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RESEARCH ARTICLE

Acceptability of internet-delivered cognitive behavioural therapy for adults with symptoms of obsessive-compulsive disorder: A meta-analysis

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Abstract

Objectives: Obsessive-compulsive disorder (OCD) is a chronic mental health disorder. Internet-delivered cognitive behaviour therapy (ICBT) is demonstrated to be effective for OCD; however little is known about the acceptability of the treatment. Therefore the aim of this study was to examine the acceptability of ICBT for adults with OCD symptoms using a meta-analytic approach.

Method: Seventeen studies ($N = 1661$; M_{age} range = 28–41 years; 58%–93% female) were included in this analysis.

Results: The random effects pooled estimates indicated that 16.3% (95% CI: 9.8%–25.7%) of participants did not commence the treatment once they were enrolled in the study, 27.6% (95% CI: 19.0%–38.2%) did not complete the treatment, and 27.0% (95% CI: 18.2%–38.0%) did not complete the post-treatment questionnaires of the study. The mean score on the Client Satisfaction Questionnaire ranged from 22.4 to 26.5. Overall, pooled estimates indicated that 81.6% (95% CI: 76.1%–86.0%) of participants were satisfied with the ICBT intervention and 84.7% (95% CI: 72.8%–92.0%) indicated that they would recommend the treatment to a friend. Some of the acceptability moderator analyses indicated that self-guided ICBT interventions had lower levels of acceptability compared with clinician-guided interventions. However, given low power, these results should be considered preliminary.

Conclusions: This study has important implications in the dissemination of ICBT for OCD.

KEYWORDS

internet delivered cognitive behaviour therapy, meta-analysis, obsessive-compulsive disorder

Practitioner points

- Internet-delivered cognitive behaviour therapy (ICBT) is an efficacious treatment for obsessive-compulsive disorder (OCD); however little is known about the acceptability of the treatment.
- This study demonstrates that ICBT is an acceptable treatment for OCD.
- Clinician-guided interventions may be more acceptable than self-guided ICBT interventions for OCD.

BACKGROUND

Obsessive-compulsive disorder (OCD) is characterized by the presence of obsessions and/or compulsions that cause clinical significant distress and/or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association, 2022). The prevalence of the disorder is approximately 3% in Australia (Australian Bureau of Statistics, 2020-2022) and similar prevalence rates are observed worldwide (Ruscio et al., 2010). The disorder is chronic, with a few patients experiencing remission without an effective treatment (Melkonian et al., 2022).

Cognitive behavioural therapy (CBT) is an effective treatment for OCD with multiple meta-analyses demonstrating large within-group and between-group effect sizes (Olatunji et al., 2013; Öst et al., 2015; Rosa-Alcázar et al., 2008). As such, CBT is considered a first-line treatment for OCD (American Psychiatric Association, 2007; Katzman et al., 2014). CBT also appears to be more effective than psychopharmacological interventions in the treatment of OCD (Öst et al., 2015). CBT for OCD typically involves psychoeducation on symptoms, exposure to feared stimuli and prevention of compulsive behaviours (exposure and response prevention; ERP), and/or cognitive intervention to challenge maladaptive cognitions (Abramowitz, 2006).

Despite the efficacy of CBT for OCD (Olatunji et al., 2013; Öst et al., 2015; Rosa-Alcázar et al., 2008) many individuals do not receive this treatment (Kohn et al., 2004; Stobie et al., 2007). That is, when individuals with OCD do seek treatment they are often not provided with an evidence-based treatment (Schwartz et al., 2013). There are also multiple barriers that exist in individuals seeking treatment for OCD including the cost of treatment, geographical isolation, lack of access to trained clinicians, and stigma (Baer & Minichiello, 2008; Belloch et al., 2009; Goodwin et al., 2002; Marques et al., 2010).

Internet-delivered CBT (ICBT) provides a way to overcome barriers to accessing care for some patients with OCD. ICBT involves the patient accessing evidence-based materials in the form of online lessons or modules. ICBT can be delivered as a therapist-guided or self-guided intervention. Therapist-guided interventions involve brief clinician support throughout treatment via telephone, text messaging, or video, while self-guided interventions do not involve any support from a clinician. A recent meta-analysis pooling the between-group effect sizes of self-guided compared with therapist-guided ICBT interventions across a variety of anxiety and related disorders found that at post-treatment there was a small but significant pooled between-group effect size difference, with therapist-guided interventions being slightly more effective at post-treatment than self-guided interventions (Oey et al., 2023). Direct comparisons of therapist-guided and self-guided ICBT for OCD demonstrate that they are generally equivalent however (Lundstrom et al., 2022). ICBT interventions may also be open access (i.e., anyone can access) or closed (i.e., participants log in with unique username and password; Andersson et al., 2013).

