Supplementary Online Content

Karyotaki E, Riper H, Twisk J, et al. Efficacy of self-guided internet-based cognitive behavioral therapy in the treatment of depressive symptoms: a meta-analysis of individual participant data. *JAMA Psychiatry.* Published online February 22, 2017. doi:10.1001/jamapsychiatry.2017.0044

This supplementary material has been provided by the authors to give readers additional information about their work.

eMethods. Supplemental Methods

Search Strings for PubMed

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Generic IPD Protocol

The methods of the IPD meta-analysis should be in compliance with the PRISMA IPD statement[1]

Identification and selection of studies:

- An existing database on psychological treatments for adult depression will be used. This database has been developed in 2006 and it is updated annually by a systematic literature search in the databases of PubMed, PsycINFO, Embase and the Cochrane Library[2]. Two researchers will examine the papers for eligibility. In case of disagreement, consensus will be sought, and if needed a third senior researcher will be consulted.

- Primary studies from meta-analyses of psychological treatment for depression will be also checked to ensure that no published studies are missing.

- In addition, the research team will ask key researchers in the field if they are aware of unpublished trials on the topic of interest.

- The inclusion process of the studies will be reported in a PRISMA IPD flow chart.

Data acquisition:

Frist or senior authors of eligible papers will be contacted requesting permission to use their datasets. If there is no response, reminders will be sent two weeks and one month after the first contact. If there is no response after one month, the trial will be excluded as ‘unavailable’

Data extraction:

Data to be extracted from RCTs are:

- Reference

- The year of publication

- Country

- Recruitment (e.g. community, primary care)

- Patient characteristics (e.g. target group, the anonymised unique patient identifier)

- Therapy characteristics (e.g. type of psychotherapy, treatment format, duration, etc.)
- Group variable (randomized group)
- Control characteristics (e.g. type of control)
- Comorbidities (e.g. comorbid anxiety disorder)
- Outcome data (continuous depression scores at baseline, post-treatment and follow up assessments)
- Demographic characteristics (e.g. age, gender, educational status, marital status, employment status)
- Data related to risk of bias assessment

Included studies will be described in text and tables. Two researchers will extract data independently; potential disagreements will be solved through discussion and if need the project coordinator will be consulted.

Checking Data:

After receiving databases from authors the following should be checked with the publish paper:

- The means and standard deviations of the continuous depression measure, age, and any other continuous measure.
- The frequencies of gender, and a few other reported demographic or clinical characteristics.
- Where possible, the post-treatment means with the papers and rates of missing data/dropout.

Entering Data:

- All patients that are randomized from each RCT should be included into the merged IPD database.
- Variables from primary RCTs will be recoded according to the merged IPD database coding.

Risk of bias assessment:

The validity of included studies will be assessed using the criteria of the Cochrane Collaboration Risk of bias assessment tool[3]. Two reviewers will conduct assessment of the quality independently. In case of unclear items, the primary authors of the included RCTs will be asked to provide clarifications.

Data Analysis

- Mixed models will be used for the regression analysis (building a model with an interaction effect between the variable of interest and treatment group).

- In case of varying outcome measures (dependent variables), the measures will be standardized. Dichotomous variables (e.g. response) can also be used. It is preferable to do both of these procedures, and use one as a sensitivity analysis.

- The current state of the field suggests using multiple imputations to deal with missing data. Complete cases analysis will follow to ensure robustness of the results.

- In case of missing studies, a traditional meta-analysis will be performed to examine differences between studies that provided data and studies that did not.

Traditional Meta-analysis

We used data reported in the published papers to calculate the effect sizes (Hedges' g) showing the difference between self-guided iCBT and control conditions on depressive symptoms severity. Hedges' g is the difference between the average score of the self-guided iCBT group and the average score of the control group at the post-treatment assessment, divided by the pooled standard deviation, adjusting for small sample bias. Hedges's g of 0.2 is considered to be small, 0.5 as moderate and 0.8 as large[4]. The difference between studies that did and did not provide data was tested in a subgroup analysis. Heterogeneity was examined by calculating I^2 indicating heterogeneity as a percentage (with 25% as low, 50% as moderate, and 75% as high)[5]. The 95% confidence intervals (CI) around I^2 were calculated using the non-central chi-squared-based approach in the heterogi module of Stata[6,7]. We examined publication bias by visually inspecting the funnel plot, by using the trim and fill procedure and Egger's test of funnel plot asymmetry[8,9].

eTable 1. Studies Characteristics

Studies	Diagnosis	Recruitment	N sessions	Intervention	N - intervention	Control group	N - Control	Outcome measure	IPD available	Average no of sessions completed	Country
Berger et al. (2011)[10]	BDI-II > 13	Community	11	F-SG CBT	25	WL	26	BDI-II	Yes	7	CH
Christensen et al. (2004)[11]	K10 > 21	Community	5	TS - CBT	182	Attention placebo	178	CESD	Yes	NR	AU
Clarke [25] et al. (2002)	Depression (HMO diagnosis)	HMO	7	F-SG CBT	144	TAU	155	CESD	No	NA	US
Clarke et al. (2005)[26]	Depression (HMO diagnosis)	HMO	7	TS CBT	155	TAU	100	CESD	No	NA	US
Clarke et al. (2009)[27]	Depression (HMO diagnosis)	HMO	7	F-SG CBT	83	TAU	77	PHQ-8	No	NA	US
De Graaf et al. (2009)[12]	BDI-II > 15	Primary care	9	F-SG CBT CBT&TAU	100 100	TAU	100	BDI-II	Yes	4	NL
Farrer et al. (2011)[14]	K10 > 22	Tel-counselling service	5	F-SG CBT TS CBT	38 45	No treatment	35	CESD	Yes	2	AU
Gilbody et	PHQ-9 > 9	Primary	8	TS CBT	210	TAU	239	PHQ-9	Yes	2	UK

