Reviewer's report

Title: Psychosocial functioning in patients with treatment-resistant depression after group cognitive behavioral therapy

Version: 1 Date: 11 September 2009

Reviewer: Ingrid Sochting

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This study set out to examine whether adding group cognitive behavior therapy to medication would improve psychosocial functioning in patients with treatment-resistant depression. 43 patients were followed over a 12 week group therapy program, and 20 were also assessed at 1-year follow-up.

This clinical research question is well-defined and the study well executed. 43 patients enrolled and about half of those available at follow-up seems adequate for this type of study.

Advise is to accept after discretionary revisions.

Following are suggestions for discretionary revisions.

1. It provides an important contribution to the literature on the effectiveness of psychological interventions for depression. The introduction is missing references to other key studies in the area of augmenting antidepressant medication treatment with CBT. Although the focus is on treatment resistant depression, the work of, for example, DeRubeis et al. Archives of General Psychiatry, Vol. 62, April 2005 seems relevant showing that cognitive therapy can be as effective as medications for the initial treatment of moderate to severe major depression.

About 40% of the patients in the study under review had a first episode. The DuRubeis et al study had initial Hamilton Rating Scale for Depression mean (HRSD) score of about 23 whereas the study under review had a mean HRSD score of 14.2, which is in the milder range and surprisingly low for a treatment resistant population. The authors may wish to comment on that. Are their patients more impacted by poor coping skills in various areas of life as opposed to actual symptoms of depression?

2. The standard CBT Depression protocol used in this study is primarily focused on symptoms and in particular cognitive and behavioural. Whilst patients do get opportunities to set goals and practice new ways of thinking in the “real world” as part of their homework, the CBT protocol does not include stress management, communication skills, interpersonal functioning. Other studies showing that integrated therapies as opposed to monotherapies had greater effects on improving psychosocial functioning. This aim is to show that a combined approach, CBT with medication, can improve symptoms and psychosocial functioning at end of treatment and one year later. How do the authors explain
the improvement in psychosocial functioning when their CBT protocol was not integrated with another psychological therapy? Did the group format perhaps provide opportunities for practicing new skills? Did they deviate from the CBT protocol at times and allowed for a more interpersonal component to take place as group members supported each other?

3. Interesting that more men than women enrolled in the therapy and study considering that depression is twice as prevalent among women compared to men. Also, women still to seek depression treatment more often than men. Was this issue discussed in the groups? Is this a more typical scenario in the country where the study took place? What may account for this gender balance?

4. It would be helpful for the authors to comment on level of depression and take that into consideration when drawing conclusions. The discussion section needs to be softened “It seems reasonable to conclude that combining cognitive behavioral group therapy with medications could improve social functioning more than medication alone.” This may be limited to patients who may be mild to moderately depressed at least as measured by the HRSD.

5. Other clinically relevant questions to be addressed. 1. Why were the groups so small in size like 5 – 6 when about 8 is the more usual in the group therapy literature? Was there a therapeutic rationale for this small group size and the proportionally large therapist number, like some groups may have had three therapists and five patients. That also allows for much individual attention perhaps at the expense of the group climate factors. 2. The drop-out rate of only five of 43 (about 11%) is very low and commendable for group therapy. Can the authors explain this? Was there any group therapy preparation or prior experience with group? Cultural factors? Once you commit, you stay? Pleasing/fearing the therapists (authorities)?

6. Limitations section. How do the authors suggest a controlled study be designed?

7. Proof read the manuscript. There are several typos and a few sentences that do not work well in English.

I declare that I have no competing interests.