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## Clinical and demographic characteristics of patients with obsessive-compulsive symptoms using internet-delivered and face-to-face cognitive behavior therapy

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### ABSTRACT

**Objective:** Internet-delivered cognitive behavioural therapy (ICBT) is an effective treatment for obsessive-compulsive disorder (OCD). However, little is known about the characteristics of individuals who engage with this treatment and whether they are comparable to those who engage in face-to-face treatment for OCD. The aim of the current study was to examine the demographic and clinical characteristics of participants who engaged in a large open trial of self-guided ICBT for OCD and compare their characteristics with those who completed face-to-face treatment for OCD, as described in large, published studies.

**Method:** Three hundred and twenty-three participants ( $M_{age} = 33.27$ ;  $SD = 12.22$ ; 74.1% female) were included in the study.

**Results:** Participants in the ICBT group were significantly younger in age, were more likely to be female, and less likely to take psychotropic medication for their OCD symptoms, compared to participants who completed face-to-face treatment. There were no significant differences between the groups on OCD symptom severity or on depressive symptom severity.

**Conclusion:** Although slight differences in demographic characteristics were found between the ICBT group and face-to-face CBT group, the groups had similar clinical characteristics, indicating individuals who seek both treatment modalities are comparable to one another.

### KEY POINTS

#### What is already known about this topic:

- (1) ICBT for OCD provides the same information and skills that are typically taught in face-to-face treatment.
- (2) Preliminary evidence suggests that individuals who consider commencing ICBT for OCD have similar characteristics to those who choose to engage in face-to-face treatment for OCD.
- (3) Some meaningful differences in characteristics have been observed within other psychiatric populations when ICBT, face-to-face treatment, and/or epidemiological samples have been compared, indicating the possibility that some meaningful differences could also exist among individuals with OCD who actually engage in ICBT.

#### What this topic adds:

- (1) This is the first known study to compare the demographic and clinical characteristics of individuals who enrolled in ICBT for OCD, delivered in a self-guided manner, to those who completed face-to-face treatment.
- (2) Slight differences in demographic characteristics were observed between the ICBT and face-to-face treatment group; namely, those who engaged in ICBT were more likely to be female and younger in age, and less likely to be medicated for symptoms.
- (3) Similar clinical characteristics were observed between the ICBT and face-to-face treatment groups on the severity of OCD and depressive symptoms, indicating that individuals with OCD who engage in ICBT are clinically representative of those in the general population.

### ARTICLE HISTORY

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### KEYWORDS

CBT; cognitive-behavioural therapy; clinical characteristics; demographic characteristics; internet-delivered CBT; obsessive-compulsive disorder

Obsessive-compulsive disorder (OCD) is characterised by persistent and unwanted intrusive thoughts, images, and/or urges, as well as repetitive and time-consuming compulsive behaviours (American Psychiatric Association,

2013). The disorder is common, with a prevalence of approximately 2–3% (Australian Bureau of Statistics, 2020–2021; Kessler et al., 2012). The disorder is disabling, with impairments consistent with those observed in

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patients with severe mental health disorders, such as schizophrenia (Macy et al., 2013). The disorder is chronic in nature (Visser et al., 2014), with research demonstrating that OCD rarely remits spontaneously without treatment (Melkonian et al., 2022), and subsequently has a significant impact on quality of life (Huppert et al., 2009).

Cognitive behaviour therapy (CBT) is an effective treatment for OCD with multiple meta-analyses demonstrating large effect sizes (Olatunji et al., 2013; Öst et al., 2015). Generally, CBT is delivered in the office setting for 1–2 hours per week (Abramowitz et al., 2003), although more intensive treatment protocols have also been examined and found to be effective (Storch et al., 2008). More recently, CBT for OCD has also been delivered via the internet. Internet-delivered CBT (ICBT) involves the provision of structured online lessons that provide the same CBT information and skills that are taught in face-to-face treatment, often with the inclusion of asynchronous clinician guidance via the telephone or email (Titov, 2011).

Multiple randomised controlled trials (RCTs) across different research groups now demonstrate the efficacy of ICBT for OCD with a pooled within-group effect size of  $g = 1.17$  (Wootton, 2016). The approach has also been shown to be effective when delivered as part of routine care (Wootton et al., 2021) and this treatment approach has been found to be as efficacious as face-to-face treatment (Lundström et al., 2022). ICBT reduces many barriers that individuals can experience when accessing traditional face-to-face treatments, such as financial costs associated with treatment, difficulties in accessing trained mental health professionals, and fears of stigma (Marques et al., 2010). Thus, ICBT offers individuals the opportunity to access cost-effective evidence-based treatment remotely.

