PEER REVIEW HISTORY

BMJ Open publishes all reviews undertaken for accepted manuscripts. Reviewers are asked to complete a checklist review form (see an example) and are provided with free text boxes to elaborate on their assessment. These free text comments are reproduced below. Some articles will have been accepted based in part or entirely on reviews undertaken for other BMJ Group journals. These will be reproduced where possible.

ARTICLE DETAILS

TITLE (PROVISIONAL)	“I call it the blame and shame disease”: A qualitative study about perceptions of social stigma surrounding type 2 diabetes
AUTHORS	Browne, Jessica; Ventura, Adriana; Mosely, Kylie; Speight, Jane

VERSION 1 - REVIEW

REVIEWER	Jeffrey S. Gonzalez, PhD Albert Einstein College of Medicine
REVIEW RETURNED	10-Jul-2013
GENERAL COMMENTS	This is a fine qualitative study on an important topic. The manuscript is well-written and clear. The following comments are mostly minor and intended to further improve the final manuscript. General comments: Authors state that data saturation was achieved but do not explain how they determined this. May be helpful to readers if they provide more of a rationale for the "concealed" focus on stigma in the interview. I understood the rationale for not advertising the study as being about stigma for recruiting purposes, but it would help to explain further the approach in the interview itself. Also, When presenting results from the explicit question, authors provided a percentage. However, for the majority of the results, no other numbers/proportions are presented. I would recommend being consistent throughout and either providing numbers or not. For example, under the Blame and Shame heading when it is stated that the theme was "highly salient" I found myself wanting to know how many people said it since a number had been provided early on. Recommend including the interview questions, or at least the main ones so readers have a better sense of what the interviews were like. In Methods section, authors did a nice job describing their recruitment and coding process in a clear and transparent way. Since there was quite a big proportion of content that was only really read by one person, I am wondering if those later meetings to review content of the codes also included any changes to the coding scheme. Also, when authors describe resolving discrepancies, it could be interesting to include a short description of the nature of any discrepancies, since that can be a benefit of having multiple coders. (Refer to Barbour 2001) In the discussion, authors mention their model and I was not sure (or had forgotten) what their model was. It might be helpful to provide a graphic to demonstrate the model. On a related note, I felt that the table with the list of codes was not necessary since it was the same as the paper headings, so you could replace that table with a picture of your proposed model.

Authors propose future research to address diabetes stigma in healthcare settings, etc… It is an interesting and difficult question as to how you deal with the issue of blame when managing diabetes does require active self-management and effort. It could be helpful to expand on this discussion point since it seems like a tricky area. Perhaps interviews with healthcare providers could be a helpful next step to find out how they navigate this area and talk to their patients about making lifestyle changes without blaming them or alienating them.

The primary area for further research proposed in this paper is a comparison between type 1 and type 2. However, I think there are more interesting things that could be proposed from this research. Since qualitative research is supposed to generate hypotheses rather than draw conclusions, it would enhance the discussion to provide additional suggestions for future questions provoked by this research. Another suggestion is for testing messages about diabetes, seeing if stereotype threat exists in healthcare settings…perhaps those that sense a stigma are less likely to show up to medical appointments if they think they're going to be judged/blamed?

Also, another major issue not addressed in this paper is differences in stigma between insulin users and non-insulin users (with the exception of it being mentioned as one of the negative stereotypes). One possible limitation of the sample is that only a small proportion used insulin, which is not necessarily enough to draw conclusions. But that could be an important future direction to focus on stigma of being on insulin for those with type 2 diabetes. (See Rubin, R.R., Peyrot, M., 2001. Psychological issues and treatments for people with diabetes. Journal of Clinical Psychology 57, 457–478.)

Specific comments:
In the first paragraph of the introduction, authors may want to add prevalence of type 2 diabetes in Australia.

In Transcription and Analysis section 2nd paragraph, recommend including the academic discipline(s) represented by the research team. Was it multidisciplinary? From what disciplines were the two primary coders? Also it isn't specified how many people were in the full research team.

In Results section, I was at first slightly confused that the paper began with reporting responses to the explicit question about stigma. Since this was the final question in the interview, it may make sense for the results to come after what participants said when not directly asked about stigma.

The second quote provided in the Results section does not really add anything and could be paraphrased and omitted.

The first quote presented under the "Negative Stereotyping" theme feels very similar to the quotes presented under "Blame and Shame", and then the second quote in that code ("it can be frustrating…") was not a very useful quote. Are there alternatives? It seems like there is also conceptual overlap between Negative Stereotyping and Blame and Shame, so it would help to break those apart or consider merging them into one code.