al. (2015)[15]		care	5	gr1[a] TS CBT gr2[a]	242						
Kleiboer et al. (2015)[16]	CESD > 15 CESD < 40	Community	5	F-SG CBT	107	WL	106	CESD	Yes	2	NL
Klein et al. (2016)[18b]	PHQ-9 > 4; PHQ-9 < 15	Community & primary care	11	F-SG CBT	192	TAU	187	PHQ-9	Yes	NR	DE
Meyer et al. (2009)[20]	Depression (BDI)	Community	11	F-SG CBT	320	WL	76	BDI	Yes	4	DE
Meyer et al. (2015)[21]	PHQ-9 > 14	Community & primary care	11	F-SG CBT	78	TAU	85	PHQ-9	Yes	8	DE
Mira et al. (submitted)[28]	Mild to moderate depression (BDI < 28)	Community	8	TS - CBT	44	WL	44	BDI-II	Yes	7	SP
Moritz et al. (2012)[22]	Depression (BDI)	Community	11	F-SG CBT	105	WL	105	BDI	Yes	6	DE
Phillips et al. (2014)[23]	PHQ-9 > 9	Workplaces	5	F-SG CBT	318	Attention placebo	319	PHQ-9	Yes	NR	UK
Spek et al. (2007)[24]	EDS > 12	Community	10	F-SG CBT	67	WL	58	BDI	Yes	5	NL

&TAU: Self-guided web based CBT combined with TAU; AU: Australia; BDI: Beck Depression Inventory; CESD: Centre of Epidemiological Studies Depression Scale; CH: Switzerland; DE: Germany; EDS: The Edinburgh Depression Scale; F-SG: Full self-guided; gr: group; HMO: non-profit Health Maintenance Origination; K10: Kessler Psychological Distress Scale; N: Number of participants; NA: Not available' NL: the Netherlands; no: number; NR: Not reported; PHQ: Patient Health Questionnaire; SP: Spain; TAU: Treatment As

Usual; TS: support for technical issues related to the website usage; UK: the United kingdom; US: the United States; WL: Waiting List

[a] Both Group 1 and Group 2 were forms of web-based CBT for which technical support only was available, used as an adjunct to treatment as usual

[b] Klein et al. 2016 trial provided therapeutic support to participants with moderate symptoms of depression at the baseline (PHQ-9 > 9) while participants with mild depressive symptoms received no support throughout the trial. Participants of this trial were stratified by severity of depression during randomization and thus, we decided to exclude all participants who received therapeutic support (PHQ-9 > 9; n = 634) from all the analyses of the present IPD meta-analysis.

eTable 2. Demographic and Clinical Characteristics of the Included Sample

Characteristics	
Mean Age in years (SD)	42 (11.7)
Gender, females, n (%)	2531/3832 (66)
Education, secondary education, n (%)	1368/2574 (53)
Employed, n (%)	2262/3146 (72)
Being in a relationship, n (%)	2119/3613(59)
Participants who did not provide BL data, n (%)	71/3876 (1.8)
Participants who dropped out from studies, n (%)	1048/3876 (27)
CES-D at the baseline, mean (SD)	25.7 (10.8)
BDI at the baseline, mean (SD)	28.3 (14.4)
PHQ-9 at the baseline, mean (SD)	14.1 (5.4)
Comorbid Anxiety, n (%)	761/1761 (43)

BDI: Beck Depression Inventory; CES-D: Centre of Epidemiological studies for depression scale; n: number of patients; PHQ-9: the Patient Health Questionnaire – 9 items; SD: Standard Deviation

eTable 3. Risk of Bias Assessment

Study: Berger et al. 2011[10]		
Bias	**Authors' judgment**	**Support for judgment**
Random sequence generation (selection bias)	Low risk of bias	*'Participants were randomized into one of the three conditions using a computerized random number generator'* (www.random.org) (p. 257)[10]
Allocation concealment (selection bias)	Low risk of bias	*'The allocation schedule was generated by an independent researcher'* (p. 257) [10]
Blinding of participants and personnel (performance bias)	Not applicable	Blinding of participants and personnel is not possible in psychotherapy research due to the nature of the treatment.
Blinding of outcome assessment (detection bias)	Not applicable	Use of self-report outcome measures.
Incomplete outcome data (attrition bias)	Low risk of bias	Missing values were imputed by the IPD meta-analysis (see IPD meta-analysis methods section).
Selective reporting (reporting bias)	Low risk of bias	The study protocol is not available but it is clear that the published report includes all expected outcomes, including those that were pre-specified.
Other bias	Low risk of bias	The study appears to be free of other sources of bias.
Study: Christensen et al. 2004[11]		
Bias	**Authors' judgment**	**Support for judgment**
Random sequence generation (selection bias)	Low risk of bias	According to the authors, computer-generated random numbers (using SPSS) were used to assign participants to treatment arms.
Allocation concealment (selection bias)	Low risk of bias	According to the authors, an independent statistician performed the randomization and the allocation was concealed from the investigators.
Blinding of participants and personnel (performance bias)	Not applicable	Blinding of participants and personnel is not possible in psychotherapy research due to the nature of the treatment.

