Reviewer's report

Title: A Pilot Randomised Controlled Trial of Cognitive Behavioural Therapy for Antenatal Depression

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Reviewer: Traolach Brugha

Reviewer's report:

This paper provides a wealth of information on the context of antenatal depression treatment, in this case with CBT. Few researchers have examined this very important setting. There is much valuable material here.

Minor essential revisions

International readers will be less familiar with the CIS-R. The authors have chosen to use the CISR Depression threshold. How does this compare with other measures in use according to each recommended threshold, such as the BDI, EPDS, HAM-D? My understanding is that it uses a relatively high threshold which is in keeping with description of the severity of the recruited cases.

Discretionary changes

There is scope for adding to the weight of the paper by expanding the discussion of its implications. There is a growing trend for primary care depression intervention research to make use of Internet, telephone and non specialist modes. If it is correct that the cases in this pilot trial were more towards the moderate and severe end of the scale, in setting the trial context, is it possible to comment that those more novel and lower cost approaches might not be appropriate or in some cases ethically acceptable? The authors have shown that a more specialist model of care is feasible but could make a stronger case for its justification.

As often with trial pilots there is a certain ambiguity about whether the aim is feasibility or is really about the primary outcome, recovery. The pilot demonstrates the feasibility of a treatment already known to be effective in adulthood. Why recommend a costly full scale trial of CBT for treatment of antenatal depression (‘A sufficiently large trial to provide evidence of the effectiveness and cost effectiveness of such an intervention is needed as this cannot be assumed by simply extrapolating from evidence outside the antenatal period’)? The authors do discuss reasons why the extrapolation to pregnancy of treatments that are effective at other times, is inadequate. However only one of their reasons is strictly speaking about whether it works or not. The paper could be more significant if the point were restated from the start: CBT is known to work but can it be implemented within the healthcare system during pregnancy? This study shows that it can. Of course the case for a trial might be made based on different objectives and outcomes: indirect costs, effects on the foetus and
child in the shorter and longer term, benefits for the family etc. Further research recommendations might focus on these important context specific outcomes as of primary interest, although secondary to amelioration of depression. This would then add weight to the case for primary research on the benefits of non drug treatment of antenatal depression.

Additional minor points

'midwives only referred 65.6% of those eligible for assessment' - a discussion of the reasons for this would be of interest. Could it be that reliance on the three Wholly questions is not adequate or that midwives are not adequately trained in the recognition of depression?

Not all readers will know what the NICE three question screen is.

**Level of interest:** An article of importance in its field

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

No competing interests