ICBT has been shown to be an efficacious treatment. For example, multiple randomized controlled trials have demonstrated that ICBT results in large effect sizes when compared to passive control groups (i.e., waitlist control; Wootton et al., 2013, 2019) and medium to large effect sizes when compared to

active treatments (i.e., supportive therapy, progressive muscle relaxation; Andersson et al., 2012; Kyrios et al., 2018). The results also appear to be durable with results lasting up to 24 months post-treatment (Andersson et al., 2014). More recently, it has been demonstrated that ICBT is effective for OCD when delivered as part of real-world treatment settings (Flygare et al., 2022; Luu et al., 2020; Wootton et al., 2021), and also that clinician-guided (but not self-guided) ICBT is equivalent to in-person CBT for OCD (Lundstrom et al., 2022).

While ICBT has been demonstrated to be an efficacious treatment, ICBT for OCD cannot be widely disseminated unless it is also deemed to be acceptable by the individuals who receive the intervention. There is limited research investigating the acceptability of ICBT for OCD. Treatment acceptability refers to the degree to which an individual perceives a treatment procedure to be "fair, reasonable, appropriate and un-intrusive for a given clinical problem" (Milosevic et al., 2015). Acceptability consists of multiple dimensions *including perceived cruelty or unfairness, consistency with one's beliefs about how treatment should be and whether the treatment is recommendable to others* (Milosevic et al., 2015), and can be measured before (prospective acceptability), during (concurrent acceptability), and after (retrospective acceptability) treatment (Sekhon et al., 2017). While treatment acceptability is potentially related to treatment adherence, treatment outcome, and dropout, there is little empirical evidence supporting this and acceptability of ICBT for OCD is generally measured only at the conclusion of treatment. Currently, there is only one review that has examined the acceptability of ICBT for OCD, and this was focussed on the paediatric literature. This study found preliminary evidence to support the acceptability of ICBT in a systematic review of six studies (Babiano-Espinosa et al., 2019); however this was a narrative synthesis and acceptability of ICBT for OCD was not quantified.

While many ICBT studies examine acceptability of the treatment, there are multiple ways that acceptability can be measured. Firstly, acceptability may be measured via the proportion of patients that dropout of treatment. This includes the proportion of patients that do not commence the treatment, do not complete the treatment itself, or do not complete the treatment questionnaires. Secondly, acceptability may be inferred based on mean scores on standardized measures such as the Client Satisfaction Questionnaire (Larsen et al., 1979). Finally, acceptability may also be assessed via purpose-built treatment satisfaction questions, and often reports the percentage of patients who were "satisfied" with the intervention, or the percentage of patients would recommend the treatment to a friend. Currently, no studies have been attempted to obtain these acceptability outcomes across studies. Thus, the aim of this study was to collect the data on the acceptability of ICBT for OCD using a meta-analytic approach. A secondary aim was to examine whether clinician-guidance moderated the acceptability of ICBT for OCD.

METHOD

The PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines were followed in reporting this review (Page et al., 2021). A protocol for this review was pre-registered via PROSPERO (International Prospective Register of Systematic Reviews; ID CRD42023416780).

Eligibility criteria

To be included in the meta-analysis, each study was required to (1) be published, or in press, in an English language peer reviewed journal; (2) include adult participants (aged over 18) experiencing elevated symptoms of OCD as measured on any clinician-administered or self-report measure of obsessive-compulsive symptoms (there were no pre-determined cut scores); (3) use an internet-delivered cognitive behavioural therapy (ICBT) intervention specifically for OCD (clinician-guided or self-guided); (4) include acceptability data; and (5) include original data.

Information sources and search strategy

The PROSPERO database was assessed to ensure that no similar systematic review had been published or was being undertaken. Four relevant databases were searched: EMBASE, Medline, CINAHL, and Scopus. The literature search involved a combination of thesaurus and free-text terms generated by authors who conducted the database searches. We used the following search terms to search the databases for three main concepts (obsessive-compulsive disorder, internet-delivered treatment, and CBT): (ocd; obsessive-compulsive*) AND (internet; computer; web) AND (cbt; cognitive*; behav*). Search terms were identified by the researchers, as well as through literature searches of previous search strategies within ICBT reviews. The final search was conducted on 7th April, 2023.

Study selection

Records identified from search methods were recorded and duplicates were removed prior to initial screening. The title and abstracts of each citation were examined and screened against the pre-specified inclusion and exclusion criteria described above by the first author, and 20% were co-screened by the final author. The researchers were over-inclusive at the title/abstract review stage to ensure that relevant studies were not omitted. At the full text review stage, the first author reviewed all manuscripts against all inclusion and exclusion criteria, and again 20% were co-screened by the final author. Disagreements at both stages were settled through discussion. Inter-rater reliability was not calculated.

