PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Uncovering social and psychosocial health factors through participatory qualitative research with low-income adults in a suburb of Montréal, Québec
AUTHORS	Wang, Caroline; Loignon, Christine; Hudon, Catherine

VERSION 1 - REVIEW

REVIEWER	Peter Kinderman University of Liverpool, UK. I have published widely on similar topics: the need to address social determinants of mental and physical health. I have no personal links to the authors and no other competing interests.
REVIEW RETURNED	17-Jul-2019

GENERAL COMMENTS	I enjoyed reading this paper, and learned a lot from it. I think there some changes that would strengthen the paper (and address some minor issues): 1. The research is based on 'Freire's pedagogy', something I am not familiar with. It would help to explain this briefly for the (perhaps UK-based) reader. 2. The research was approved by the relevant ethics oversight body, but the methods section first outlines the process followed (which seems to minimise prior ethical approval) and only mentions formal approval later - I would have preferred the formal approval to come first (in both senses). 3. The paper occasionally slips into stating that, for instance: "a core factor harming the health of participants was" ... whereas, in fact, it can only be the case that this research addresses emergent themes in the perceptions, experiences or beliefs of participants. 4. A particular strength of this paper is the link between EARLY LIFE EXPERIENCES, and especially the EXPECTATIONS set up in early years and later health status. I would like that to be drawn out more (because the social determinants of health are well known). 5. On that note... while MARMOT is cited (and that is good), I would have expected reference to Whitehead and Dahlgren, and (if the authors wish to be topical) Philip Alston. 6. Then (again, c.f. Marmot, Whitehead and Dahlgren), more could be made of INEQUALITY. This / these were mentioned, but more could be written. 7. In that context, I had not come across Tarlov (but that is perhaps my inadequacy). 8. What is NEW about this paper (for me) is the role of early experience in setting up expectancies - and therefore disparities.

	There are theoretical models that address such discrepancies between perceived and desired states (particularly 'Perceptual Control Theory'), and the paper could be strengthened, in my judgment, with some focus on psychological mediators (although, to declare a conflict of interest, this is an area in which I have published a little).

REVIEWER	Eleonora Uphoff University of York, UK
REVIEW RETURNED	22-Jul-2019

GENERAL COMMENTS	Thank you for the opportunity to read this paper. I recognise this is an important topic, and qualitative research in this area is very welcome and much needed. My comments mostly relate to what I believe is a lack of transparency about the aims and methods of the study, clarification of the context in which this study takes place, and embedding this work within the wider literature. Abstract I would rewrite objectives to “that may harm the health…” as this study does not have the appropriate design to establish causal links. Introduction The first paragraph is very abstract, talking about ‘social factors’, ‘psychosocial factors’, and ‘social circumstances’. It would be helpful to introduce the study by focussing on the mechanisms rather than the terminology. The circumstances we live in, as individuals, within relationships, and in communities, influence our health. These interactions with our society may cause stress, give a sense of support or control, or they may heighten feelings of depression and anxiety. There are other examples of psychosocial mechanisms you do not mention. Relationships may give access to better/ healthier jobs, friends may encourage you to smoke or to stop smoking, a family member may babysit your children so that you can attend a GP appointment. It would be good to consider the psychosocial determinants literature more comprehensively (even though you can keep it brief). You may for example look at Mel Bartley’s book ‘Health Inequality: An introduction to concepts, theories, and methods’. Or any similar literature. Tarlov[19] proposed a mechanism through which social circumstances influence health… this mechanism has not been further investigated. Your objective is to identify and describe social and psychosocial factors harming the health of low-income adults, but you already mention the mechanism you want to identify in this sentence above. The study aim therefore does not seem right; you do not set out to simply identify any factors, but to find evidence for the mechanism proposed by Tarlov? Please explain this better in the introduction/ study aim. Methods Setting and participants: please make clear here and in the abstract that this study was done in a city/ region (which one?) in Canada. I would also think it is of interest to the reader, and helps interpret results, if there was more information about low-income/ food poverty in Canada or this specific region in either the introduction or discussion section.

