) increase the applicability of our findings. We have included the points mentioned above in methods section of our manuscript.

Because our analysis did not stratify for individuals who have/have not received mental health care, we concluded that including this data in manuscript tables does not fall within the scope of the study. We recognize this is a limitation of our study and have included this in our limitations section along with a call for closer attention to differences among African Americans who have/have not utilized mental health care.

Point 3: Several details outlined in the COREQ checklist are absent from the current manuscript, particularly regarding participant recruitment and researchers' positionality.

Response 3: More information on the recruitment process and a section titled "*Research Team and Reflexivity*" describing the researcher teams positionality was added to the methods section.

Point 4: Is the research question focused on the experience of Black women specifically? And the men/male participants were asked about women's experiences? If so, that should be made clearer. Also, were individuals with identities outside of the male/female binary interviewed or invited to participate?

Response 4: Participants were asked questions specific to their own gender. The table in the submission only included the questions women were asked, so the table was fixed to include both versions of the questions and an explanation was added of the gender-specific questions. All participants in the registry from which we recruited identified within the male/female binary, so no people outside the binary were interviewed.

Point 5: How did the research team handle participants' conflation of stress and depression? At several points, example quotes mention the two together, yet these are not the same construct.

Response 5: The authors acknowledge that stress and depression are different constructs. Nevertheless, our research team opted to include responses that referred to stress. Prior studies have shown that among African Americans the terms depression and stress were used interchangeably and when asked to define depression, respondents often described it as feeling down, stressed, and isolated. As a result, for questions that explicitly asked about depression but resulted in responses that used depression and/or stress, participant responses were included in analysis. We acknowledge the conflation of these terms presents a limitation for study findings and hope to engage in a future study that better captures the nuance of language in defining depression among African Americans and its influence on health behavior.

Specific comments:

Point 6: Page 4 Line 15: In this series of sentences, it would be helpful to clarify what exactly is meant by functional disability and/or how it was measured in this study.

Response 6: Further explanation on how functional disability was described in this study has been added.

Point 7: Page 4 Line 26: Need a citation for this statement.

Response 7: This sentence was removed and the introduction was reorganized to improve clarity.

Point 8: Page 5 Line 9: Please provide more detail about how many participants were recruited or contacted and a sense of how many declined. The detail about non-participation (as outlined in the COREQ checklist) is not present. How were these 30 selected and identified? Any other further detail about the recruitment and selection process would be helpful.

Response 8: Information about how many participants were contacted was added.

Point 9: What were the inclusion and exclusion criteria?

Response 9: Our inclusion criteria are now listed and expanded upon in the methods section of our manuscript under “procedures.”

Point 10: In the Analysis section, including a discussion of how codes were identified and managed would be helpful. Were codes generated a priori based on TDF/interview questions or was an inductive approach used?

Response 10: We expand on our coding process and management in the analysis section.

Point 11: The Analysis section should include some mention of the research team’s identities/background and training/domains of expertise and acknowledge how this can inform the analysis process. I do not see the personal characteristics outlined in the COREQ checklist presented in the paper.

Response 11: Thank you for this meaningful comment. We have included a section on research team background etc. in the analysis section of the manuscript.

Point 12: Page 7 Line 25: More detail about the consent process needs to be provided (or explicitly linked with the content presented on page 5, line 14-17). This also connects to my earlier comment about recruitment: what were the inclusion/exclusion criteria? Were patients contacted about interest and participation and immediately interviewed, or was there a screening call followed by a separate study visit call? This process is not as clear to readers as it needs to be.

Response 12: Thank you for this comment, we have added an expanded explanation of our recruitment process to the procedure section under methods.

Point 13: Page 7, line 31: What does “30 interviews were pulled and analyzed” mean here? Were more participants interviewed but their data not used?

Response 13: We revised “30 interviews were pulled an analyzed” to “interviews were analyzed until saturation was reached.” We have also included a more robust discussion of our coding process and saturation in the methods section of our manuscript.

Point 14: Tables 2 and 3 should be combined into a single table, stratified by gender identity, or presented jointly. Were other demographic variables available? Such as marital status (which could play a role in social support), education, type of T2DM medication/management, etc. The tables as they are currently presented are pretty sparse.

Response 14: The tables have been combined. No other demographic variables were collected.

Point 15: Patient identifiers could include more information to orient readers to who is quoted, such as gender identity and age.

Response 15: Ages and gender identity have been included in the quotes.

Point 16: Page 8 Line 48-50: I’m not sure this second quote fits the theme of knowledge or the two-step process previously introduced, especially without more detail of the connection or context.

Response 16: A description of the domain has been added to better explain how the construct relates to the domain. The second quote was meant to highlight the second step of the 2-step process described, and that has been clarified.