	Consider renaming/reorganizing "Discrimination and restricted opportunities". The quotes provided are about actual restricted opportunities. However, the second quote seems like it could fit better in the section about type 1 vs. type 2 comparisons. And then the first quote is so specific that I was wondering what the other examples of restricted opportunities were. If this was the main example, perhaps this shouldn't warrant an entire section. Also, the second paragraph in the section ("While no-one described…") seems like it belongs in the "unwillingness to disclose condition" section. Finally, the last quote in this section seemed to be off-topic from the purpose of the project because her physical condition was actually limiting her rather than it being about social stigma limiting her. Under "Unwillingness to disclose condition", since the first quote and two paragraphs are about participants being willing to disclose, consider renaming the heading. Or else put the positive examples at the end of the section. Under "Psychological distress", with gender comparison it would be helpful to report the actual numbers if you are going to make this comparison. Otherwise, I would omit it. In Discussion section (paragraph 2), authors could hypothesize as to why younger people felt greater stigma than older people. Is it due to increased media attention? Or the fact that older people are more likely to have chronic diseases anyway so they have more acceptance about it? Would be worth expanding on that a bit more, if only just a sentence. In discussion of concern about how stigma could lead to compromised self-care, was there any evidence of this in your findings? Was this something that was asked about? It makes sense that it would be a concern, but if it did not come up in the present study, would be helpful to discuss why that might be and make suggestions for future research to try to examine that. Under Implications and future directions, authors state that obesity and diabetes stigma "seem to be somewhat distinct." How? It also seems that there is considerable overlap that the participants discussed, as well as in the self-blaming concept. Please elaborate on how they are distinct. Sentence in discussion that states "It is apparent from our findings…may lead to sub-optimal biomedical and psychological outcomes." While data presented does support some evidence for distress, the results presented did not seem to support sub-optimal biomedical outcomes.

REVIEWER	Gareth Treharne University of Otago, Department of Psychology
REVIEW RETURNED	03-Aug-2013

REPORTING & ETHICS	1. In the objectives section of the abstract the phrasing makes it sound like the aim was to do interviews. It should be rephrased to put more emphasis on the knowledge generation aims. 2. It would be more appropriate to report median age and diabetes duration given the (appropriately) small sample size and apparent (but expectable) skew. 3. In the results section of the abstract it is hard to determine how many themes were formulated and what was the content of the themes. 4. The conclusion of the abstract that “people with T2DM experience or perceive diabetes-related social stigma” sounds like a realist epistemological conclusion from a large survey. It would be more appropriate to make a justifiable conclusion about the thematic nature of the stigmatisation that was reported by most participants. 5. Further information should be given about the “anecdotal evidence of social stigma and discrimination now apparent[9].” (p. 4). 6. Some explanation should be given for the aside in the stated aim of having “a particular (but concealed) focus on the perception and experience of diabetes-related stigma” (p. 4). Why conceal this focus? And is this concealment possible? Why were the authors concerned about hearing from “participants with extreme negative experiences” (p. 4)? 7. The qualifications of the interviewers should be noted. How was the practice of reflexivity enacted by the interviewers and other researchers? 8. It is notable that no mention is made to ethnicity within the manuscript. Was participants’ ethnicity recorded as part of the demographic questionnaire? If it was recorded it should be reported. If it was not recorded then the participants should ideally be re-contacted to determine this crucial characteristic of participants from a multicultural society influenced by post-colonial health disparities. Was any attempt made to recruit an ethnically diverse sample as part of the “Care [that] was taken to recruit a diverse sample” (p. 13)? 9. The use of ‘you’ in the first quote on p. 6 does not read as direct statement that participants “did not experience stigma themselves but believed that others with T2DM did”. 10. The note that “The media, healthcare professionals, family, and friends were identified as sources of stigma and stigmatising practices” (p. 7) seems at odds with the methodology of “Indirect questioning (i.e. not explicitly referring to ‘stigma’) invited participants to discuss their own social experience in a range of contexts, including healthcare settings, the workplace, their social and/or family environments, and in the media” (p. 5). 11. The results section does not explicitly outline any structure to the themes/subthemes that are presented. Information about this that is presented in Table 2 should be described in the main text with further information about the core knowledge claims being made. 12. Information under the subheading “Unwillingness to disclose condition” (p. 10) is repetitive of information on p. 8 about disclosure. G. Treharne, senior lecturer, University of Otago, New Zealand.