Data extraction

The first and final author independently extracted all data. The data extracted from each study included (1) general information about the study (publication type and country of origin), (2) the characteristics of the study participants (including age, % females, and method of diagnosis), (3) study eligibility (inclusion criteria, sample details, study design, and types of intervention), (4) study characteristics (aim, design, number of participants, and type of intervention), and (5) acceptability data.

Data synthesis

Data were collected using Comprehensive Meta Analysis Version 3.0. Acceptability was examined in three ways: firstly, via dropout rates, including proportion of participants who did not commence the treatment, did not complete the treatment, and did not complete the post-treatment questionnaires. For these analyses the pooled estimate (with 95% confidence interval) was calculated using the random effects model (Borenstein et al., 2009). Secondly, mean scores were extracted using the Client Satisfaction Questionnaire (CSQ) when it was administered (Larsen et al., 1979). The CSQ is a self-report measure designed to assess client satisfaction with health and human services including public health treatments (Larsen et al., 1979). CSQ scores are summed across 8 items and total scores range from 8 to 32, with a higher number indicating greater satisfaction (Larsen et al., 1979). Due to the small number of studies using this outcome measure, data were not pooled but are reported descriptively. Thirdly, any other acceptability data that were reported in each study were extracted, such as (1) percentage of participants who were 'mostly or very satisfied' or (2) percentage of participants who would recommend the ICBT intervention to a friend. For these analyses the pooled estimate (with 95% confidence interval) was also calculated using the random effects model. Publication bias was assessed using the Duval and Tweedie's Trim and Fill method (Duval & Tweedie, 2000). Heterogeneity was assessed using the I^2 statistic and was interpreted as low (25%), medium (50%) and high (>75%), consistent with the conventions of Higgins et al. (2003). Planned

moderator analyses were conducted based on the clinician guidance provided in each study (e.g., self-guided, clinician-guided, or as requested).

Quality analysis

Study quality was analysed using the Öst Risk of Bias tool, as it specifically focuses on psychotherapy outcomes and is suitable for evaluating remote treatments, and both controlled and uncontrolled studies (Öst, 2008). The Öst Risk of Bias tool is a 22-item measure of study quality and each item is rated on a three-point scale with total scores ranging from 0 to 44. Higher scores indicate higher study quality. The items related to therapist contact and/or adherence, etc., were removed from analysis as they did not relate to all studies (i.e., self-guided studies; item 14–17 and item 22). The first author and final author conducted the quality analysis independently, and the quality ratings are outlined in Table 1.

RESULTS

Search results

A total of 17 studies (with 20 treatment arms) met final inclusion criteria for review (see Figure 1). Search strategies resulted in a total of 2900 citations. After removing duplicates, 1692 records remained. Of these, 1631 were excluded based on title and abstract screening, resulting in 61 studies. A total of 81 studies were excluded at the title/abstract screening stage for being published in a language other than English. When reviewed in full against the inclusion and exclusion criteria, 44 studies were excluded resulting in 17 included in this systematic review.

Study characteristics

Table 1 provides a description of the included studies. Of the eligible studies, 8/17 (47.01%) were RCTs and 9/17 (52.94%) studies were open trials. A total of 1661 participants were included across all studies. The included studies were conducted in a range of countries including Australia (8/17; 47.01%), Sweden (5/17; 29.41%), United States of America (2/17; 11.76%), United Kingdom (1/17; 5.88%), and Germany (1/17; 5.88%). Six of the 20 treatment arms (30.00%) were self-guided interventions and 12/20 (60.00%) were clinician-guided. The remaining 2/20 treatment arms (10.00%) provided clinician contact as requested. The duration of interventions ranged from 8 to 17 weeks. The primary outcome assessed in 15 of the 17 studies was the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS; Goodman et al., 1989). Of those studies that utilized the Y-BOCS, the mean baseline scores ranged from 19.87 to 25.8. The mean age of participants included in the studies ranged from 28 to 41 years. The proportion of female participants in the included studies ranged from 57.5% to 93.3%.

Dropout

Participants who did not commence treatment

12/20 (60.00%) treatment arms provided data on the proportion of participants who did not commence treatment. As outlined in Table 2 the proportion of participants who did not commence the intervention ranged from 1.2% to 42.2%. Under the random effects model the overall pooled estimate

TABLE 1 Study characteristics.

