










Minimal contact psychotherapy reduces the risk of major depression in people with subthreshold depression

Willemse GRWM, Smit F, Cuijpers P, *et al.* Minimal-contact psychotherapy for sub-threshold depression in primary care—randomised trial. *Br J Psychiatry* 2004;**185**:416–21.

Q Does minimal contact psychotherapy reduce depressive symptoms and improve quality of life for people with subthreshold depression?

METHODS

	Design: Randomised controlled trial.
	Allocation: Unconcealed.
	Blinding: Single blinded (assessors).
	Follow up period: 12 months.
	Setting: 19 general practices, the Netherlands; time frame not stated.
	Patients: 216 adults (18–65 years) with subthreshold depression (at least one core symptom and one to four current symptoms of depression; Instel screening instrument). Exclusions: DSM-IV depressive disorder, dysthymia, bipolar disorder, social phobia, agoraphobia or panic disorder in the previous year; already receiving or awaiting mental health treatment; life-threatening comorbidity; suicidality; psychosis; schizophrenia; or dementia.
	Intervention: Minimal contact cognitive behavioural therapy: self-help manual teaching cognitive behavioural mood management skills, including registration exercises and assignments. A community mental health worker conducted an initial interview and provided support by telephone (five <15 minute fortnightly calls, and one call 2 months later). Participants could also make use of any other health services. Usual care: standard primary care provided by general practitioners or other health professionals.
	Outcomes: Incidence of major depression (DSM-IV), and depressive symptoms (Center for Epidemiological Studies Depression scale (CES-D), score range 0–60, higher score means more symptoms).
	Patient follow up: 82% at 12 months, however only 40% completed the intervention.

MAIN RESULTS

Minimal contact psychotherapy significantly reduced major depressive disorder at 12 months compared with usual care (minimal contact psychotherapy *v* usual care: 12% *v* 18%, RR 0.7, 95% CI 0.4 to 1.1; intention to treat analysis). Minimal contact psychotherapy significantly reduced depressive symptoms compared with usual care at 12 months (minimal contact psychotherapy *v* usual care, mean CES-D score: 9 *v* 11; *p* = 0.03).

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CONCLUSIONS

Minimal contact psychotherapy, based on a self-help manual with minimal support from health professionals, reduces the incidence of major depression in people with subthreshold depression.

NOTES

Of participants in the intervention group 22% did not start the intervention, and another 37% failed to complete the intervention, mainly due to lack of time, not feeling depressed or motivational problems. Men and those with better subjective functioning (RAND-33) were less likely to complete the intervention. Although the study was underpowered due to the small number of participants the intervention had a significant effect on outcome.

Commentary

This paper addresses an important area in medicine, namely to identify those at high risk of developing a disorder and ultimately to intervene and prevent expression of this disorder. Such preventative strategies have been proposed for those at high risk of developing schizophrenia but rarely for those at risk of developing major depression.¹ The authors hypothesised that a non-harmful intervention, namely minimal contact psychotherapy using a self-help manual, would prevent those with subthreshold depression in primary care from subsequently developing a major depressive episode. Subthreshold depression is important: it is much more prevalent than major depression; it commonly leads to psychosocial disability; and almost 20% of people with subthreshold depression develop a major depressive episode with a year.²

Willemse *et al* found that minimal contact psychotherapy significantly reduced the risk of major depression over 1 year compared with usual treatment. Subthreshold depression poorly predicted major depression and the number needed to treat to prevent one person developing major depression was relatively high (NNT=16). The potential clinical implications are important as this study suggests that a preventive psychological strategy could prevent onset of major depression in those at high risk in primary care. However, the findings should not be overstated because, as the authors have stated, the study was somewhat underpowered, differences were relatively small, and the study population may not have been representative of those with subthreshold depression in primary care as only 36% of those identified as being at high risk of subthreshold depression actually underwent a diagnostic interview. Furthermore, only 40% of those randomised to minimal contact psychotherapy actually completed the intervention. Therefore, the main clinical message from this study is to suggest the need for larger scale studies in such patients. Future studies in this area need to specifically target people at even higher risk, such as those with a strong genetic risk of developing major depression.

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