	You say this was participatory research, with participants being involved in different stages of the study. How did they contribute? Were any changes made based on their input? You may discuss this in the results instead of methods if more appropriate. At the moment, it reads to me this is a qualitative study with focus group type sessions. If you wish to brand the study as 'participatory research', it needs to be much clearer how participants impacted on the study design and results. How many participants did you aim to recruit? Data collection: the structure of the sessions is clear to me, but the content not so much. Did the facilitator ask questions? What kind of questions? Did the facilitator have a list of topics/ themes to discuss? What were the activities? Especially in the first few sessions, it would be useful to know how much the discussion was guided by the facilitator, and to what extend it was led by the participants. Results/ discussion Dissonance between circumstances and ideal: this section does explain dissonance, but it does not really address the link with health, except maybe in the very last sentence (the quote). Is there more information from your data on how this dissonance affected the health of these participants? In the results you describe multiple ways in which people on a low-income may struggle. One of them is the dissonance between current and previous/ideal circumstances, but this is only a minor part of the results you presented. In the discussion however, it is very prominent. I think this is not justified; it appears you simply sought to find evidence fitting your hypothesis. I believe you should be more transparent about this. Secondly, your emphasis on the mismatch between current and previous/ideal circumstances could be interpreted as somewhat dismissive of people's experience. Surely the main problem is the day-to-day struggles people on a low-income face with financial problems, unemployment or insecure employment, stigma, food poverty, health problems, social isolation, and so on. The dissonance you describe may be part of the puzzle, but to suggest the main 'problem' is that people's expectations do not match their reality could be seen as offensive (although I understand it is not meant to be). It would be good to further interpret your findings and pre-empt this. There is very little detail about the limitations of this study. Could you please expand? For one, I find it problematic that you suggest this study investigates a link between psychosocial factors and health. Most of the participants had both health problems and low-income, and this is a cross-sectional study. You can investigate factors identified by participants as important, but you cannot establish a causal relationship with a qualitative sample of N=8. I would also like to see a reflection on the external validity of the study; how representative are these 8 participants for people with low-income in this area of Canada? Figure page 30: I am unclear how lack of love and support leads to an ideal of the world, and this leads to dissonance between circumstances and ideal. Please explain in the text or remove this diagram. Also, surely unjust norms and policies cause health problems too (arrow missing). I think this diagram is quite simplistic and does not add much to the study.

REVIEWER	Sinead Furey Ulster University, Northern Ireland
REVIEW RETURNED	03-Oct-2019

GENERAL COMMENTS	Thank you for the opportunity to review this interesting paper. I think a considerable strength of this paper is the clarity of the authors' writing style and the well-explained inclusion / exclusion criteria for the research. The abstract is clear. There is a welcome realization and recommendation for future research to replicate the study with larger sample sizes from different sub-populations. The introduction is well summarized with context from the published literature. The authors have presided over an ethically-compliant study, although greater detail would be welcome regarding if incentives beyond travel reimbursement were offered to encourage participation. The methodology section is strong - excellent study design in respect of participatory approach throughout - from data collection to its analysis and sense-checking. My main recommendation is the potential for additional illustrative quotes to be curated from the transcripts and subsequent analysis to more fully humanize the interpretation of the themes and inter-related subthemes. Additionally, is there anything to be interpreted as different by gender etc across the themes - the authors should consider presenting more demographical identifiers (gender, age, ethnicity, education etc) to classify the participants from who you quote verbatim under each theme. This in turn would allow the research objective around 'social inequalities' to be explored more fully by differentiating between the sample's demographic characteristics when contributing quotations under the themes and inter-related sub-themes. Minor, infrequent typographical errors have been identified: Page 2; line 19: Insert a period at the end of the Setting sentence. Page 4; line 15: 'associated with' instead of 'associated to' Page 13; line 47: Delete the unnecessary quotation mark after "... the answer." Page 15; line 17: Add comma after affectively Page 16; line 18: Delete unnecessary quotation mark before so for me.

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1

1. The research is based on 'Freire's pedagogy', something I am not familiar with. It would help to explain this briefly for the (perhaps UK-based) reader.

