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Letter to the Editor

Minimal clinical contact may contribute to Internet cognitive behavioural therapy (iCBT) efficacy relative to wait-list control condition

Internet-based cognitive behavioural therapy (iCBT) interventions allow a wider access to evidence-based psychological treatments for people with anxiety or depressive disorders. Newby *et al.* (2013) recently published a two-part study including a comparison of iCBT *versus* wait-list control for mixed anxiety and depression. Using a wait-list control results in an inflated effect-size of treatment, especially in iCBT studies (So *et al.* 2013). Moreover, such a control may represent a potential bias, as underlined by Andersson & Cuijpers (2009) in their meta-analysis of Internet-based treatments for depression. They found a significant difference between treatments with therapist support, compared with non-supported treatments (d=0.61 *v.* d=0.25, respectively); and recommended to further investigate the role of therapist factors in computerized treatments. Newby *et al.* (2013) provided regular contacts with their clinician to the treatment group participants until they completed one-third of iCBT; thereafter, this contact was made available, at patients' request. On the contrary, participants in the wait-list control group were not offered such contacts. Therefore, part of the observed difference of efficacy between groups may be attributed to this factor, thus introducing a systematic bias in comparison. Posternak & Zimmerman (2007) assessed the therapeutic impact of follow-up assessments on placebo response in antidepressant trials through meta-analysis. They found that clinical assessments incur a significant therapeutic effect for participants on placebo, representing up to 40% of the placebo response. Thus, minimal contact with a clinician may result in therapeutic effect that is confounded with the effect of iCBT as the wait-list control did not include such contact. It can be argued that contacts by email and phone are less effective than face-to-face contacts. But, according to Hassanian-Moghaddam *et al.* (2011), even sending postcards to patients may result in their mental health improvement. It seems that in a treatment-as-usual (TAU) group, this factor is better controlled as contacts with a clinician are provided to this group, but nevertheless TAU results in a wide observed distribution of quantity and quality of clinician support. Newby *et al.* (2013) suggest that the quality of clinician support may modify adherence to iCBT. We, therefore, suggest that clinician support *per se* may contribute to the efficacy of the iCBT protocol, when compared with a simple wait-list control, in an unknown proportion.

Declaration of Interest

None.

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