Point 17: Regarding Domain #4: Is there more data to present here? Perhaps a figure with the distribution of responses and/or representative quote? This appears to show participants felt remarkably confident in speaking with providers, which is an important finding and could be expanded.

Response 17: Thank you for this comment we have included a representative quote for this finding.

Point 18: Page 11 Line 34: From what I read of the reported results, it seemed like participants identified racism and discrimination as a precipitator of depression. I didn't see the data that connected it as a barrier to care. In fact, Domain #4 suggested a high degree of confidence in participants' ability to seek care. The greater social stigma and the perceptions of others was discussed more directly as a barrier. Could the authors expand and clarify here?

Response 18: Thank you for this comment which points out our need to clarify how this result relates directly to a barrier or facilitator of mental health care usage. After revisiting documentation of our original findings, coding and identification of themes, we have edited the text of domain #1 (knowledge) to include perceived racism and discrimination as a direct barrier to accessing mental health care. We have also included a more robust discussion of this association in the discussion section.

Point 19: Page 11 Line 45: Was an increased likelihood of depression one of this study's findings? The experience of participants with their mental health diagnoses/lived experience with depression was unclear and could be expanded and clarified. I'd also suggest an assessment of "increased likelihood of a Black person with T2DM developing depression" warrants a comparator group and larger sample; this isn't the kind of conclusion to draw from qualitative data. If this statement is coming from this research team's prior work or another study, a citation would be appropriate here.

Response 19: We have restated this section to clarify that this statement is coming from another study and added the appropriate citation.

Point 20: Page 12 Line 3: I agree the implied connection between experiences with mental health and diabetes management is of interest – did participants speak more directly to this? If so, this could be an area to expand and amplify in the Results section.

Response 20: Participants did not speak more directly to the connection. They stated that depression negatively affects decision making, and we are speculating that this could thus affect their diabetes self-management.

Point 21: Page 12 Line 12: Interesting thread of this Discussion – I'd suggest the authors link this back to the Results that focused on the gender of the provider in their study to make that connection more explicit.

Response 21: Our participants did not address how the gender of the provider affected their comfort level in seeking mental health care. These findings from other studies were included to provide more context for stigma surrounding mental health care.

Point 22: Page 12 Line 52-56: Again, this would be a place to draw a direct comparison to the results of this study. More detail regarding the experiences with depression and participants' responses to it from your sample would be good to include in the Results to tie into this part of the Discussion section.

Response 22: Participants in our study did not express that they would be able to deal with their depression on their own. These sentences were included to provide context from other literature. We have

Point 23: The Introduction describes a gap in the literature regarding a lack of practical solutions for co-occurring T2DM and depression (Page 4 Line 44) – if this is the gap identified, how does this study contribute to the reducing this gap?

Response 23: This study contributes by highlighting barriers and facilitators people with T2D face in seeking mental health care. These findings can be as a springboard for future research on tailoring interventions to leverage facilitators and address barriers to mental health care engagement and access among African Americans with type 2 diabetes and depression. We have added clarification of this point throughout the discussion section.

Point 24: A final quick comment on the Abstract: Are there stronger statements to be made regarding the study's conclusions apart from findings "aligning with current literature"? Can the novel contributions of the findings be elevated more?

Response 24: A sentence emphasizing unique findings was added to the abstract.

VERSION 2 – REVIEW

REVIEWER NAME	<i>Dorey, Tracey</i>
REVIEWER AFFILIATION	City University of London
REVIEWER CONFLICT OF INTEREST	Na
DATE REVIEW RETURNED	04-Apr-2024

GENERAL COMMENTS	Many thanks for the opportunity to review the revised manuscript. I appreciate the time and consideration of the review comments and feel they have been well addressed. Congratulations on an interesting and important paper.
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REVIEWER NAME	<i>Salvia, Meg G.</i>
REVIEWER AFFILIATION	Harvard University T H Chan School of Public Health
REVIEWER CONFLICT OF INTEREST	Na
DATE REVIEW RETURNED	11-Apr-2024

