LETTER OF REVIEWERS

Reviewer A:
Recommendation: Revisions Required

Relevance: High
Novelty: High
Presentation and writing: Moderated

Comments for authors:
Title and Abstract
1. The abstract is structured and concise; however, we recommend dividing it into explicit sections (Background, Objective, Methods, Results, Conclusion), as required by the journal's editorial policy. This would improve readability. Additionally, the syntax of certain phrases should be revised for clarity in English. For example, the sentence "Strategies such as personalized reminders, constant clarification of objectives..." can be rewritten to enhance clarity.

Introduction
2. The introduction provides a solid rationale for the study. However, key references are missing for certain claims, such as: "Technology-mediated interventions have increasingly been used in Latin America...". I recommend including recent Latin American studies to support this statement. Currently, only one reference is provided.
3. At the end of the introduction, there is a "Justification" section that appears to overlap with the study objective. We suggest removing this subtitle.

Methods
4. I suggest adding to the design section whether the RCT is registered in clinical trial and its registration number.
5. In the Participants section, a sample size calculation should be conducted to assess whether the study has sufficient power to perform the logistic regression (the main analysis). We suggest ensuring at least 80% power. Although the analysis is exploratory, this should be acknowledged either as a limitation or explained if not performed.
6. In the "Assessment Instruments" section, we suggest including the sensitivity and specificity values for both the BAI and BDI-II. Additionally, the prevalence of depressive and anxiety symptoms (as dichotomized outcomes) should be reported as supplementary results.
7. This section should also define what constitutes "dropout". It should be clarified whether dropout was considered separately for each module, i.e., participants could complete one module but not the other, or conditionally, such that missing one module excluded the participant from completing subsequent modules. It is also necessary to specify how this information was obtained (e.g., from the web platform). Additional information should be included regarding the minimum time spent or the minimum number of activities required to classify a module as completed or not.
8. The Ethics section should specify whether informed consent was obtained, and if so, whether it was written or verbal, and administered in person or online.
9. The procedure is clearly and appropriately detailed. However, the data collection period (month and/or year) should be reported, as this is essential for replication.
10. The analysis plan should clarify which variables were included in the final logistic regression model and whether multicollinearity or other assumptions were assessed.

Results
11. Table 1 is unclear. It is not evident whether participants who did not complete one module were allowed to complete subsequent ones. We recommend adding a breakdown of the number of participants who

completed each module, those who did not (dropouts), and, if applicable, the cumulative dropout rate for participants who were excluded for not completing previous modules.
12. All tables should clearly indicate the sample size, e.g., (n = 89).
13. In Table 3, differences are presented based on anxiety and depression levels. However, it is unclear what cut-off points were used. Given the clinical nature of these scores, it is preferable to avoid using arbitrary categories such as “low”, “medium”, and “high”, and instead rely on thresholds derived from sensitivity and specificity data. If these categories are retained or dichotomized, the cut-off values and corresponding diagnostic accuracy should be reported in the Methods section.
14. We suggest merging Tables 2 and 3.
15. Table 2 should report the mean age (in years) for each group.
16. There is inconsistency in how certain variables are treated—as ordinal in some cases and continuous in others (e.g., BAI and BDI-II scores in Tables 3 and 4). We suggest a consistent presentation, and given the potential for attrition bias, it may be more appropriate to analyze these variables dichotomously.
17. The criteria for including variables in the adjusted model are unclear. Were only statistically significant variables included? Was stepwise selection, forward selection, or backward elimination used? The method for variable selection should be clearly explained and justified in the Analysis Plan section.
18. Table 4 should indicate, in a footnote, which variables were included in the adjusted model.
19. We also recommend combining Tables 2, 3, and 4, as they could be integrated into a single table without loss of clarity.

Discussion
20. The discussion should address whether data loss mechanisms were evaluated, and if missingness was consistent with MCAR (Missing Completely at Random), MAR (Missing at Random), or MNAR (Missing Not at Random).
21. A subsection on limitations should be added, highlighting the small sample size, self-selection bias, and lack of post-intervention follow-up.
22. A subsection on implications for digital health or public health should be included, explaining how the findings inform future RCTs or real-world studies.
23. While the discussion states that anxiety was associated with higher dropout, this finding should be compared with international studies or those conducted in similar cultural contexts to strengthen the interpretation.
24. The discussion of the high dropout rate would benefit from reference to theoretical models of adherence to digital psychological interventions (e.g., Theory of Planned Behavior).
25. A conclusion subsection should be added at the end of the manuscript.