Blinding of outcome assessment (detection bias)	Not applicable	Use of self-report outcome measures.
Incomplete outcome data (attrition bias)	Low risk of bias	Missing values were imputed by the IPD meta-analysis (see IPD meta-analysis methods section).
Selective reporting (reporting bias)	Low risk of bias	No indication of selective reporting based on the trial registration (ISRCTN77824516).
Other bias	Low risk of bias	The study appears to be free of other sources of bias.
Study: De Graaf et al. 2009[12]		
Bias	**Authors' judgment**	**Support for judgment**
Random sequence generation (selection bias)	Low risk of bias	*'The randomization code will be given to an independent IT-specialist who will develop a computer program to carry out the group allocation. On entry into the trial the computer program provides the next available number.'* (p. 4 of the protocol de Graaf et al. 2008)[13]
Allocation concealment (selection bias)	Low risk of bias	*'The randomization code will not be revealed until participant inclusion is complete.'* (p. 4 of the protocol de Graaf et al. 2008)[13]
Blinding of participants and personnel (performance bias)	Not applicable	Blinding of participants and personnel is not possible in psychotherapy research due to the nature of the treatment.
Blinding of outcome assessment (detection bias)	Not applicable	Use of self-report outcome measures.
Incomplete outcome data (attrition bias)	Low risk of bias	Missing values were imputed by the IPD meta-analysis (see IPD meta-analysis methods section).
Selective reporting (reporting bias)	Low risk of bias	No indication of selective reporting based on the published protocol (de Graaf et al. 2008)[13]
Other bias	Low risk of bias	The study appears to be free of other sources of bias.
Study: Farrer et al. 2011[14]		
Bias	**Authors' judgment**	**Support for judgment**

Random sequence generation (selection bias)	Low risk of bias	*'A block randomization procedure with stratification based on sex, site of recruitment and severity of psychological distress at screening was used.'* (p. e28099)[14]
Allocation concealment (selection bias)	Low risk of bias	*'Allocation of participants to trial conditions was conducted independently by a research assistant not otherwise involved with the trial'* (p. e28099)[14]
Blinding of participants and personnel (performance bias)	Not applicable	Blinding of participants and personnel is not possible in psychotherapy research due to the nature of the treatment.
Blinding of outcome assessment (detection bias)	Not applicable	Use of self-report outcome measures.
Incomplete outcome data (attrition bias)	Low risk of bias	Missing values were imputed by the IPD meta-analysis (see IPD meta-analysis methods section).
Selective reporting (reporting bias)	Low risk of bias	No indication of selective reporting based on the trial registration (ISRCTN93903959).
Other bias	Low risk of bias	The study appears to be free of other sources of bias.
Study: Gilbody et al. 2015[15]		
Bias	**Authors' judgment**	**Support for judgment**
Random sequence generation (selection bias)	Low risk of bias	*'Participants were allocated by simple randomization to one of three groups without any restrictions placed on the sequence (that is, no blocking or stratification was included in the randomization procedure)'* (page 3)[15]
Allocation concealment (selection bias)	Low risk of bias	*'At the point of recruitment we used an automated computer data entry system to conceal treatment allocation from the study researchers. This was administered remotely by the York Trials Unit and used a computer-generated code'* (page 3)[15]
Blinding of participants and personnel (performance bias)	Not applicable	Blinding of participants and personnel is not possible in psychotherapy research due to the nature of the treatment.

Blinding of outcome assessment (detection bias)	Not applicable	Use of self-report outcome measures.
Incomplete outcome data (attrition bias)	Low Risk of bias	Missing values were imputed by the IPD meta-analysis (see IPD meta-analysis methods section).
Selective reporting (reporting bias)	Low risk of bias	No indication of selective reporting based on the trial registration (ISRCTN91947481).
Other bias	Low risk of bias	The study appears to be free of other sources of bias.
Study: Kleiboer et al. 2015[16]		
Bias	**Authors' judgment**	**Support for judgment**
Random sequence generation (selection bias)	Low risk of bias	*'Random allocation took place at the individual level by an independent researcher who was not involved in the study. The allocation schedule was derived by computer using a random number generator. Block randomization was applied with variable block sizes containing 6, 8, 10, or 12 allocations'* (p. 64)[16]
Allocation concealment (selection bias)	Low risk of bias	*'The allocation schedule will be made with a computerized random number generator by an independent researcher and will be unknown to the investigators.'* (From protocol Donker et al. 2009 p. 3)[17]
Blinding of participants and personnel (performance bias)	Not applicable	Blinding of participants and personnel is not possible in psychotherapy research due to the nature of the treatment.
Blinding of outcome assessment (detection bias)	Not applicable	Use of self-report outcome measures
Incomplete outcome data (attrition bias)	Low Risk of bias	Missing values were imputed by the IPD meta-analysis (see IPD meta-analysis methods section).
Selective reporting (reporting bias)	Low Risk of bias	No indication of selective reporting based on the published protocol (Donker et al. 2009)[17]
Other bias	Low Risk of bias	The study appears to be free of other sources of bias.
Study: Klein et al. 2016[18]		

Bias	Authors' judgment	Support for judgment
Random sequence generation (selection bias)	Low risk of bias	*'Participants were randomized equally (1:1) to the two groups (intervention or control). Randomization was stratified by the PHQ-9 (PHQ-9 <10 vs. PHQ-9 ≥10). Block randomization with variable block sizes was used.'* (p. 220)[18]
Allocation concealment (selection bias)	Low risk of bias	*'The allocation schedule was created by an independent investigator with a computerized random number generator; the other investigators were blinded to this schedule*' (p. 220)[18]
Blinding of participants and personnel (performance bias)	Not applicable	Blinding of participants and personnel is not possible in psychotherapy research due to the nature of the treatment.
Blinding of outcome assessment (detection bias)	Not applicable	Use of self-report outcome measures.
Incomplete outcome data (attrition bias)	Low Risk of bias	Missing values were imputed by the IPD meta-analysis (see IPD meta-analysis methods section)
Selective reporting (reporting bias)	Low Risk of bias	No indication of selective reporting based on the published protocol (Klein et al. 2013)[19]
Other bias	Low Risk of bias	The study appears to be free of other sources of bias.