VERSION 1 – AUTHOR RESPONSE

Response to comments from reviewer 1 (Tanenbaum and Gonzalez)
Reviewers request presentation of evidence of data saturation. Table 2 has now been extended to present this information, with additional minor text edits to address this issue on pages 5 and 7.
Reviewers request a rationale for the concealed emphasis on stigma. We did not conceptualise our approach to be 'concealing' the focus on stigma, but rather an attempt to avoid using highly specific jargon that may confuse participants, and cause an unnecessary focus on the negative. This has been explained on page 5.
Reviewers suggest that either results be quantified throughout, or not at all. The revised Table 2 now enables readers to review how many participants discussed each theme. Quantification of qualitative data is often a difficult issue in qualitative papers, and there was substantial discussion amongst the authorship team prior to submission, and again prior to revision, about how to deal with this issue. Conceptually we don't believe it makes sense to quantify each statement throughout the text in the results section given the design of the study, and the small sample. However, we did choose to quantify the 'perceptions of stigma' section so that readers could get some indication about whether most people perceived/experienced stigma or not. We anticipated that if we did not quantify this section, it would be a key question asked by reviewers or readers. Thus, we have made one exception to the quantification of the data for the purposes of attempting to answer what is likely to be the most salient question in the minds of readers. But to do so throughout would be distracting and misleading, in our opinion.
Reviewers recommend that we include the interview questions. We will offer the full interview schedule as supplementary material to the journal.
The reviewers request some additional detail in the methods section. Specifically, it was asked whether meetings to review coding framework resulted in any changes. Where changes were made in the process, it is already stated. If it is not stated that changes were made, then none were made. The reviewers also request more information about the nature of the discrepancies. An example has been added on page 6 to assist readers' understanding.
The reviewers suggest including a figure of the model. This is an excellent suggestion, and we have taken the opportunity to revise the model previously published in light of the findings of the current study. The revised model is now presented in the discussion section and has been included as figure 1.
Reviewers suggest that the point about stigmatisation in healthcare settings be expanded upon to address the subtle distinction between individual responsibility for self-care and blaming. This is a helpful suggestion, and refers to some earlier work that we have done. We have added a comment on this issue on page 13.

The reviewers provide helpful additional suggestions for future research. In part these were already addressed in the first paragraph of page 13, but this has now been expanded upon to improve clarity.
The reviews also suggest an examination of insulin versus non-insulin users. We agree this is an important issue. However, the small sample in the current study precludes this level of analysis (only 5 of the 25 participants were using insulin). Further, our discussion is driven by the data, and the data do not reflect many insulin-specific issues, with the exception of where it is already mentioned as part of the discussion on negative stereotypes.
Diabetes prevalence in Australia has been added to the opening paragraph as per the reviewers' suggestion.
The lack of clarity about the nature of the research team was a result of our use of the term 'research team' instead of 'authorship team', which is what was really meant. Thus, the disciplines of the team can be determined from the affiliations of the authors. We have also added some detail on page 5 under the 'Interview Schedule and Procedure', and 'Transcription and Analysis' sections to explain that the interviews and coders have expertise in health psychology.
The reviewers query the order of presentation of the results, given that questions explicitly about stigma were at the end of the interview schedule. It was not our intention to follow the order of the interview schedule in the presentation of results. Instead we presented results in the order in which they most helpfully address the research questions that guided this study. As the key research question was about the perceptions and experiences of stigma in this sample, it makes sense to first address whether the sample did indeed experience/perceive stigma, before delving deeper into exactly what this looks like for participants.

The reviewers felt that the second quote in the results section was unnecessary. However, we are eager to present both sides of the story - that some people experience stigma and others do not. We believe it is important for the reader to hear, in the participants' own words, that sometimes stigma is not at all part of the person's lived experience.

The reviewers suggest the blending of the Blame and Shame theme and the Negative Stereotyping theme. It is true that one may lead to the other, and that understanding one helps in the understanding of the other. However, blame and shame captures a relevant attitude and the affective responses to this attitude, whereas the negative stereotyping captures some of the broader attributions about a person that are made. It will be important to keep these ideas distinct going forward in order to examine in subsequent work whether one leads to the other. We have revised the quotes presented in response to the reviewers' comments, in order to minimise repetition.