We thank the reviewer for this comment. We added a sentence in the Method section to explain Freire's pedagogy (Page 6, Paragraph 2, Sentence 2).

2. The research was approved by the relevant ethics oversight body, but the methods section first outlines the process followed (which seems to minimise prior ethical approval) and only mentions formal approval later - I would have preferred the formal approval to come first (in both senses).

We appreciate the reviewer's comment. We now mention ethical approval earlier in the Method section (Page 7, Paragraph 2, Sentence 1).

3. The paper occasionally slips into stating that, for instance: "a core factor harming the health of participants was" ... whereas, in fact, it can only be the case that this research addresses emergent themes in the perceptions, experiences or beliefs of participants.

We understand the reviewer's point. We clarified that sentence in the abstract (Page 2, Last Paragraph, Sentence 1) and other similar sentences throughout the paper, to make clear that the factor was "identified as" or "reported as" harming the health. Alternatively, for some sentences, we followed the suggestion of reviewer 2 and used "that may harm the health."

4. A particular strength of this paper is the link between EARLY LIFE EXPERIENCES, and especially the EXPECTATIONS set up in early years and later health status. I would like that to be drawn out more (because the social determinants of health are well known).

We thank the reviewer for arising this point. To draw this point out more, we now discuss it before the other social factors that are well known, and we edited the paragraph (we rewrote the first sentence, moved one sentence, and added a sentence at the end of the paragraph) (Page 24, Paragraph 1).

5. On that note... while MARMOT is cited (and that is good), I would have expected reference to Whitehead and Dahlgren, and (if the authors wish to be topical) Philip Alston.

We thank the reviewer for these references. The Dahlgren and Whitehead model[1] is a model of determinants of health, which includes structural and social factors but does not include psychosocial factors and social status. This model also emphasizes lifestyle factors. By contrast, the framework of the World Health Organization's Commission on Social Determinants of Health is more comprehensive, including structural, social, and psychosocial factors as well as social status/position.[2,3] This framework also shows a relationship between behavioral factors and psychosocial factors. Thus, we prefer to cite this framework. We added a reference to this framework in the Introduction section (Page 4, Paragraph 1, Sentence 4).

Philip Alston is the Special Rapporteur on extreme poverty and human rights of the United Nations Human Rights Council. We added a reference to his work in the Introduction section (Page 5, Paragraph 2, Sentence 3).

6. Then (again, c.f. Marmot, Whitehead and Dahlgren), more could be made of INEQUALITY. This / these were mentioned, but more could be written.

We acknowledge the reviewer's comment. We added two sentences about the gradient association in the Introduction section (Page 4, Paragraph 1, Sentences 2-3).

7. In that context, I had not come across Tarlov (but that is perhaps my inadequacy).

The notion of identity has not been widely discussed in the social determinants of health and health inequality literature. Tarlov is one of the few who have discussed this notion in this literature. Interestingly, in the book suggested by Reviewer 2, the author does discuss identity as being one of her "own hunches about why health inequality exists and is so persistent." (p. 18)[4] We added this to the discussion (Page 23, Last Paragraph, Sentence 5).

8. What is NEW about this paper (for me) is the role of early experience in setting up expectancies - and therefore disparities. There are theoretical models that address such discrepancies between perceived and desired states (particularly 'Perceptual Control Theory'), and the paper could be strengthened, in my judgment, with some focus on psychological mediators (although, to declare a conflict of interest, this is an area in which I have published a little).

We thank the reviewer for this comment and for highlighting the novelty of this paper.

Other theories that address discrepancies between perceived and desired states are not as simple and precise as the dissonance presented in this paper and have not been considered much in the field of health inequality.

Perceptual Control Theory is a model of control and behaviour, based on negative feedback control, where perception is compared to a desired state and if there is discrepancy, a behaviour is done in order for the perception to match the desired state.[5] It is more an explanation of how the individual functions than a health factor, whereas the dissonance presented in this paper is a possible health factor (may influence health).