Study: Meyer et al. 2009[20]

Bias	Authors' judgment	Support for judgment
Random sequence generation (selection bias)	Low risk of bias	*'Randomization was performed via a computer-generated list of random numbers. After generating a list of 500 random numbers and sorting them by size, the highest 20% were marked to indicate that they referred to the control condition. The list was then resorted to its original order and newly enrolled participants were consecutively placed onto this list. If a new participant received a marked number, he or she was assigned to the control condition; otherwise, the new participant was assigned to the immediate-access condition. This procedure ensured that an 80:20 chance—but no predictable sequence—existed with regard to whether a new participant would be assigned to the immediate-access or the delayed-access condition'* (p.5)[20]

Allocation concealment (selection bias)	Low risk of bias	According to the authors: The way they concealed allocation, is as follows: * A research assistant checked whether all inclusion and exclusion criteria were met, so that the person could be admitted to the trial and randomized. * If criteria were met and the person was admitted, this research assistant informed the Principal Investigator and/or the person who was the study/project manager that this particular person had been included and is "ready for randomization". All that was given was the participant ID but no other information, such as any participant data. * The PI and/or project study manager then placed the included participant's ID on the pre-generated list of random numbers. This list was not known or available to the research assistant because it was kept in an encrypted, password-protected file to which only the PI and/or study manager had access. * The PI and/or study manager then performed the randomization by placing the ID onto this list, and then they informed the research assistant about the randomization result. * After this, the research assistant could proceed to inform the participant about the randomization result and provided further instructions regarding next steps. This method is an adequate way of achieving concealed allocation because there is no way that the person responsible for admitting participants into the trial can know what the upcoming group assignment will be.
Blinding of participants and personnel (performance bias)	Not applicable	Blinding of participants and personnel is not possible in psychotherapy research due to the nature of the treatment.
Blinding of outcome assessment (detection bias)	Not applicable	Use of self-report outcome measures.
Incomplete outcome data (attrition bias)	Low Risk of bias	Missing values were imputed by the IPD meta-analysis (see IPD meta-analysis methods section).

Selective reporting (reporting bias)	Low risk of bias	No indication of selective reporting based on the trial registration (ISRCTN64953693/64953693).
Other bias	Low risk of bias	The study appears to be free of other sources of bias.

Study: Meyer et al. 2015[21]

Bias	**Authors' judgment**	**Support for judgment**
Random sequence generation (selection bias)	Low Risk of bias	*'Randomization was conducted with an allocation schedule of random numbers that was created by a computerized random number generator'* (p. 50)[21]
Allocation concealment (selection bias)	Low Risk of bias	*'Participants who were deemed eligible after the telephone interview were consecutively placed on this list by one of the researchers (J.B.), who did not conduct telephone interviews and did not have contact with or knowledge of individual study participants'* (p. 50)[21]
Blinding of participants and personnel (performance bias)	Not applicable	Blinding of participants and personnel is not possible in psychotherapy research due to the nature of the treatment.
Blinding of outcome assessment (detection bias)	Not applicable	Use of self-report outcome measures.
Incomplete outcome data (attrition bias)	Low Risk of bias	Missing values were imputed by the IPD meta-analysis (see IPD meta-analysis methods section).
Selective reporting (reporting bias)	Low risk of bias	No indication of selective reporting based on trial registration (NCT02178631).
Other bias	Low risk of bias	The study appears to be free of other sources of bias.

Study: Mira et al. (submitted)

Bias	**Authors' judgment**	**Support for judgment**
Random sequence generation (selection bias)	Low risk of bias	According to the authors, the random sequence was generated by the computer software Random Allocation, version 1.0. Participants were stratified based on depression severity.
Allocation concealment (selection	Low risk of bias	According to the authors, an independent researcher performed the

bias)		randomization and the allocation was concealed from the investigators.
Blinding of participants and personnel (performance bias)	Not applicable	Blinding of participants and personnel is not possible in psychotherapy research due to the nature of the treatment.
Blinding of outcome assessment (detection bias)	Not applicable	Use of self-report outcome measures.
Incomplete outcome data (attrition bias)	Low Risk of bias	Missing values were imputed by the IPD meta-analysis (see IPD meta-analysis methods section).
Selective reporting (reporting bias)	Low Risk of bias	No indication of selective reporting based on the trial registration (NCT02148354).
Other bias	Low Risk of bias	The study appears to be free of other sources of bias.

Study: Moritz et al. 2012[22]

Bias	**Authors' judgment**	**Support for judgment**
Random sequence generation (selection bias)	Low risk of bias	According to the authors, a pseudo-random sequence was used.
Allocation concealment (selection bias)	Low risk of bias	According to the authors, allocation was conducted by an independent researcher and it was concealed from the investigators.
Blinding of participants and personnel (performance bias)	Not applicable	Blinding of participants and personnel is not possible in psychotherapy research due to the nature of the treatment.
Blinding of outcome assessment (detection bias)	Not applicable	Use of self-report outcome measures.
Incomplete outcome data (attrition bias)	Low Risk of bias	Missing values were imputed by the IPD meta-analysis (see IPD meta-analysis methods section).
Selective reporting (reporting bias)	Low Risk of bias	No indication of selective reporting based on the trial registration (NCT01401296).
Other bias	Low Risk of bias	The study appears to be free of other sources of bias.