Reviewers suggested re-naming the ‘Discrimination and Restricted Opportunities’ sub-heading, however we have decided to keep the section title as is. This is the topic or theme being discussed, and we make it clear in the text that examples of the latter were more common than the former. However, discrimination was not unheard of. The two examples we present in this section - not being able to adopt and being excluded from support services - were perceived by the participants as real examples of discrimination as evident in the quotes and accompanying explanations. In response to the reviewers' observation about the last quote - it is indeed true that this relates to the physical condition of having diabetes (as highlighted by the reviewers), but that is what we are trying to capture. Having diabetes does impact opportunities in life - we want to highlight that this is a real issue for some people. It reflects the seriousness of the condition, which then has social and occupational impacts. We have now selected a different quote from the same participant in regards to the same issue which we think better illustrates this point.

In response to the reviewers' suggestion, we have omitted the discussion about workplace issues in the ‘Discrimination and Restricted Opportunities’ section due to the fact that this is repetitive of the issues in the ‘Unwilling to Disclose’ section.

The reviewers suggest that the comments and quotes about people being willing to disclosure their condition should be moved to the end of the ‘Unwilling to Disclose’ section, which has now been done. This has improved the flow of presentation of results.

The reviewers suggest either omitting the gender-specific comments under Psychological Distress or providing more detail. We have omitted.

The reviewers request that we hypothesise about the reasons why younger people seemed to perceive the stigma more strongly. We have added a comment on this issue on page 12. Younger adults with T2DM face many pressures unique to their age group and perceive that existing T2DM services are not relevant to them. These factors may contribute to the more pronounced stigma experienced by younger participants.

The reviewers asked whether there were any discussions by participants in regards to delaying or omitting self-care activities. Although we allowed scope for this in the interviews, it was not raised by many participants, and was not a primary area of concern for those few who did raise it. There is not sufficient content to identify a true theme here. Our comments on page 13 are our own commentary on what we perceive to be possible threats if people avoid disclosing their condition. We have slightly revised the language we used here to make this clearer.

The reviewers query the distinction between the obesity and diabetes stigmas and request further clarification. This has now been added to pages 13-14. Much of what was discussed by participants was specific to having T2DM, and not only being overweight or obese. Given that the obesity and diabetes stigmas are not one and the same, further research in the area of diabetes-related stigma is required, and we cannot solely rely on the obesity stigma literature to inform future work in the area of diabetes. Considerable research has already been undertaken with regard to understanding, combating, or minimising the impact of the obesity stigma in healthcare or health education settings. Similar work must now be undertaken with reference to diabetes-related stigma.

The reviewers query whether the findings really point strongly to impaired biomedical outcomes. We agree this was extrapolation from the evidence, which suggested some disengagement with healthcare and unwillingness to disclose the condition presenting threats to self-care. We have amended the language on page 13 to better reflect the data.

Response to reviewer 2 (Treharne)

The reviewer highlights some problematic wording of the aims section in the abstract. This has been amended to improve clarification in both the abstract and the Article Summary sections.

The reviewer suggests replacing means with medians. This has now been done throughout the paper (abstract, results, table 1).

The reviewer highlights the fact that it was difficult to identify the main themes in the abstract. Abstract text has now been amended improve clarity. The reviewer also suggests that the conclusion in the abstract was too strong, given the study design. We agree, and have amended it accordingly.

The reviewer requests more information about the anecdotal evidence of diabetes stigma. We have now provided an example on page 4, which we believe helps to illustrate the issue.

The reviewer also requests additional information about the concealed focus on stigma in the advertisements and the interviews. With regards to the advertisements, we have amended the language slightly on page 5 to highlight that we were trying to avoid attracting ONLY participants with extreme negative experiences so as to avoid gathering unrepresentative data. In regards to the interview schedule, we did not conceptualise our approach to be 'concealing' the focus on stigma, but rather an attempt to avoid using highly specific jargon that may confuse or lead participants, and cause an unnecessary focus on the negative. This has now been explained on page 5.

The reviewer requests information about the qualifications of the interviewers, which has been added to page 5.

The reviewer queries how the practice of reflexivity was enacted. We have added detail about interviewer discussions, note-taking, and reflection to page 5 under ‘Interview schedule and procedure’.

The reviewer requests information on ethnicity. Unfortunately this data was not recorded, and participants cannot be re-contacted as all data have been de-identified and cannot be linked with contact information. A note about ethnicity not being part of the purposive sampling procedure has been added on page 14 under 'Limitations'.

The reviewer highlights the fact that the final sentence in the first paragraph of the ‘Perceptions of Social Stigma’ section did not connect well with the quote. The language has been changed here to improve clarity.