Other theories such as person-environment fit theories are conceptually nearer to the dissonance presented in this paper. However, these theories conceptualize and operationalize the person, the environment, and their interactions differently according to each theory[6,7], and many of these theories refer to the work environment, whereas the dissonance presented in this paper refers to the whole circumstances of a person, including the person's health status. Nevertheless, these theories support the concept of dissonance: a better person-environment fit, "no matter how fit is conceptualized and operationalized", leads to positive outcomes such as "higher job satisfaction, less stress, better work adjustment, and larger likelihood to persist."[7] As little is known about "the psychological processes underlying the perceptions of fit, such as how they form," [7] our paper provides a possible explanation with the role of early experience in setting up expectancies.

Regarding psychological mediators, rumination has been found to mediate the association between negative life events and anxiety/depression, in a cross-sectional study.[8] Rumination could be seen as not accepting the current circumstances, and in that sense, could support the concept of dissonance. In the present study, acceptance of the circumstances was a strategy reported by participants to live and feel better (data reported elsewhere[9]), and this strategy may explain why participants with reduced mobility did not express current profound malaise as the mental-health participants did.

We added this discussion on theoretical models and psychological mediators in the Discussion section (Page 22, Paragraph 1, 2 Last Sentences; Page 22, Paragraph 2, 3 Last Sentences).

Reviewer: 2

Abstract

1. I would rewrite objectives to "that may harm the health…" as this study does not have the appropriate design to establish causal links.

We understand the reviewer's point. What we mean is "factors harming the health of low-income adults, according to these people," as the participants answered/discussed the question "what harms our health?" We followed the reviewer's suggestion in the abstract (Page 2, Paragraph 1, Sentence 2) and throughout the paper.

Introduction

2. The first paragraph is very abstract, talking about 'social factors', 'psychosocial factors', and 'social circumstances'. It would be helpful to introduce the study by focussing on the mechanisms rather than the terminology. The circumstances we live in, as individuals, within relationships, and in communities, influence our health. These interactions with our society may cause stress, give a sense of support or control, or they may heighten feelings of depression and anxiety.

We appreciate the reviewer's comment. We have rewritten the first paragraph to focus on mechanisms rather than terminology (Page 4, Paragraph 1). We still take care to define the terms for consistency throughout the paper but we define them later in the paper, as followed: "psychosocial factors" (Page 4, Paragraph 2, Sentence 1) and "social factors" / "social circumstances" (Page 6, Paragraph 1, Last Sentence).

3. There are other examples of psychosocial mechanisms you do not mention. Relationships may give access to better/ healthier jobs, friends may encourage you to smoke or to stop smoking, a family member may babysit your children so that you can attend a GP appointment. It would be good to consider the psychosocial determinants literature more comprehensively (even though you can keep it brief). You may for example look at Mel Bartley's book 'Health Inequality: An introduction to concepts, theories, and methods'. Or any similar literature.

We thank the reviewer for this comment as well as for the reference. In Bartley's book,[4] psychosocial factors are social support and "psychosocial work hazards" (job demands, work control, job strain, and effort-reward imbalance). We have rewritten the paragraph to present psychosocial factors more comprehensively, including more information about social support / relationships (Page 4, Paragraph 2, Sentence 4; Page 5, Paragraph 1).

4. Tarlov[19] proposed a mechanism through which social circumstances influence health… this mechanism has not been further investigated.

Your objective is to identify and describe social and psychosocial factors harming the health of low-income adults, but you already mention the mechanism you want to identify in this sentence above. The study aim therefore does not seem right; you do not set out to simply identify any factors, but to find evidence for the mechanism proposed by Tarlov? Please explain this better in the introduction/study aim.

We thank the reviewer for arising this point. We did not seek to find evidence for the mechanism proposed by Tarlov, as we became aware of the dissonance reported in our study through the process of data collection and data analysis in our study. We had to consider more closely the mechanism proposed by Tarlov when we sought to relate our finding to the literature. To remove all possible ambiguity, we removed from the introduction the text that was pointed out by the reviewer (Page 5, Paragraph 1).