Study: Phillips et al. 2014[23]

Bias	Authors' judgment	Support for judgment
Random sequence generation (selection bias)	Low Risk of bias	*'A list was produced by the Nottingham Clinical Trials Unit to allow simple (unrestricted) randomization'* (p. 743)[23]
Allocation concealment (selection bias)	Low Risk of bias	*'Once potential participants had completed the screening questions, if eligible for inclusion in the trial, they were given a study ID, allocated through the website, and they were then invited to join the trial. If participants consented, they were randomized by the portal designers at ANU. In this way the randomization status of participants was concealed from their employers and from the research team until the study was completed.'* (p.743)[23]
Blinding of participants and personnel (performance bias)	Not applicable	Blinding of participants and personnel is not possible in psychotherapy research due to the nature of the treatment.
Blinding of outcome assessment (detection bias)	Not applicable	Use of self-report outcome measures.
Incomplete outcome data (attrition bias)	Low Risk of bias	Missing values were imputed by the IPD meta-analysis (see IPD meta-analysis methods section)
Selective reporting (reporting bias)	Low Risk of bias	No indication of selective reporting based on the trial registration (ISRCTN24529487).
Other bias	Low Risk of bias	The study appears to be free of other sources of bias.

Study: Spek et al. 2007[24]

Bias	Authors' judgment	Support for judgment
Random sequence generation (selection bias)	Low Risk of bias	According to the authors, a computer random sequence generator was used.
Allocation concealment (selection bias)	Low Risk of bias	*'At the end of the clinical interview, eligible participants were randomized. For this purpose a random allocation sequence was generated. The randomization list was kept in an administrative office that was not related to the study. After the inclusion of a participant in the study, the interviewer made a telephone call to the ' randomization office ' to inquire to which condition the participant was randomized. On the randomization list, the time and date of randomization were noted.'*

		(p.4)[24]
Blinding of participants and personnel (performance bias)	Not applicable	Blinding of participants and personnel is not possible in psychotherapy research due to the nature of the treatment.
Blinding of outcome assessment (detection bias)	Not applicable	Use of self-report outcome measures.
Incomplete outcome data (attrition bias)	Low Risk of bias	Missing values were imputed by the IPD meta-analysis (see IPD meta-analysis methods section).
Selective reporting (reporting bias)	Low Risk of bias	The study protocol is not available but it is clear that the published report includes all expected outcomes, including those that were pre-specified.
Other bias	Low Risk of bias	The study appears to be free of other sources of bias.

eTable 4. Effect Sizes for Self-guided iCBT vs Control Comparator Conditions in Adults With Depressive Symptoms, 2-Stage IPD

Outcomes	N	g	95% CI[b]	I^2	95%CI	p[c]
Depression severity at post-treatment full sample	13	0.27	0.17 to 0.37	55%	16 to 76%	<.001
Subgroups						
Type of control						
TAU vs.	4	0.20	-0.02 to 0.42	75%	30 to 91%	.41
Other	9	0.30	0.19 to 0.41	28%	0 to 67%	
Recruitment						
Community	7	0.32	0.22 to 0.43	0%	0 to 71%	
Community and/or primary care	4	0.20	-0.02 to 0.42	75%	30 to 91%	0.60
Other	2	0.34	-0.15 to 0.84	81%	N/A	
Support						
Pure self-guided iCBT	9	0.26	0.16 to 0.36	24%	0 to 64%	.80
Technically supported iCBT	4	0.30	0.02 to 0.59	80%	47 to 92%	
Depression severity at post-treatment Completer sample	13	0.32	0.17 to 0.46	71%	49 to 83%	<.001
Subgroups						
Type of control						
TAU vs.	4	0.20	-0.09 to 0.50	83	58 to 93%	.31
Other	9	0.37	0.22 to 0.52	50%	0 to 77%	
Recruitment						
Community	7	0.40	0.27 to 0.51	0%	0 to 71%	.50

Community and/or primary care	4	0.20	-0.09 to 0.50	83%	58 to 93%	
Other	2	0.37	-0.32 to 1.06	85%	N/A	
Support						
Pure self-guided iCBT	9	0.33	0.18 to 0.47	55%	5 to 79%	.94
Technically supported iCBT	4	0.31	-0.06 to 0.67	85%	62 to 94%	