Author and year	Location	Study design	*N*	YBOCS baseline	Program	Number of weeks	Guidance	Mean age	% female	Study quality
Al-Asadi et al. (2014)[a]	AUS	OT	251	NR	OCD STOP!	12	SG	40.97	66.30	9
Andersson et al. (2011)	SWE	OT	23	20.00	OCD-NET	15	G	39.00	65.00	16
Andersson et al. (2012)	SWE	RCT	50	21.42	OCD-NET	10	G	33.00	66.00	25
Diefenbach et al. (2015)	USA	OT	24	24.92	OC-Fighter	17	G	37.08	66.00	18
Kyrios et al. (2018)	AUS	RCT	89	22.58	OCD STOP!	12	G	32.59	65.20	27
Lovell et al. (2017)	UK	RCT	157	25.03	OC-Fighter	12	G	32.00	58.00	22
Lundstrom et al. (2022)	SWE	RCT	40	21.80	OCD-NET	14	SG	31.64	70.00	28
—	—	—	42	22.50	OCD-NET	14	G	32.00	64.30	—
Lundström et al. (2023)	SWE	OT	434	22.53	OCD-NET	12	G	31.40	63.00	14
Mahoney et al. (2014)	AUS	RCT	37	NR	OCD program	10	AR	37.69	59.00	18
Olofsdotter Lauri et al. (2022)	SWE	OT	19	23.36	Other	10	G	28.00	74.00	16
Patel et al. (2018)	USA	OT	40	25.80	OCD-NET[b]	12	G	36.61	57.50	19
Schröder et al. (2020)	DEU	RCT	64	20.20	Other	8	SG	41.45	75.00	13
Wootton et al. (2011)	AUS	OT	23	20.90	OCD program	8	G	35.18	59.00	18
Wootton et al. (2013)	AUS	RCT	15	23.53	OCD Course	8	G	39.93	93.30	22
—	—	—	15	19.87	OCD Course	8	G	38.58	64.70	—
Wootton et al. (2014)	AUS	OT	16	21.81	OCD Course	8	SG	32.62	87.50	15
—	—	—	28	20.79	OCD Course	10	SG	35.90	67.90	—
Wootton et al. (2019)	AUS	RCT	65	22.52	OCD Course	8	SG	34.03	81.50	20
Wootton et al. (2021)	AUS	OT	225	21.69	OCD Course	8	AR	34.82	68.00	15

Abbreviations: AR, clinician guidance as requested; G, clinician-guided; NR, not reported; OT, open trial; RCT, randomized controlled trial; SG, self-guided.

[a]Indicates that some data for this study were extracted from Klein et al. (2011).

[b]Indicates that English translation of the Swedish program was used.