Methods

5. Setting and participants: please make clear here and in the abstract that this study was done in a city/ region (which one?) in Canada. I would also think it is of interest to the reader, and helps interpret results, if there was more information about low-income/ food poverty in Canada or this specific region in either the introduction or discussion section.

We agree with the reviewer's comment. We added the name of the city and region in Canada, in the Method section (Page 7, Paragraph 1, Sentence 2) and in the abstract (Page 2, Paragraph 3). We also added more information about low income and food poverty in the province of Québec and in Canada, in the Method section (Page 7, Paragraph 1, Sentences 3-5).

6. You say this was participatory research, with participants being involved in different stages of the study. How did they contribute? Were any changes made based on their input? You may discuss this in the results instead of methods if more appropriate. At the moment, it reads to me this is a qualitative study with focus group type sessions. If you wish to brand the study as 'participatory research', it needs to be much clearer how participants impacted on the study design and results.

We thank the reviewer for this comment. We added a statement under the subheading 'Patient and Public Involvement' in the Method section, where we clarify participants' contribution (Page 7, Last Paragraph; Page 8; Page 9, Paragraphs 1-2).

7. How many participants did you aim to recruit?

We aimed to recruit 10 to 15 participants. We added this information as well as the number of participants recruited and the number of participants who abandoned, in the Method section (Page 10, Paragraph 1, Sentences 2-3).

8. Data collection: the structure of the sessions is clear to me, but the content not so much. Did the facilitator ask questions? What kind of questions? Did the facilitator have a list of topics/ themes to discuss? What were the activities? Especially in the first few sessions, it would be useful to know how much the discussion was guided by the facilitator, and to what extend it was led by the participants.

We appreciate the reviewer's comment. Both the participants and facilitator asked questions to deepen or clarify what was said. The facilitator did not have a list of topics/themes to discuss, but asked questions to deepen or clarify what was said. To enhance clarity regarding the role of the facilitator and the activities, we converted sentences to an active form and converted enumeration of activities into a list with bullet points. We added and modified this information in the Data Collection section (Page 10, Paragraph 3, Sentences 3-4; Page 10, Paragraph 4; Page 11, Paragraph 1).

Results/ discussion

9. Dissonance between circumstances and ideal: this section does explain dissonance, but it does not really address the link with health, except maybe in the very last sentence (the quote). Is there more information from your data on how this dissonance affected the health of these participants?

We thank the reviewer for this comment. From our data, dissonance affected participants' identity, self-esteem, and wellbeing. We made this explicit in the first sentence of the section (Page 14, Paragraph 2, Sentence 1). We also added three quotes as well as a sentence to an existing quote, to better illustrate this (Page 15, Paragraphs 1-2).

10. In the results you describe multiple ways in which people on a low-income may struggle. One of them is the dissonance between current and previous/ideal circumstances, but this is only a minor part of the results you presented. In the discussion however, it is very prominent. I think this is not justified; it appears you simply sought to find evidence fitting your hypothesis. I believe you should be more transparent about this.

We thank the reviewer for arising this point. We did emphasize the dissonance in the discussion, as it is the result that appears new to us in regard to current literature and that may contribute to a better understanding of the association between social circumstances and health. As mentioned previously, we did not have the dissonance as an initial hypothesis (see reply to comment 4, from reviewer 2). We clarified in the discussion the reason why we discuss further this result (Page 21, Paragraph 1, Last 2 Sentences). We also added results related to dissonance (for comment 9, from reviewer 2) (Page 15, Paragraphs 1-2), which better balance the results presented.

11. Secondly, your emphasis on the mismatch between current and previous/ideal circumstances could be interpreted as somewhat dismissive of people's experience. Surely the main problem is the day-to-day struggles people on a low-income face with financial problems, unemployment or insecure employment, stigma, food poverty, health problems, social isolation, and so on. The dissonance you describe may be part of the puzzle, but to suggest the main 'problem' is that people's expectations do not match their reality could be seen as offensive (although I understand it is not meant to be). It would be good to further interpret your findings and pre-empt this.