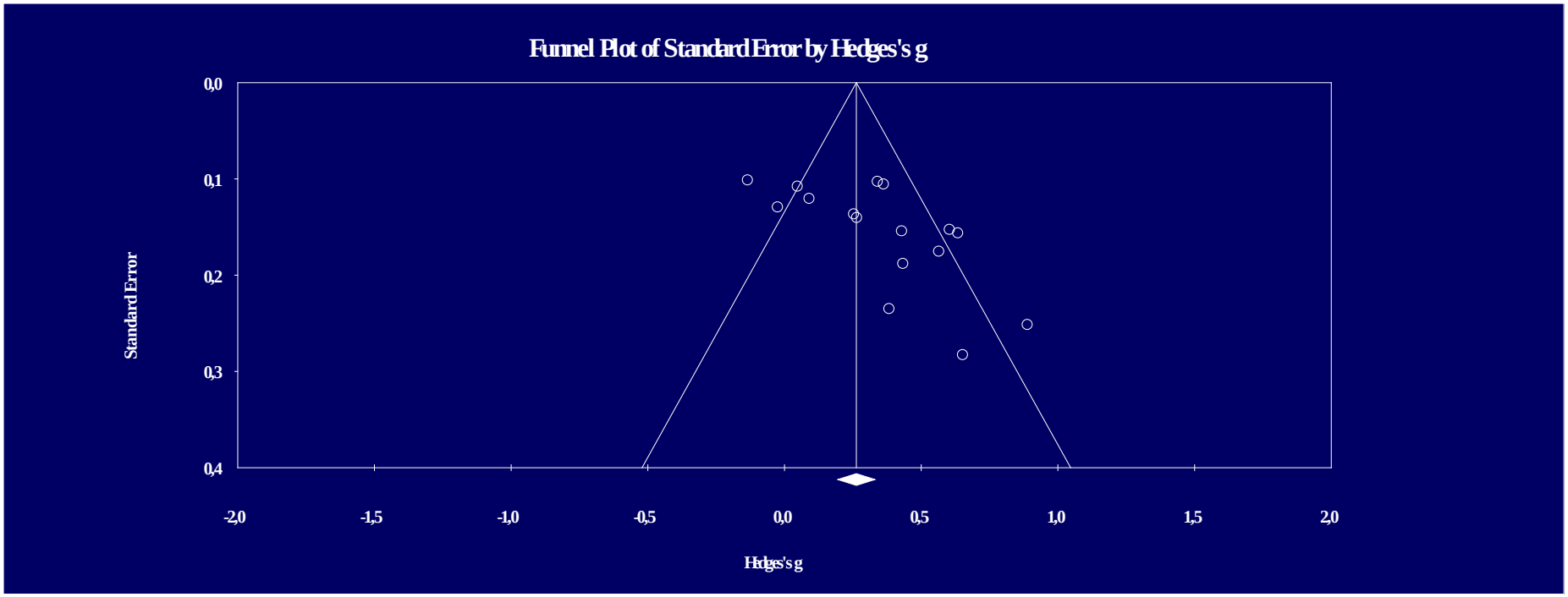
[a] Subgroup analyses were conducted only in the cases where at least three comparisons were available per group. g = Hedges's g; N: Number of studies; N/A: Not applicable
[b] 95% CI: 95% Confidence Intervals; p: p-value
[c] p-value between groups

eTable 5. Effect Sizes for Self-guided iCBT vs Control Comparator Conditions in Adults With Depressive Symptoms, 2-Stage IPD

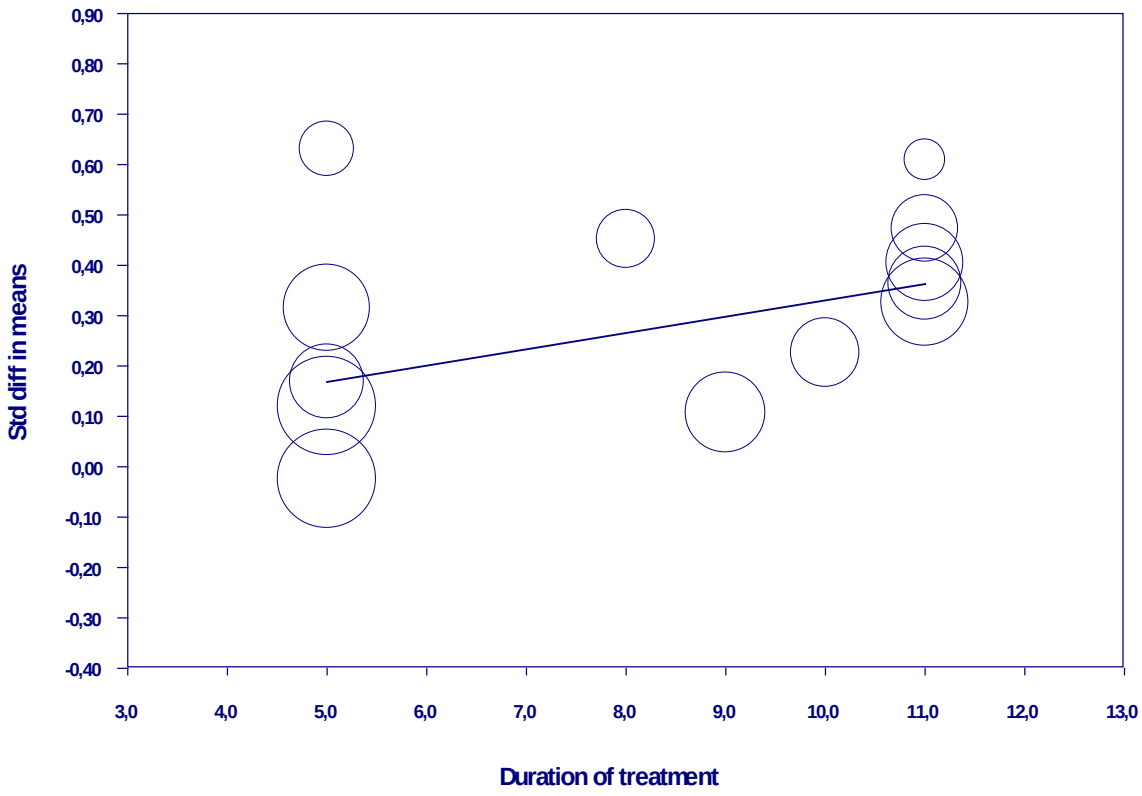
Outcomes	N	OR	95% CI[b]	I^2	95%CI	p[c]
Treatment response at post-treatment full sample	13	1.95	1.52 to 2.50	52%	9 to 74%	<.001
Subgroups						
Type of control						
TAU vs.	4	1.66	1.05 to 2.63	70%	14 to 90%	.37
Other	9	2.12	1.60 to 2.83	33%	0 to 69%	
Recruitment						
Community	7	2.32	1.36 to 3.06	0%	0 to 71%	
Community and/or primary care	4	1.66	1.05 to 2.62	70%	14 to 90%	.46
Other	2	1.90	0.74 to 4.87	63%	N/A	
Support						
Pure self-guided iCBT	9	2.04	1.52 to 2.74	44%	0 to 74%	.68
Technically supported iCBT	4	1.81	1.09 to 3.01	65%	0 to 88%	
Treatment response at post-treatment Completer sample	13	1.88	1.34 to 2.64	64%	35 to 80%	<.001
Subgroups						
Type of control						
TAU vs.	4	1.63	0.95 to 2.79	74%	27 to 91%	.46
Other	9	2.13	1.31 to 3.42	61%	20 to 81%	
Recruitment						
Community	7	2.22	1.61 to 3.08	3%	0 to 72%	.62