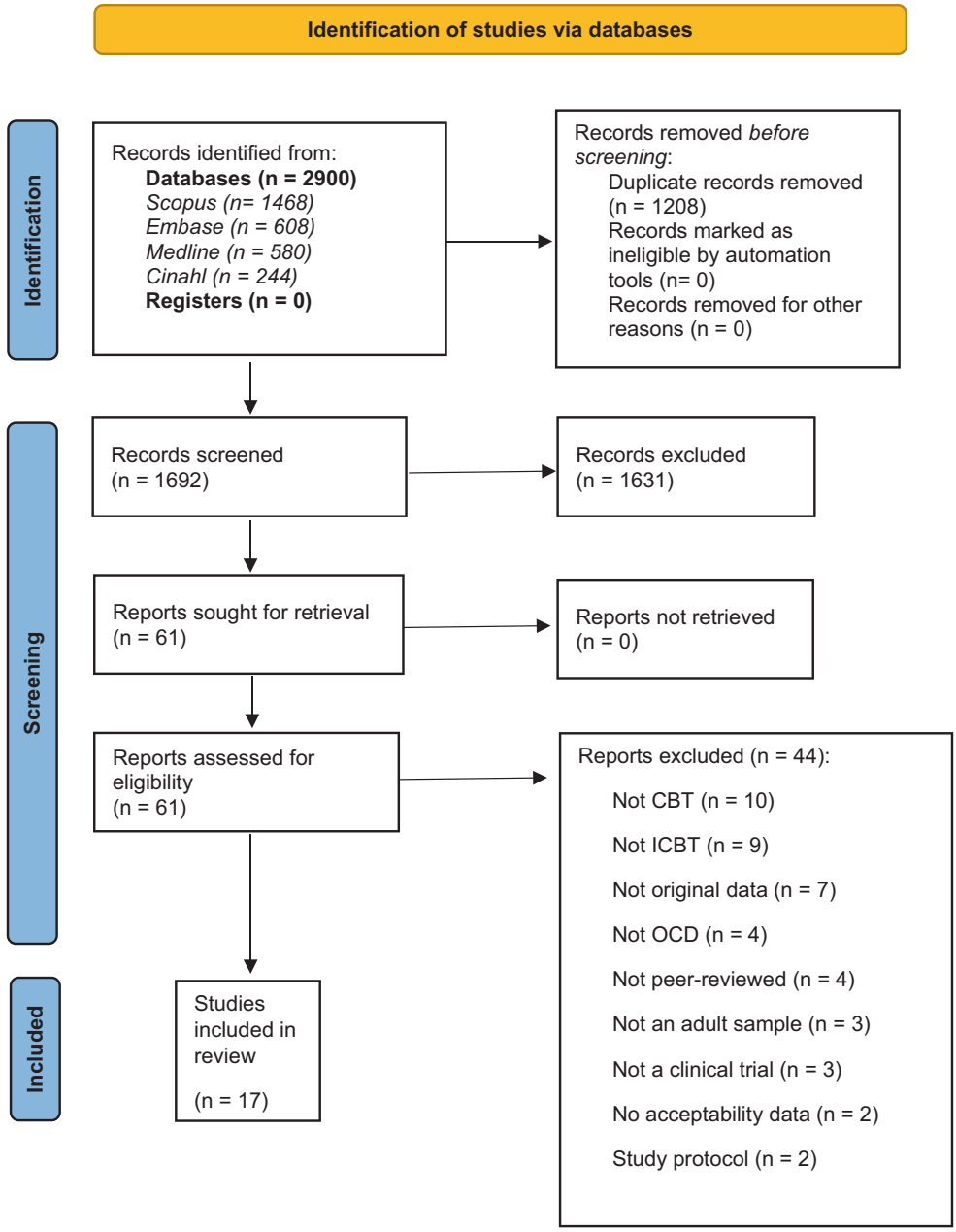

FIGURE 1 PRISMA Flowchart of the study selection process.

was 16.3% (95% CI: 9.8%–25.7%). There was a high level of heterogeneity ($Q = 51.92$, df = 11; $p < .001$; $I^2 = 78.81$); however there was no evidence of publication bias. Moderator analyses indicated that while self-guided interventions had a higher proportion of participants who did not commence the treatment ($k = 5$; 21.9% 95%CI: 11.7%–37.2%) than those in clinician-guided interventions ($k = 6$; 8.3%; 95% CI: 2.0%–28.1%) and 'as requested' clinician contact interventions ($k = 1$; 15.9%; 95% CI: 7.8%–29.8%), the difference was not significantly different ($Q = 1.917$, df = 2, $p = .383$).

Participants who did not complete treatment

14/20 (70.00%) treatment arms provided data on the proportion of participants who did not complete treatment. As outlined in Table 2 the proportion of participants who did not commence the intervention ranged from 6.7% to 60.0%. Under the random effects model the overall pooled estimate was 27.6% (95% CI: 19.0%–38.2%). There was a high level of heterogeneity ($Q = 108.677$, df = 13; $p < .001$; $I^2 = 88.04$); however there was no evidence of publication bias. Moderator analyses indicated that there was a statistically significant difference between the guidance groups ($Q = 11.998$, df = 2, $p = .002$). Self-guided interventions ($k = 3$; 51.3% 95% CI: 35.8%–66.6%) had a significantly higher proportion of participants who did not complete the treatment compared with those in the 'as requested' clinician contact interventions ($k = 2$; 31.7% 95% CI: 26.3%–37.6%) and the 'as requested' group also had a significantly higher proportion of participants who did not complete the treatment compared with those in the clinician-guided interventions ($k = 9$; 19.9%; 95% CI: 12.9%–29.4%).

Participants who did not complete post-treatment questionnaires

18/20 (90.00%) treatment arms provided data on the proportion of participants who did not complete the post-treatment questionnaires. As outlined in Table 2 the proportion of participants who did not commence the post-treatment questionnaires ranged from 2.4% to 85.7%. Under the random effects model the overall pooled estimate was 27.0% (95% CI: 18.2%–38.0%). There was a high

TABLE 2 Event rate (pointed prevalence; %) with 95% confidence intervals for dropout data.