<p>GENERAL COMMENTS</p>	<p>I've included notes in the review manuscript document, mostly with respect to clarifications in meaning and connections within the text.</p> <p>[SM1] Who does this refer to? Participants' recognition of their own symptoms? Or providers' screening and recognition? I'm interested here because this could have implications for education and messaging.</p> <p>[SM2] Are Strengths omitted from this bulleted list intentionally? Otherwise, this would be a place to highlight key findings and implications.</p> <p>[SM3] Missing reference here?</p> <p>[SM4] Missing reference here?</p> <p>[SM5] I'd continue to suggest making it more clear that you're talking about knowledge and awareness of symptoms by participants (rather than medical providers screening).</p> <p>[SM6] I appreciate the authors' effort to further clarify this second quote, but it still reads as a bit unclear. Did they say more about this, or did other participants have contributions that can be summarized here? (The next paragraph maybe does some of this — if these two statements are connected, it might not be helpful to separate them as paragraphs.) It isn't clear if they're talking about knowledge in terms of treatment seeking/where to go or how to get help, or knowledge in terms of self-care. It isn't clear what the participant is actually referring to here.</p> <p>[SM7] This quote and addition seems to be speaking specifically about participant-provider trust as the underlying factor that increases confidence in discussing concerns with providers. That could be highlighted more directly.</p> <p>[SM8] Again, this quote is speaking to positive patient-provider relationships being a required component. This might be something to incorporate in the Discussion, too: how these systems-level factors impact conversations. I'm not reading these quotes as specific to participants' self-confidence re: speaking to providers. These quotes read as participants having what seems like a high level of self-confidence in perceiving if a provider is trustworthy in terms of disclosing concerns. This content may fit better with Domain #7 (Reinforcement), or it could be mentioned that these Domains may be connected.</p> <p>[SM9] This potentially points to something providers could shift (or advocate for system-wide changes) to emphasize elements providers and healthcare systems can improve to facilitate these relationships and open pathways to mental health discussions.</p> <p>[SM10] Also "Knowledge," yes?</p> <p>[SM11] I'd recommend this continue the paragraph format of the Discussion section rather than a bulleted list.</p>
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VERSION 2 – AUTHOR RESPONSE

Reviewer 3

Point 1: Page 2, Line 87: Who does this refer to? Participants' recognition of their own symptoms? Or providers' screening and recognition? I'm interested here because this could have implications for education and messaging.

Response 1: This sentence was amended to reflect that it refers to self-recognition of depressive symptoms rather than provider screening.

Point 2: Page 2, Line 93: Are Strengths omitted from this bulleted list intentionally? Otherwise, this would be a place to highlight key findings and implications

Response 2: A sentence describing the methodological strength of the study has been added to the bulleted list.

Point 3: Page 3, Line 140: Missing reference here?

Response 3: Thank you for bringing this to our attention. The reference has been added.

Point 4: Page 3, Line 141: Missing reference here?

Response 4: Thank you for bringing this to our attention. The reference has been added.

Point 5: Page 11: Line 318: I'd continue to suggest making it more clear that you're talking about knowledge and awareness of symptoms by participants (rather than medical providers screening).

Response 5: This sentence was amended to reflect that it refers to self-recognition of depressive symptoms rather than provider screening.

Point 6: Page 11, Line 324: I appreciate the authors' effort to further clarify this second quote, but it still reads as a bit unclear. Did they say more about this, or did other participants have contributions that can be summarized here? (The next paragraph maybe does some of this — if these two statements are connected, it might not be helpful to separate them as paragraphs.) It isn't clear if they're talking about knowledge in terms of treatment seeking/where to go or how to get help, or knowledge in terms of self-care. It isn't clear what the participant is actually referring to here.

Response 6: We have combined these two paragraphs in order to clarify how the quote has been interpreted and linked to the knowledge domain.

Point 7: Page 11, Line 344: This quote and addition seems to be speaking specifically about participant-provider trust as the underlying factor that increases confidence in discussing concerns with providers. That could be highlighted more directly.

Response 7: The relationship between confidentiality, trust, and confidence has been made more explicit.

Point 8: Page 11, Line 352: Again, this quote is speaking to positive patient-provider relationships being a required component. This might be something to incorporate in the Discussion, too: how these systems-level factors impact conversations. I'm not reading these quotes as specific to participants' self-confidence re: speaking to providers. These quotes read as participants having what seems like a high level of self-confidence in perceiving if a provider is trustworthy in terms of disclosing concerns. This content may fit better with Domain #7 (Reinforcement), or it could be mentioned that these Domains may be connected.

Response 8: Thank you, we have included a sentence that these domains may be connected: "This statement also suggests that participants have high self-confidence in judging a provider's trustworthiness in disclosing concerns. This content also aligns with Domain #7 (Reinforcement) and indicates a connection between these domains."

Point 9: Page 15, Line 553: This potentially points to something providers could shift (or advocate for system-wide changes) to emphasize elements providers and healthcare systems can improve to facilitate these relationships and open pathways to mental health discussions.

Response 9: We agree with this statement and have included it at the end of the aforementioned paragraph. "These findings emphasize the importance of trust and the need for development of strategies to better facilitate relationships between mental health care providers and African American patients with type 2 diabetes."

Point 10: Page 16, Line 587: Also "Knowledge," yes?

Response 10: Yes, we agree that this awareness and recognition of depressive symptoms as a facilitator is part of both domains. 'Knowledge' has been added here.

Point 11: Page 16, Line 608: I'd recommend this continue the paragraph format of the Discussion section rather than a bulleted list.

Response 11: This section was changed to be in paragraph format.