Community and/or primary care	4	1.63	0.95 to 2.80	74%	27 to 91%	
Other	2	1.88	0.27 to 12.75	82%	N/A	
Support						
Pure self-guided iCBT	9	1.97	1.27 to 3.06	64%	26 to 82%	.83
Technically supported iCBT	4	1.82	0.97 to 3.40	71%	17 to 90%	

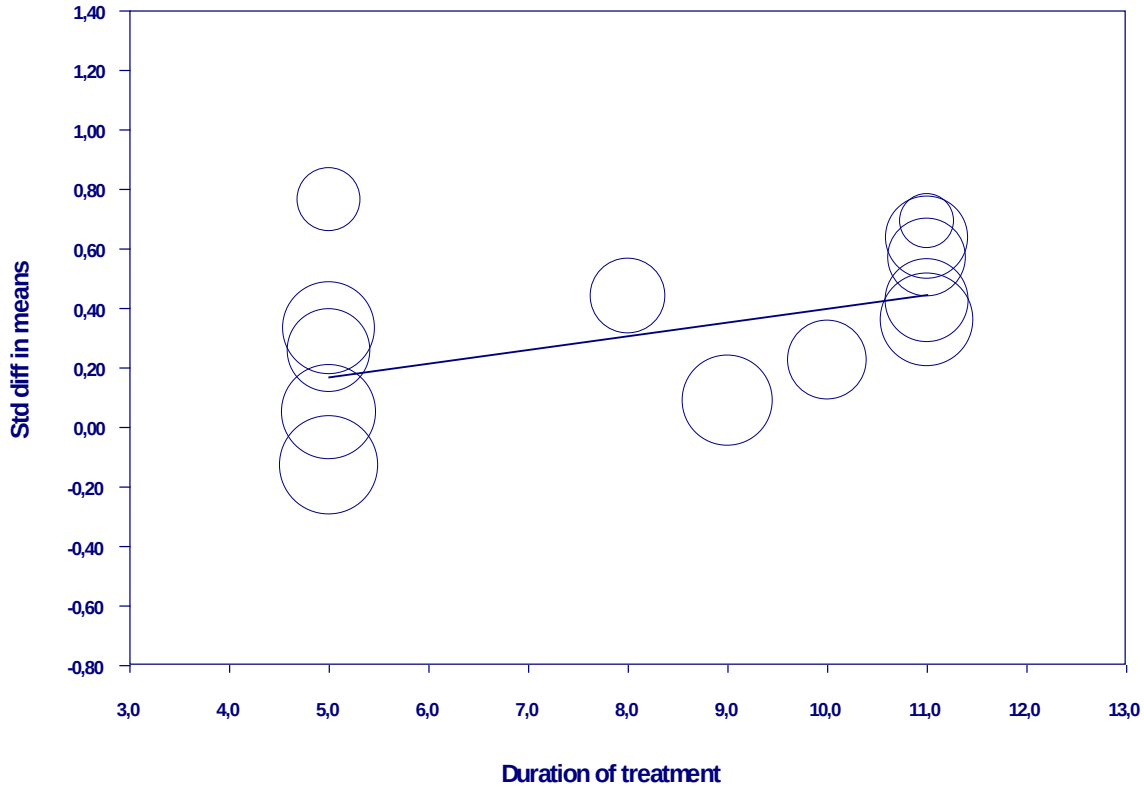
[a] Subgroup analyses were conducted only in the cases where at least three comparisons were available per group. N: Number of studies
[b] 95% CI: 95% Confidence Intervals; OR: Odds Ratio; p: p-value
[c] p-value between groups