We understand the reviewer's comment. The daily struggles and the dissonance generate different issues for the participants: the former is stressful and constraining, the latter generates profound malaise, loss of identity and of self-esteem. In that sense, the latter appears highly problematic. In

addition, the dissonance may add to daily struggles: if two low-income people experience similar social circumstances (e.g. they both struggle), the one who experiences greater dissonance may suffer more. We added this latter sentence to the discussion (Page 21, Paragraph 1, Sentence 6). To reduce the emphasis on dissonance as a "core factor", we modified sentences throughout the paper to remove the notion of "core factor" (e.g. in the abstract: Page 2, Last Paragraph, Sentence 1; in the Results section: Page 14, Paragraph 1, Sentences 2-3).

12. There is very little detail about the limitations of this study. Could you please expand? For one, I find it problematic that you suggest this study investigates a link between psychosocial factors and health. Most of the participants had both health problems and low-income, and this is a cross-sectional study. You can investigate factors identified by participants as important, but you cannot establish a causal relationship with a qualitative sample of N=8.

We thank the reviewer for this comment. We added limitations regarding study design and duration of the study, in the Discussion section (Page 25, Paragraph 2, Sentence 2 and Last Sentence). We agree with the reviewer that we cannot establish a causal relationship with qualitative methods and that we could only investigate factors identified by participants.

13. I would also like to see a reflection on the external validity of the study; how representative are these 8 participants for people with low-income in this area of Canada?

We appreciate the reviewer's comment. The participants had various characteristics commonly found among low-income people in Québec and Canada. We added this information in the Discussion section (Page 25, Paragraph 2, Sentence 5). The recruitment of these participants was possible by recruiting through an organization that provides food bank services, which services are used by low-income adults, and by excluding full-time postsecondary students and retired persons receiving pension.

14. Figure page 30: I am unclear how lack of love and support leads to an ideal of the world, and this leads to dissonance between circumstances and ideal. Please explain in the text or remove this diagram. Also, surely unjust norms and policies cause health problems too (arrow missing). I think this diagram is quite simplistic and does not add much to the study.

Figure 1 presents three main themes (bold text) and sub-themes (regular text) of social and psychosocial factors reported by participants as harming their health. Since each of the subthemes was reported as harming the health of participants, we did not add arrows from any of them to "Health Problems and Healthcare Issues" as this would be redundant and would clutter the figure. The figure puts in one place all the themes, sub-themes, and links between them as reported by participants.

Regarding the first part of reviewer's comment, lack of love and support refers to adverse experiences starting early in life and thus to early social experiences. As we understand the ideal

"as being part of one's conception (opinion or image) of the self and the world, which conception is formed through social interactions early in life,"[10,11] the early social experiences of "lack of love and support" hence contribute to the formation of the ideal. An example of how lack of love and support leads to the ideal and to dissonance is presented in the article when we discuss the experience of having parents with high expectations and how these expectations could be integrated in one's ideal and that one could have difficulty achieving this ideal, because of the consequences of lack of love and support (i.e. low self-identity, low selfesteem, tendency to overgive or overperform, as reported in

this study) (Page 24, Paragraph 1, Sentence 2). We clarified these points in the legend of Figure 1 (Page 27, Paragraph 4, Last 3 Sentences).

Reviewer: 3

1. The abstract is clear. There is a welcome realization and recommendation for future research to replicate the study with larger sample sizes from different sub-populations.

The introduction is well summarized with context from the published literature. The authors have presided over an ethically-compliant study, although greater detail would be welcome regarding if incentives beyond travel reimbursement were offered to encourage participation.

We thank the reviewer for this comment. Additional incentives included childcare, psychosocial worker, and coffee, snacks, and sometimes lunch. We added this information in the Method section (Page 7, Paragraph 2, Sentences 3-4).

2. The methodology section is strong – excellent study design in respect of participatory approach throughout – from data collection to its analysis and sense-checking.

My main recommendation is the potential for additional illustrative quotes to be curated from the transcripts and subsequent analysis to more fully humanize the interpretation of the themes and inter-related sub-themes.

We appreciate the reviewer's comment. For the following themes and sub-themes, we added quotes to better illustrate participants' perceptions and experiences, which provide greater insight about the themes and sub-themes.