However, to date, little is known about the characteristics of individuals with OCD who choose to engage in ICBT. Wootton et al. (2011) compared the demographic characteristics of individuals with OCD who were seeking ICBT treatment ( $n = 129$ ) to those who completed a face-to-face treatment in a specialist outpatient clinic ( $n = 135$ ). Although a significantly greater proportion of females were represented in the ICBT sample compared to the face-to-face sample, no other significant demographic differences were found. Additionally, the severity of OCD symptoms within the internet sample was comparable to those found in face-to-face sample. While this preliminary study demonstrates that individuals who are considering commencing ICBT for OCD are similar to those who choose to access face-to-face treatment, this study has a number of important limitations. First, the ICBT sample had not commenced an ICBT treatment, instead,

they comprised of individuals who were interested in receiving ICBT. Second, while overall severity of OCD symptoms was similar in both groups, the type of symptoms experienced by each group is unknown and it is possible that some patients with OCD may be particularly drawn to ICBT treatment because of the nature of their symptoms (i.e., those who have intrusive thoughts of a violent or sexual nature may prefer ICBT because of the increased anonymity). Third, symptoms of depression were not measured, which is an important factor to consider as depression is the most common comorbid psychiatric condition in OCD (Hong et al., 2004; Torres et al., 2006), and it is possible that individuals with greater severity of depressive symptoms may be more drawn to ICBT due to the ease of access it provides, and the less demands it has on time and resources.

Few studies have examined the demographic and clinical characteristics of individuals who engage in ICBT within other psychiatric populations. Although the characteristics of such individuals have been largely similar to those who engage in face-to-face treatment, or those within the general population, some differences have been observed in other disorders. For instance, Titov et al. (2010) examined differences in characteristics among individuals diagnosed with anxiety disorders and found that those who were interested in ICBT and those who had been identified in a national epidemiological survey were of similar age (43.0 and 42.0 years, respectively); however, significantly older than those who engaged in face-to-face treatment (32.8 years). Additionally, the ICBT group were more likely to be married (54.1%) compared to those who engaged in face-to-face treatment (33.8%) and those identified in the national survey (31.9%). Furthermore, although the ICBT group ( $M = 26.1$ ) were slightly more distressed than those identified in the national survey ( $M = 21.1$ ), those who engaged in face-to-face treatment ( $M = 33.2$ ) were most distressed. Interestingly, the ICBT and face-to-face groups were more disabled than those identified in the national survey, with their mean scores ( $M = 14.7$  and  $12.1$ , respectively) being double that of those in the national survey ( $M = 7.0$ ).

In a similar study, Spence et al. (2011) compared the demographic and clinical characteristics of individuals seeking ICBT for posttraumatic stress disorder (PTSD) with participants in a large epidemiological sample. This study had similar findings, with the ICBT group being more likely to have attained higher educational qualifications (57.8% vs 36.5%) and were more distressed ( $M = 32.4$  vs  $20.7$ ) and disabled ( $M = 32.1$  vs  $19.9$ ) than those identified in a national epidemiological survey. Although the findings of this study are limited as they did not

include a comparator face-to-face treatment group, it provides further preliminary evidence that there may be some meaningful differences between those who engage in ICBT as opposed to other treatment modalities.

In summary, limited research has examined the symptom and demographic characteristics of individuals who engage in ICBT for OCD, and whether they are similar or dissimilar to those who engage in face-to-face treatment for OCD. Understanding any similarities and/or differences may help policy makers with the appropriate planning and design of mental health services for individuals with OCD. More specifically, if the groups were found to be similar, both modes of treatment modalities could be offered to individuals based on patient preference. If the groups were found to be different, only the treatment modality that would be suitable based on the individuals characteristics could be offered to ensure they optimally engage and make treatment gains. Therefore, the aim of this study is to replicate and extend on the findings of Wootton et al. (2011) by reporting the characteristics of a large international sample of individuals who enrolled in an ICBT treatment for OCD and to compare these individuals with those who have previously completed face-to-face CBT. It was hypothesised that the ICBT group would demonstrate similar demographic, OCD symptom severity, and depression severity profiles to those who have completed face-to-face CBT.

