# Letters

COMMENT & RESPONSE

## Internet-Based Self-help Interventions for Depression in Routine Care

**To the Editor** The outstanding individual participant data meta-analysis by Karyotaki and colleagues[1] highlights the efficacy of self-guided internet-based interventions for depressive symptoms, thereby making the case for the use of individual participant data meta-analysis as a gold standard for evidence-based mental health care. However, the discussion would have benefited from a more differentiated point of view regarding the clinical significance of their findings.

First, the reported mean effect size of $g = 0.27$ (95% CI, 0.17-0.37) is only slightly above the lower cutoff point for clinical relevance in the treatment of depression suggested before (standard mean difference = 0.24).[2] Given the reported risk of publication bias for psychotherapy for depression,[1] the use of the rather weak wait-list comparison group in many of the included trials, and the immense between-study heterogeneity ($I^2$ = 71%; 95% CI, 51%-82%), conclusions on the clinical value of pure self-guided internet-based interventions seems premature. In this context, we encourage the authors to share their insights on potential moderators and mediators that might explain the substantial heterogeneity of treatment effects. Although this can only be of a speculative nature at this stage, this might guide future studies in the field.

Second, although this study demonstrated the efficacy of unaccompanied self-help interventions, one needs to consider that this evidence is based on randomized clinical trials, which bring a per se rather high structuring of participants and high research attention that is highly unlikely to be found in routine clinical care. Because the securing of commitment represents an adherence-promoting element in self-help interventions, it can be assumed that the effect sizes for pure self-help intervention under laboratory conditions are significantly overestimated for their potential in routine care. Such an assumption is supported by pragmatic studies in which no additional benefit of unaccompanied self-help programs compared with the standard treatment was found.[3] Hence, a clear concept for ensuring adherence, such as through minimal guidance from a professional or lay health worker, seems favorable, where only the former are trained to adequately deal with crises. Taken together with the fact that guided self-help approaches for depression are superior over pure self-help interventions,[4] preference should be given to self-help approaches with at least some form of adherence promoting, and intervention process monitoring, guidance whenever possible.

**David Daniel Ebert, PhD**
**Harald Baumeister, PhD**

**Author Affiliations:** Department of Clinical Psychology and Psychotherapy, Friedrich-Alexander-University Erlangen-Nuremberg, Nuremberg, Germany (Ebert); Department of Clinical Psychology and Psychotherapy, Institute of Psychology and Education, University of Ulm, Ulm, Germany (Baumeister).

**Corresponding Author:** David Daniel Ebert, PhD, Friedrich-Alexander-University Erlangen-Nuremberg, Department of Clinical Psychology and Psychotherapy, 90453 Erlangen, Germany (david.ebert@fau.de).

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