The reviewer comments that the discussion about sources of stigma seems to be at odds with the methodology of not asking directly about stigma. However, we did ask directly about stigma, but we only used the word 'stigma' once the participant had used it spontaneously, or we introduced it at the end of the interview. Preceding questions were a mix of broad exploratory questions about experiences in different social situations, and direct questions about participants' experiences of certain social phenomena (e.g. being treated differently because of their condition) which were reflective of the technical definition of stigma used in this study. This enabled us to explore aspects of stigma without using the word 'stigma' constantly, which we anticipated might be perceived as jargon or as unnecessarily negative by participants.

The last paragraph of the ‘Perceptions of Social Stigma’ section has been edited and rearranged to address the reviewer's concern that the structure of the themes and subthemes is unclear and the knowledge claims were not summarised. We hope these edits address these concerns. Instead of relying on information in Table 2, the information is now presented in text.

In response to the reviewer's suggestion, we have omitted the discussion about workplace issues in the ‘Discrimination and Restricted Opportunities’ (page 9) section due to the fact that this is repetitive of the issues in the ‘Unwilling to Disclose’ section.

VERSION 2 – REVIEW

REVIEWER	Gareth Treharne University of Otago, Department of Psychology
REVIEW RETURNED	19-Sep-2013

GENERAL COMMENTS	My initial comments have all been addressed and this manuscript now makes a clear contribution to the literature on stigmatisation of type 2 diabetes. I have a few minor comments that I suggest the authors address. 1. The results subsection of the abstract is still a little vague ("Specific themes included"). It would be preferable for readers to be told how many themes were formulated and briefly what they all were ("included" suggests there were other themes that are not mentioned). 2. The term "general population" is not quite what I think the authors mean in the summary section on strengths and limitations on p. 3 and in the discussion on p. 12: "These people may be more engaged in their diabetes care and in diabetes issues than the general population." 3. The term "peak consumer body" (p. 4) is unclear. 4. Phrasing: "those that could" (p. 9) should read "those participants who could". 5. The discussion point about axes of representativity on p. 13 needs to be completed ("Care was taken to recruit a diverse sample and this was largely achieved (in terms of ….)"). 6. The discussion of the limitation of not having recorded ethnicity is acceptable. It would be good to note that future research on diabetes in Australia would benefit from further culturally sensitive collaboration with indigenous communities and citing the work of Dussart (Diet, diabetes and relatedness in a central Australian Aboriginal settlement: some qualitative recommendations to facilitate the creation of culturally sensitive health promotion initiatives. Health Promot J Austr. 2009;20:202-7).

REVIEWER	Jeffrey Gonzalez Albert Einstein College of Medicine
REVIEW RETURNED	25-Sep-2013

GENERAL COMMENTS	One methodological issue and a few remaining questions/suggestions: Methodological issue: Given that you have such a rigorous way of determining coder agreement for the first few transcripts, it begs the question of why you only had one coder read 17 of the transcripts. I think it would really strengthen the methodology section to be able to say you had two coders read all the transcripts, particularly because the way it is now there is such a sharp contrast between your initial

	rigor and then having one person code the majority alone. As the paper reads now, this stands out as a limitation. Smaller questions/suggestions: How did you determine that saturation was achieved at participant #11? Table 2 with the checkmarks doesn't fully explain how you determined that saturation was reached, so an additional sentence of explanation would be beneficial and maybe Table 2 is not needed. In addition to stating that interviewers have backgrounds in health psychology, did they have specific training in interviewing and/or qualitative methods? I think you can omit the sentence about the participant ID being used to distinguish audio files. Consider omitting this quote because it can be paraphrased: “I don't believe there would be any stigma at all to having type 2 diabetes. I just can't imagine how it would arise” (#13; man, 69yrs) Consider omitting the phrase "in their diabetes journey" from the first sentence in "Unwillingness to disclose condition" because it's a bit casual. Shouldn't the "blame and shame" quote go under the code with that title? It seems like psychological distress could be combined with the blame and shame code…since shame is a form of psychological distress. As it is organized now, it's confusing to see the "blame and shame" quote not under that code. I would consider omitting the theme of comparisons with type 1 entirely because you already address that issue in the "Discrimination and restricted opportunities" theme. The additional quote under the "Comparisons" code doesn't add much, and it feels redundant to come back to that point since you already addressed it earlier with a much more descriptive quote. You could also move the additional quote up to go with the more descriptive one since it would make sense for them to be together. Consider changing title to "Proposed theoretical framework of diabetes-related stigma" since the following section starts with "Implications…" In the last paragraph before "limitations" section, the word "perceived" should be "perceive." It's helpful to see the model drawn out in Figure 1. Since this paper appears to be expanding upon a proposed model from another paper, it might be helpful to refer to the figure earlier when talking about the model, and possibly highlighting parts of the figure that emerged from this study as new.

