Reviewer's report

Title: Interpersonal psychotherapy (IPT) for late-life depression in general practice: a feasibility study

Version: 2 Date: 14 November 2006

Reviewer: Patrick Raue

Reviewer's report:

General

This is a well written paper on the acceptability of implementing IPT in general practice settings, and considers organizational, clinician, and patient variables.

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Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

1. The study is framed as a feasibility study of IPT in real-life general practice. However, the data come from a randomized effectiveness study (IPT vs GP Usual Care), similar to the Bruce et al and Unutzer et al studies. Therefore, the goals should be reframed as obtaining information on physician, therapist, patient acceptance of the treatment, etc, in this context.

2. Methods, Feasibility: It would be helpful to describe the “specific and open-ended questions about the intervention” for GPs, as well as how “organizational barriers and facilitating factors” were assessed.

3. Results, Patients: Of the 69 patients assigned to IPT who gave informed consent, did any fail to initiate treatment?

4. Please provide the range of MADRS scores and describe what a mean of 19.4 corresponds to as far as depression severity.

5. As reasons for dropouts were recorded, it would be of interest to list the top reasons for dropout in this section.

6. The authors’ definition of adherence is attending 10 sessions of IPT over a course of 5 months, in addition to any subjects who terminated therapy early with therapist agreement (presumably due to sustained clinical improvement). This is a relatively liberal criterion, as IPT is usually intended to be provided on a weekly basis and for a full course of treatment regardless of early improvement. Thus, statements regarding patient adherence should be qualified in relation to this definition.

7. Page 9 – Where any other incentives for therapists to participate in the study beyond learning a new type of therapy (eg, financial compensation, encouragement or requirement by the mental health centres that were approached)? Was their work supported by their employers, or was it done on their own time?

8. Page 9, Evaluation: Please provide anchor points of the CSQ. The authors state that the GPs’ “evaluation of IPT was positive” – is there any corresponding quantitative data to support this? Did their description of IPT as “time-limited, practical, and structured” come from open-ended or more specific questions?

9. The statement that “discussing depressive symptoms as part of a depressive illness… was not workable” for patients with mild depression raises questions about the validity of the PRIME MD diagnoses in these cases. Perhaps these patients were not suffering from a depressive disorder, and thus the therapeutic strategy to discuss patient symptomatic complaints vs depression makes sense. However, IPT for patients who carry a diagnosis of mild Major Depression nonetheless stresses the importance of psychoeducation about depression as a legitimate medical illness that requires treatment. There is insufficient evidence for the authors to conclude (page 13) that “IPT should be reserved to patients with moderate to severe depression.” Perhaps the authors could discuss these points further.
Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

1. Introduction, 2nd paragraph, second sentence on inadequate treatment in real world settings logically belongs toward the end of the paragraph.

2. Introduction, 2nd paragraph: In addition to the Freudenstein reference, the authors may also cite the following review of psychotherapy effectiveness in primary care: Schulberg HC, Raue PJ, Rollman BL: The effectiveness of psychotherapy in treating depressive disorders in primary care practice: clinical and cost perspectives. General Hospital Psychiatry 2002, 24:203-212.

3. Introduction, 3rd paragraph: Perhaps “adult” can be replaced with “mid life primary care patients.”

4. Methods, Patients: Please state how “severe cognitive impairment” was defined.

5. The authors mention practice nurses and community psychiatric nurses in the abstract (conclusions), but not in the text.

6. In the Reference List, numbers 13 and 21 repeat, as do numbers 15 and 25.

Discretionary Revisions (which the author can choose to ignore)

What next?: Unable to decide on acceptance or rejection until the authors have responded to the major compulsory revisions

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

Quality of written English: Acceptable

Statistical review: No

Declaration of competing interests:
I declare that I have no competing interests.