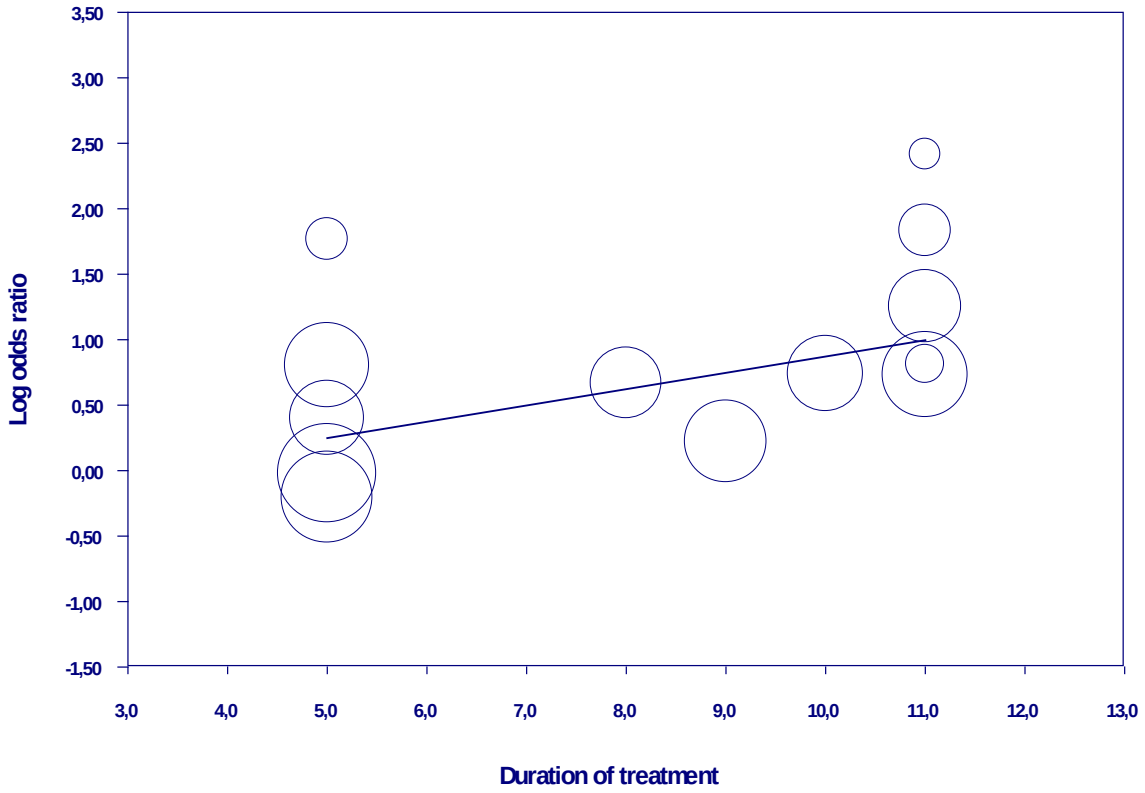
eFigure 1. Funnel Plot Showing Publication Bias: Results of Traditional Meta-analysis



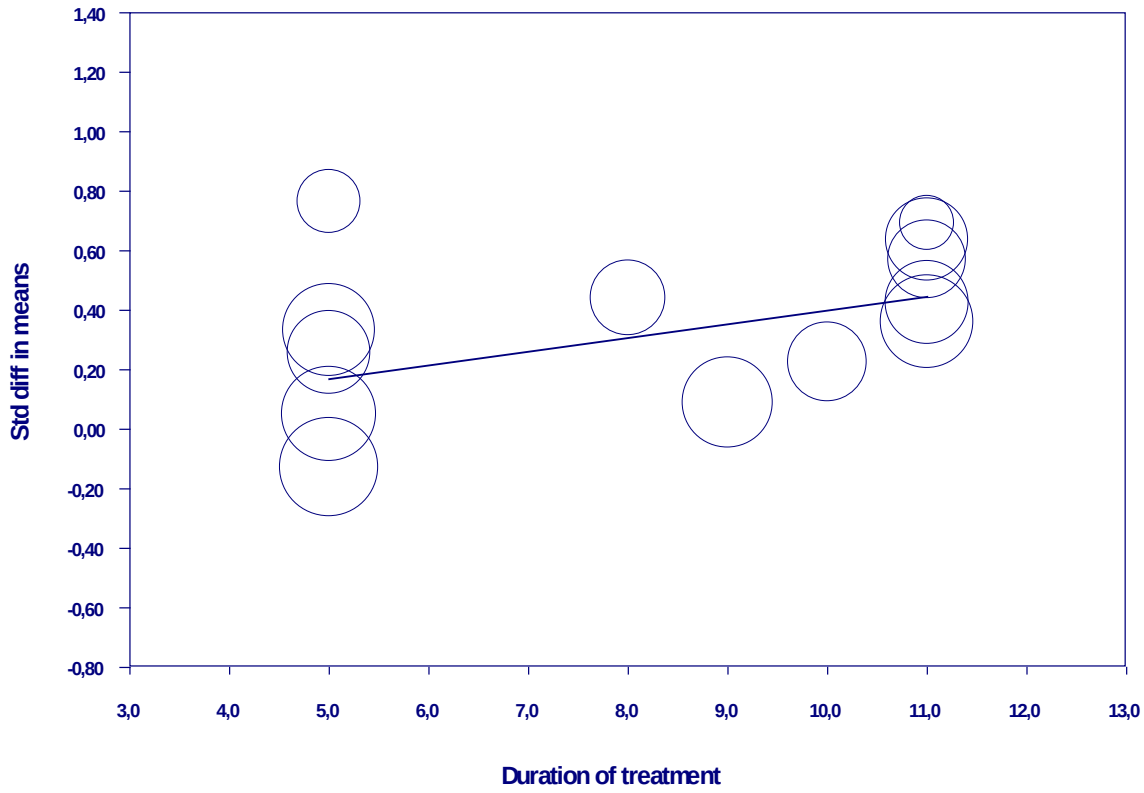
eFigure 2. Meta-regression of Analysis of the Association Between Treatment Duration and Depression Symptoms Severity (Full Sample)



eFigure 3. Meta-regression of Analysis of the Association Between Treatment Duration and Depression Symptoms Severity (Complete Cases Sample)



eFigure 4. Meta-regression of Analysis of the Association Between Treatment Duration and Treatment Response (Full Sample)



eFigure 5. Meta-regression of Analysis of the Association Between Treatment Duration and Treatment Response (Complete Cases Sample)

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