RESPONSE LETTER

Comments

Comment	Modification
Abstract 1. The abstract is structured and concise; however, we recommend dividing it into explicit sections (Background, Objective, Methods, Results, Conclusion), as required by the journal's editorial policy. This would improve readability. Additionally, the syntax of certain phrases should be revised for clarity in English. For example, the sentence "Strategies such as personalized reminders, constant clarification of objectives..." can be rewritten to enhance clarity.	Abstract 1. The name of each of the corresponding sections is included. The syntax of the entire paragraph is reviewed and the following sentences are rewritten: -"Strategies such as personalized reminders, continuous clarification of treatment goals, and tools that boost patient motivation toward treatment could effectively prevent dropouts." (Introduction section of the abstract) -"Technology has revolutionized mental health, allowing access to diverse and more accessible therapies." (Objective section of the abstract) -"This study seeks to identify the factors that influence dropout from self-guided treatments for emotional problems related to stress and trauma." (Conclusions section of the abstract)
Introduction 2. The introduction provides a solid rationale for the study. However, key references are missing for certain claims, such as: "Technology-mediated interventions have increasingly been used in Latin America...". I recommend including recent Latin American studies to support this statement. Currently, only one reference is provided.	Introduction 2 Four references are added from studies conducted in Latin America on interventions carried out using technology.
3. At the end of the introduction, there is a "Justification" section that appears to overlap with the study objective. We suggest removing this subtitle.	3 The subtitle is removed. (at the end of the introduction)
Methods 4. I suggest adding to the design section whether the RCT is registered in clinical trial and its registration number.	Method 4 The ECA registration number and date are added. (Page 8, paragraph 1)
5. In the Participants section, a sample size calculation should be conducted to assess whether the study has sufficient power to perform the logistic regression (the main analysis). We suggest ensuring at least 80% power. Although the analysis is exploratory, this should be acknowledged either as a limitation or explained if not performed.	5 It is indicated as a limitation in the corresponding section (page 12, paragraph 2)
6. In the "Assessment Instruments" section, we suggest including the sensitivity and specificity values for both the BAI and BDI-II. Additionally, the prevalence of depressive and anxiety symptoms (as dichotomized outcomes) should be reported as supplementary results.	6 Sensitivity and specificity values are added for both the BAI and BDI-II (instruments section, page 5, paragraphs 2 and 3).

7. This section should also define what constitutes "dropout". It should be clarified whether dropout was considered separately for each module, i.e., participants could complete one module but not the other, or conditionally, such that missing one module excluded the participant from completing subsequent modules. It is also necessary to specify how this information was obtained (e.g., from the web platform). Additional information should be included regarding the minimum time spent or the minimum number of activities required to classify a module as completed or not.	7 This is specified in the section on procedure (page 5, paragraph 2).
8. The Ethics section should specify whether informed consent was obtained, and if so, whether it was written or verbal, and administered in person or online.	8 Informed consent is added to the Ethical Considerations section (page 6, paragraph 3).
9. The procedure is clearly and appropriately detailed. However, the data collection period (month and/or year) should be reported, as this is essential for replication.	9 The procedure section indicates the month and year of the participants considered in the study (page 5, paragraph 1).
10. The analysis plan should clarify which variables were included in the final logistic regression model and whether multicollinearity or other assumptions were assessed.	10 The variables considered are specified in Table 3 of results (page 10)
Results 11. Table 1 is unclear. It is not evident whether participants who did not complete one module were allowed to complete subsequent ones. We recommend adding a breakdown of the number of participants who completed each module, those who did not (dropouts), and, if applicable, the cumulative dropout rate for participants who were excluded for not completing previous modules.	Results 11 The column for accumulated participants who dropped out was added, and a note was added specifying how they were considered to have dropped out (Table 1, page 7).
12. All tables should clearly indicate the sample size, e.g., (n = 89).	12 The sample data is added to all tables (Table 1, page 7; Table 2, page 8; Table 3, page 8; Table 4, page 9).
13. In Table 3, differences are presented based on anxiety and depression levels. However, it is unclear what cut-off points were used. Given the clinical nature of these scores, it is preferable to avoid using arbitrary categories such as "low", "medium", and "high", and instead rely on thresholds derived from sensitivity and specificity data. If these categories are retained or dichotomized, the cut-off values and corresponding diagnostic accuracy should be reported in the Methods section.	13 The levels points are detailed in both questionnaires. (page 5, paragraph 2; page 6, paragraph 1)
14. We suggest merging Tables 2 and 3.	14. Tables 2 and 3 are combined.
15. Table 2 should report the mean age (in years) for each group.	15. The average age of each group is added (Table 2, page 8).
16. There is inconsistency in how certain variables are treated—as ordinal in some cases and	16 It specifies how higher and lower levels were considered (page 9, paragraph 1).

continuous in others (e.g., BAI and BDI-II scores in Tables 3 and 4). We suggest a consistent presentation, and given the potential for attrition bias, it may be more appropriate to analyze these variables dichotomously.	
17. The criteria for including variables in the adjusted model are unclear. Were only statistically significant variables included? Was stepwise selection, forward selection, or backward elimination used? The method for variable selection should be clearly explained and justified in the Analysis Plan section.	17 Added in the data analysis section (page 6, paragraph 3)
18. Table 4 should indicate, in a footnote, which variables were included in the adjusted model.	18 The numbering is changed (now table 3) and the information is added.
19. We also recommend combining Tables 2, 3, and 4, as they could be integrated into a single table without loss of clarity.	19. Tables 2 and 3 have been combined, however, Table 4 has different elements as it is a logistic regression.
Discussion 20. The discussion should address whether data loss mechanisms were evaluated, and if missingness was consistent with MCAR (Missing Completely at Random), MAR (Missing at Random), or MNAR (Missing Not at Random)	Discussion 20 Added as a limitation of the study (page 11, paragraph 3)
21. A subsection on limitations should be added, highlighting the small sample size, self-selection bias, and lack of post-intervention follow-up.	21. A subsection on limitations and conclusions has been added (page 11).
22. A subsection on implications for digital health or public health should be included, explaining how the findings inform future RCTs or real-world studies.	22. Added at the end of the manuscript (page 11, paragraph 3)
23. While the discussion states that anxiety was associated with higher dropout, this finding should be compared with international studies or those conducted in similar cultural contexts to strengthen the interpretation.	23. Quotes and references supporting the discussion are added (page 10).
24. The discussion of the high dropout rate would benefit from reference to theoretical models of adherence to digital psychological interventions (e.g., Theory of Planned Behavior).	24. Reference added (Page 11, paragraph 1)
25. A conclusion subsection should be added at the end of the manuscript.	25. A subsection of conclusions is added (page 11).