Author and year	Did not commence treatment	Did not complete the treatment	Did not complete post-treatment questionnaires
Al-Asadi et al. (2014)	—	—	85.7 [80.8–89.5]
Andersson et al. (2011)	—	13.0 [4.3–33.5]	4.3 [.6–25.2]
Andersson et al. (2012)	—	12.0 [5.5–24.2]	4.0 [1.0–14.6]
Diefenbach et al. (2015)	7.7 [1.9–26.1]	29.2 [14.6–49.8]	29.2 [14.6–49.8]
Kyrios et al. (2018)	—	6.7 [3.1–14.2]	34.8 [25.7–45.3]
Lovell et al. (2017)	41.4 [34.0–49.3]	—	—
Lundstrom et al. (2022)	1.2 [.1–16.0]	—	2.4 [.3–15.1]
—	1.2 [.1–16.7]	—	10.0 [3.8–23.8]
Lundström et al. (2023)	—	12.7 [9.9–16.1]	33.6 [29.3–38.2]
Mahoney et al. (2014)	15.9 [7.8–29.8]	35.1 [21.6–51.5]	35.1 [21.6–51.5]
Olofsdotter Lauri et al. (2022)	2.5 [.2–29.8]	36.8 [18.7–59.7]	—
Patel et al. (2018)	—	30.0 [17.9–45.7]	30.0 [17.9–45.7]
Schröder et al. (2020)	42.2 [30.8–54.5]	—	26.6 [17.2–38.6]
Wootton et al. (2011)	4.3 [.6–25.2]	19.0 [7.3–41.2]	9.1 [2.3–30.0]
Wootton et al. (2013)	11.8 [3.0–36.8]	46.7 [24.1–70.7]	13.3 [3.4–40.5]
—	—	—	26.7 [10.4–53.3]
Wootton et al. (2014)	15.0 [4.9–37.6]	56.3 [32.4–77.5]	31.3 [13.6–56.7]
—	15.2 [6.5–31.6]	35.7 [20.4–54.6]	64.3 [45.4–79.6]
Wootton et al. (2019)	27.8 [19.5–37.9]	60.0 [47.7–71.1]	32.3 [22.1–44.5]
Wootton et al. (2021)	—	31.1 [25.4–37.5]	35.6 [29.6–42.0]
Pooled	16.3 [9.8–25.7]	27.3 [18.8–37.9]	27.0 [18.2–38.0]

level of heterogeneity ($Q = 229.163$, df = 17; $p < .001$; $I^2 = 92.58$); however there was no evidence of publication bias. Moderator analyses indicated that there was a statistically significant difference between the guidance groups ($Q = 8.066$, df = 2, $p = .018$). Clinician-guided ($k = 10$; 20.1%; 95% CI: 13.3%–29.1%) and self-guided ($k = 6$; 41.0%; 95% CI: 16.0%–71.6%) interventions did not significantly differ and 'as requested' ($k = 2$; 35.5%; 95% CI: 29.9%–41.5%) and self-guided interventions did not significantly differ; however 'as requested' and clinician-guided interventions did significantly differ.

Client satisfaction questionnaire

Two of the 20 treatment arms (10.00%) reported scores on the CSQ and both were clinician-guided intervention studies. Mean scores on the CSQ ranged from 22.4 to 26.5 across these two studies.

Other acceptability measure

Proportion of 'satisfied' or 'mostly satisfied'

11/20 (55.00%) treatment arms provided data on the proportion of participants who were 'satisfied' or 'mostly satisfied' with the treatment. As outlined in Table 3 the proportion of participants who were 'satisfied' or 'mostly satisfied' ranged from 66.7% to 97.7%. Under the random effects model

TABLE 3 Event rate (pointed prevalence; %) with 95% confidence intervals for acceptability data.

Author and year	Proportion 'satisfied' or 'mostly satisfied'	Proportion who would recommend intervention to a friend
Al-Asadi et al. (2014)	—	—
Andersson et al. (2011)	—	—
Andersson et al. (2012)	—	—
Diefenbach et al. (2015)	—	—
Kyrios et al. (2018)	—	—
Lovell et al. (2017)	—	—
Lundstrom et al. (2022)	—	—
—	—	—
Lundström et al. (2023)	86.9 [83.4–87.9]	—
Mahoney et al. (2014)	66.7 [46.1–82.4]	70.8 [50.2–85.4]
Olofsdotter Lauri et al. (2022)	73.7 [50.2–88.6]	73.7 [50.2–88.6]
Patel et al. (2018)	78.6 [50.6–92.9]	—
Schröder et al. (2020)	83.8 [68.3–92.5]	81.1 [65.3–90.7]
Wootton et al. (2011)	97.7 [72.3–99.9]	97.7 [72.3–99.9]
Wootton et al. (2013)	70.0 [37.6–90.0]	—
—	78.6 [50.6–92.9]	—
Wootton et al. (2014)	80.0 [30.9–97.3]	80.0 [30.9–97.3]
—	87.5 [61.4–96.9]	97.1 [66.4–99.8]
Wootton et al. (2019)	81.8 [67.7–90.6]	95.5 [83.6–98.9]
Wootton et al. (2021)	—	—
Pooled	81.6 [76.1–86.0]	84.7 [72.8–92.0]

the overall pooled estimate was 81.6% (95% CI: 76.1%–86.0%). There were low levels of heterogeneity ($Q = 13.878$, df = 10; $p = .179$; $I^2 = 29.945$) and no evidence of publication bias. Moderator analyses indicated that there was no statistically significant difference in satisfaction levels between the guidance groups ($Q = 3.462$, df = 2, $p = .177$) [clinician-guided ($k = 6$; 82.2%; 95% CI: 73.8%–88.3%); self-guided ($k = 4$; 83.2%; 95% CI: 74.6%–89.3%); and 'as requested' ($k = 1$; 66.7%; 95% CI: 46.1%–82.4%)].