VERSION 2 – AUTHOR RESPONSE

Reviewer 1 (Treharne)

Point 1. The reviewer suggested removing the vague term "included" in the results section of the abstract. This has now been done and has been replaced with the more precise phrase "Specific themes about the experience of stigma were..."

Point 2. The term "general population" on pages 3 and 12 has been replaced with "general population of adults with diabetes", as per the reviewer's suggestion to improve clarity of the sentences.

Point 3. The reviewer has identified "peak consumer body" as an unclear term. The authors are in agreement, but this is how Diabetes Australia - Vic mandate that we refer to them in formal publications. We have added "and leading charity" on page 4 in an attempt to improve clarity.

Point 4. The phrase "those that could" has been replaced with "those participants that could" as per the reviewer's suggestion

Point 5. The incomplete sentence on page 5 has been amended so that it is now a complete sentence. Apologies for the oversight and typo.

Point 6. We have revised the limitations section to expand on the possible ways forward for ensuring Australian diabetes research includes an ethnically diverse sample and is culturally sensitive (page 14).

Reviewer 2 (Tanenbaum & Gonzalez)

The reviewers point out that it would be a methodological limitation if the coding framework was developed by only one researcher reading the transcripts. We agree, and in fact this is not the method we employed, as outlined on page 6. We report that in fact two researchers read and re-read the transcripts. Perhaps the confusion has come from the fact that one researcher checked the transcripts for accuracy against the audio file - this was done for checking purposes and was not part of the analysis process. As outlined on page 12, two researchers independently read and re-read transcripts to develop the coding framework.

The reviewers have requested an explanatory statement about Table 2. This is already part of the second paragraph on page 5. However, we have expanded the sentence to improve clarity.

The reviewers query whether the interviewers had training in interviewing/qualitative skills. The researchers have training and experience in qualitative interviewing, and this has been clarified on page 6.

As per the reviewer's suggestion, the sentence "A participant ID was used to distinguish audio files and questionnaires" has been deleted.

Reviewers suggested that we omit the quote "'I don't believe there would be any stigma at all to having type 2 diabetes. I just can't imagine how it would arise'", however we decided to keep it in as it portrays a more balanced view that some people did not perceive stigma. To only paraphrase it may seem as though we are biasing the presentation of the results.

The reviewers recommend considering omitting the phrase "diabetes journey" from the manuscript on the basis that it is too casual. However, it is a commonly used phrase in the literature, especially by publications and documents produced by the International Diabetes Federation (for example, see https://www.idf.org/sites/default/files/attachments/2009_3_JC%20Mbanya%20editorial.pdf). Therefore, we have decided to maintain the phrase.

The reviewers suggested that the quote "'I call it the ‘blame and shame disease’ because I think that people get blamed and shamed and I think that makes it worse…they feel hopeless'" might fit better as an illustration of the blame and shame theme. While it is true this quote also serves to illustrate that theme, it has been included here to highlight the consequences of this blame and shame...namely psychological distress in the form of feeling hopeless. We have decided against duplicating the quote under two different headings so as to avoid repetition of information. We have also decided against collapsing the 'blame and shame' theme with the 'psychological distress' theme because blaming and shaming refers to actions directed at people with diabetes, and the psychological distress refers to one of the consequences of these actions.

Reviewers suggested that the 'comparisons with type 1' theme be omitted because of the duplication of information in the 'discrimination' theme. We agree that information was duplicated. To address this, we removed the information from the 'discrimination' theme and put it instead in the 'comparisons' theme where, as the reviewers suggestion, it is more illustrative of the point being made.

The reviewers highlighted that we have duplicated the word 'implications' in our subheadings in the Discussion section, this has been addressed by revising one of the headings to read 'A framework for diabetes-related stigma' instead of 'Implications for a proposed framework for diabetes-related stigma'. This has the added advantage of being more concise.

The incorrect 'perceived' has been edited to be 'perceive' on page 14

The reviewers suggest that we refer to Figure 1 earlier in the manuscript. We have added a reference to it on page 4. The reviewers also suggest that we explicitly explain how we have amended the model. This explanation is already part of the text on page 13.