- Dissonance between circumstances and ideal: We added three quotes and added a sentence to an existing quote, to better illustrate how dissonance affected participants' health (Page 15, Paragraphs 1-2).

- Exclusion from the labor market: We added three quotes to better illustrate participants' perceptions and experiences related to the labor market (Page 16, Last Paragraph; Page 17, Paragraph 1, Quote 1).

- Social isolation: We added three quotes and added a sentence to the existing quote, to better illustrate participants' issues related to being with others or being alone (Page 17, Last Paragraph; Page 18, Paragraph 1).

- Lack of love and support from an early age: We added two quotes to better illustrate participants' experiences of having parents with high expectations and of overperforming to seek value (Page 20, Paragraph 2, Quotes 1 and 3).

3. Additionally, is there anything to be interpreted as different by gender etc across the themes – the authors should consider presenting more demographical identifiers (gender, age, ethnicity, education etc) to classify the participants from who you quote verbatim under each theme. This in turn would allow the research objective around 'social inequalities' to be explored more fully by differentiating between the sample's demographic characteristics when contributing quotations under the themes and interrelated sub-themes.

We thank the reviewer for arising this point. We did consider presenting more demographical identifiers, such as gender, but did not find this relevant: we did not find anything to be interpreted as different by gender or other demographical identifiers. However, we found relevant to distinguish quotes from "the mental-health participants", "the participants with reduced mobility", and "the participants living alone" for certain themes and sub-themes. For example, it is interesting to see that results regarding "Social isolation" only come from "the participants living alone." Nevertheless, when describing the participants' characteristics, we do present demographical identifiers, such as "the participants who reported Québécois origins (n=5) were living alone and had no children." For results regarding "Social isolation", we found more relevant to refer to "the participants living alone" than to "the participants who reported Québécois origins and one other participant."

Additionally, we had concerns regarding identification and confidentiality of participants if too much demographical information were provided.

4. Minor, infrequent typographical errors have been identified:

Page 2; line 19: Insert a period at the end of the Setting sentence.

Page 4; line 15: 'associated with' instead of 'associated to'

Page 13; line 47: Delete the unnecessary quotation mark after "... the answer."

Page 15; line 17: Add comma after affectively

Page 16; line 18: Delete unnecessary quotation mark before so for me.

We corrected the typographical errors, as suggested.

VERSION 2 – REVIEW

REVIEWER	Eleonora Uphoff University of York
REVIEW RETURNED	06-Dec-2019

GENERAL COMMENTS	Thank you for addressing my comments and adding information to the manuscript to better explain your rationale and methods.

REVIEWER	Sinéad Furey Ulster University, Coleraine, Northern Ireland
REVIEW RETURNED	18-Dec-2019

GENERAL COMMENTS	Thank you for addressing and/or responding to my original comments and review. With reference to Point 13 above, the SRQR checklist has been used and there is inclusion of the funding details statement. My only request would be that the authors include a statement explaining how they interpret 'implicit' meaning (page 12, line 15). Minor additional proofreading required: Page 10, line 3 = multiple (and not multiples) Page 10, line 54 = awaiting (and not waiting) Page 24, line 40 = in addition to...

VERSION 2 – AUTHOR RESPONSE

Reviewer: 2

1. Thank you for addressing my comments and adding information to the manuscript to better explain your rationale and methods.

We thank the reviewer for this comment.

Reviewer: 3

1. Thank you for addressing and/or responding to my original comments and review.

With reference to Point 13 above, the SRQR checklist has been used and there is inclusion of the funding details statement.

My only request would be that the authors include a statement explaining how they interpret 'implicit' meaning (page 12, line 15).

We appreciate the reviewer's comment. As requested, we added explanations in parentheses for what we meant by "explicit" and "implicit" (Page 12, Paragraph 1, Sentence 4).

2. Minor additional proofreading required:

Page 10, line 3 = multiple (and not multiples) Page 10, line 54 = awaiting (and not waiting) Page 24, line 40 = in addition to...

We applied the corrections, as suggested.