Proportion who would recommend intervention to a friend

7/20 (35.00%) treatment arms provided data on the proportion of participants who would recommend the intervention to a friend. As outlined in Table 3 the proportion of participants who would recommend the intervention to a friend ranged from 70.8% to 97.7%. Under the random effects model the overall pooled estimate was 84.7% (95% CI: 72.8%–92.0%). There were moderate levels of heterogeneity ($Q = 11.685$, df = 6; $p = .069$; $I^2 = 48.651$). There was some evidence of publication bias with one study being trimmed (adjusted estimate: 83.2%; 95% CI: 70.4%–91.2%). Moderator analyses indicated that there was no statistically significant difference in the proportion of participants who would recommend the treatment to a friend between the guidance groups ($Q = 3.426$, df = 2, $p = .180$) [clinician-guided ($k = 2$; 88.8%; 95% CI: 37.1%–99.1%); self-guided ($k = 4$; 89.3%; 95% CI: 74.9%–95.9%); and 'as requested' ($k = 1$; 70.8%; 95% CI: 50.2%–85.4%)].

Quality analysis

Overall, the quality score ranged from 9 to 28 with a mean score of 18.53 ($SD = 5.06$). Across studies a higher risk of bias generally arose when a randomized controlled trial design was not used (9/17 studies; 52.94%), a diagnostic interview was not used (6/17 studies; 35.29%), assessor training was inadequate or not described (13/17 studies; 76.47%), a power analysis was not conducted (8/17 studies; 47.06%), or studies did not control for concomitant treatments (9/17 studies; 52.94%). All studies (17/17; 100%) used a reliable and valid outcome measure and used manualised/replicable treatments. Most studies used appropriate statistical analyses for the data (16/17 studies; 94.18%).

DISCUSSION

The aim of this study was to examine the acceptability of ICBT for OCD by examining acceptability across three domains: (1) study dropout; (2) responses on standardized assessment tools; and (3) proportions of participants who were satisfied with the treatment and/or would recommend the treatment to a friend. A meta-analytic approach was used to pool results across studies. A secondary aim was to examine whether therapist guidance impacts acceptability of ICBT for OCD using moderator analyses. Overall, ICBT was found to be an acceptable treatment for individuals with OCD.

Study dropout can be examined in multiple ways in ICBT interventions. This study found that across studies approximately 16% of participants did not commence the treatment once they were enrolled in the study, approximately 28% did not complete the treatment, and approximately 27% did not complete the post-treatment questionnaires for the study. Across all types of dropout, rates were higher in self-guided ICBT interventions compared with those in clinician-guided interventions. Thus, it appears that even a small amount of clinician contact in ICBT interventions may reduce dropout rates. However, it is important to consider this result preliminary given the small number of studies in some of the moderator analyses and high levels of heterogeneity in these analyses.

The dropout rates in this study are lower than those seen in e-therapy interventions for other disorders. For example, in a large meta-analysis of dropout in CBT across a range of mental health disorders,

and a range of treatment formats, Fernandez et al. (2015) found an average weighted dropout of 24% at pre-treatment (i.e., those that did not commence the intervention) and 34% during treatment (i.e. that did not complete the treatment). However, the results from ICBT for OCD are higher than those seen in face-to-face treatment in the same study (10% at pre-treatment and 25% during treatment). Future research may wish to focus on factors that may predict dropout in ICBT for OCD or examine how to retain participants in ICBT interventions. Future research may also wish to examine if these findings are consistent with findings from ICBT interventions for other mental health conditions.

Only two studies in this meta-analysis used the CSQ (Larsen et al., 1979) to assess treatment satisfaction and scores ranged from 22.4 to 26.5. In a psychometric study of the CSQ with individuals attending substance use treatment, Kelly et al. (2017) put forward the following cut scores: 8–21 (dissatisfied), 22–25 (mildly satisfied), 26–30 (satisfied), and 31–32 (very satisfied). Thus, participants taking part in ICBT for OCD treatments appear to be 'mildly satisfied' to 'satisfied' with the treatment. It is important to consider these findings preliminary, however given the small number of included studies that used the CSQ. It will be important for future ICBT studies to utilize the CSQ, so a more accurate representation of treatment satisfaction can be ascertained.

There were sufficient data to analyse two other forms of acceptability in this study – the proportion of participants who were satisfied with the intervention and the proportion of participants who would recommend the intervention to a friend. Across studies approximately 82% indicated a high level of satisfaction with the intervention and approximately 85% would recommend the treatment to a friend. There did not appear to be any differences in these acceptability measures based on guidance. However, it is important to highlight that these measures are generally collected at post-treatment; thus only those who provide post-treatment data are assessed on this variable. It is important for ICBT studies to assess acceptability from baseline and incorporate acceptability assessments throughout the treatment as this would allow the participants who dropout before treatment begins or dropout before treatment ends to provide an assessment of treatment acceptability.

While previous research demonstrates that there does not appear to be a long-term difference in efficacy between clinician-guided and self-guided ICBT across a number of mental health conditions (Oey et al., 2023), there is some evidence from this study to suggest that there may be differences in acceptability between clinician-guided and self-guided treatments; however these results should be considered preliminary. It is not clear why adding clinician contact may enhance the acceptability of the intervention and it is possible that it enhances only some types of acceptability, as acceptability may not be a unitary construct. To date, only one study has directly compared clinician-guided and self-guided ICBT in a controlled trial. This study found that self-guided ICBT was non-inferior to clinician-guided ICBT; however, there was a higher proportion of non-completion of questionnaires in self-guided (10%) compared with clinician guided (2%; Lundstrom et al., 2022). This was the only acceptability variable included in this study. Thus, it is important for future studies comparing the efficacy of self-guided and clinician-guided ICBT for OCD to also consider the assessment of acceptability, including the multiple ways that acceptability can be measured.

While this study demonstrates adequate acceptability of ICBT interventions for OCD, there are a number of limitations to this study that should be mentioned. Firstly, we focused on quantitative data and future research may wish to supplement this research by examining the acceptability of ICBT for OCD using a qualitative approach. Incorporating the views of lived experience experts at all points of the intervention (pre-treatment, throughout treatment, post-treatment) using a qualitative approach will provide more of a nuanced understanding of participants' experience of participating in ICBT programs for OCD. Similarly, future interventions may benefit from co-design with lived experience experts, which may ensure the acceptability of the intervention.

Secondly, while most of our analyses were adequately powered, some, such as those focussed on standardized measure of acceptability, were underpowered, with only two of the included studies using the Client Satisfaction Questionnaire (Larsen et al., 1979) to measure treatment satisfaction. The CSQ is delivered at the conclusion of therapy. It is important for future research on ICBT for OCD to integrate more standardized measures as part of their outcomes. Such measures may include the Treatment

Acceptability/Adherence Scale (Milosevic et al., 2015), which also has the benefit of being able to be administered earlier on in treatment, or even prior to treatment but after psychoeducation is provided.

Thirdly, the acceptability measures were examined at post-treatment, thus only those who completed treatment were given the opportunity to complete acceptability measures. Future research should measure the acceptability of the program from entry to the program, throughout the program, and at the conclusion of the program. It would also be advantageous to measure the long-term acceptability of these interventions and acceptability among diverse samples, such as Aboriginal and Torres Strait Islander people in Australia (Ponturo & Kilcullen, 2021). It is also important to examine the acceptability of the intervention to people other than just the participant. For instance, if health professionals do not find the interventions to be acceptable then they are unlikely to make referrals to the interventions. Similarly, carers may be unwilling to support participants to complete the intervention if they are not supportive of the intervention. Thus, acceptability of the intervention to others is also an important area for future research.

The results of this study demonstrate the acceptability of ICBT for OCD overall, however, also indicate that self-guided ICBT interventions may be less acceptable than clinician-guided interventions, at least on some metrics of acceptability. It is important for this study to be replicated as more studies examining ICBT for OCD emerge, and also important to explicitly examine acceptability in individuals who complete ICBT as part of routine care, rather than a clinical trial. However, this study has important implications in the delivery of CBT for OCD as ICBT interventions can be widely disseminated at low cost and can be integrated into routine psychological practice (Fisher et al., 2023; Newby et al., 2021). While the research on the efficacy of these interventions is robust (Hoppen et al., 2021; Wootton, 2016), this study adds to this literature by demonstrating that these interventions are also acceptable to patients.

AUTHOR CONTRIBUTIONS

Shifra Waks: Writing – original draft; methodology; investigation; visualization; conceptualization. **Karen Moses:** Software; formal analysis; validation; writing – review and editing. **Bethany M. Wootton:** Conceptualization; methodology; validation; visualization; writing – review and editing; software; formal analysis; project administration; supervision; data curation.

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The authors report that there are no competing interests to declare.

DATA AVAILABILITY STATEMENT

Data are available from the corresponding author.

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