## Method

### Design

The present study reports on the characteristics of 323 individuals who successfully enrolled in an open trial of self-guided ICBT for OCD (Wootton et al., 2023) and compares their demographic and clinical characteristics with participants who completed face-to-face CBT for OCD as published in existing research (Abramowitz et al., 2010; Launes et al., 2019; Steketee et al., 2019). The open trial was registered with the Australian and New Zealand Clinical Trials Registry (ACTRN12620000146998) and ethical approval was provided from the Human Research Ethics Committee at Macquarie University (REF No: 5201701075). Details regarding the intervention can be found in an existing publication (Wootton et al., 2019).

### Participants

Applicants applied online at the eCentreClinic website ([www.ecentreclinic.org](http://www.ecentreclinic.org)), a research website that develops and evaluates remote treatments, after reading the

participant information and consent form. Five hundred and twenty-eight participants provided consent between 18 February 2020 and 2 December 2021, and 323 were eligible to participate. Participants were primarily located in the United States of America (93/323; 28.8%), Australia (77/323; 23.8%) and the United Kingdom (44/323; 13.6%). To be included in the original trial participants were required to: (1) be able to read and speak English; (2) be aged 18 and over; (3) have regular access to the internet; (4) have no current suicidal plans or intent, or recent history of suicide attempts or deliberate self-harm; (5) score at least 7 on the Dimensional Obsessive-Compulsive Scale (DOCS; Abramowitz et al., 2010); (6) score at least 14 on the Yale-Brown Obsessive Compulsive Scale – Self-Report Version (Y-BOCS-SR; Baer, 2012); and (7) meet criteria for OCD on the Diagnostic Interview for Anxiety, Mood, Obsessive-Compulsive and Other Neuropsychiatric Disorders (DIAMOND; Tolin et al., 2018), which was delivered in a self-report format online. Participant flow is outlined in Figure 1.

## Measures

### Demographics

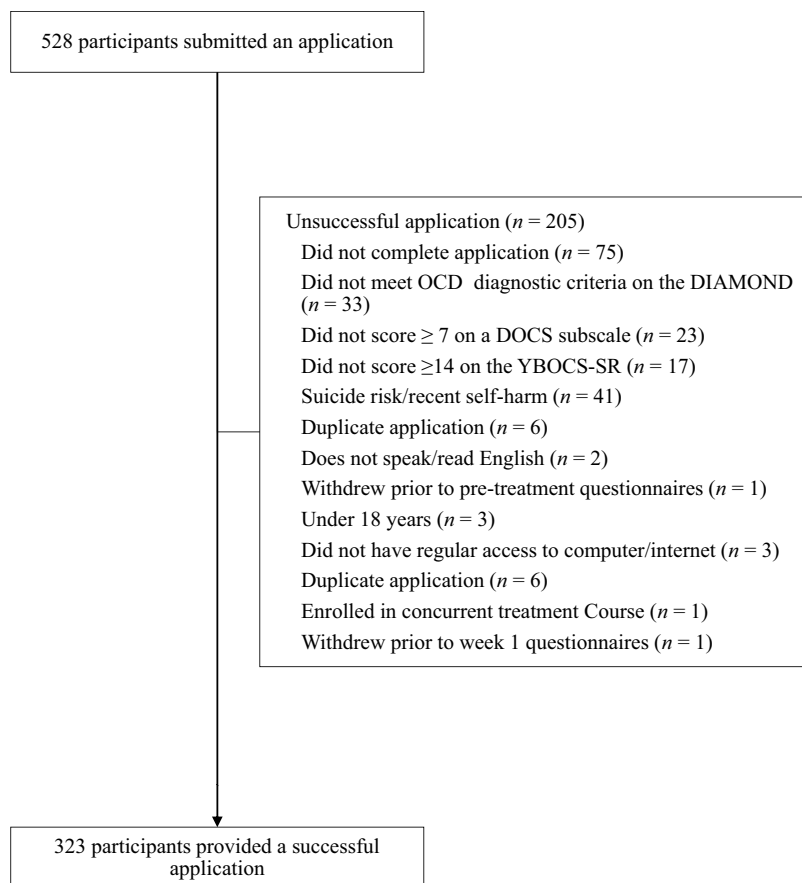
Participants completed online questionnaires enquiring about demographic information including age, gender, employment status, educational status, and medication use.

### Diagnostic interview for anxiety, mood, obsessive-compulsive, and related neuropsychiatric disorders (DIAMOND; Tolin et al., 2018)

The DIAMOND is a semi-structured diagnostic interview that assesses DSM-5 diagnostic criteria for common mental health conditions. Only the OCD module was administered in this study and participants completed the module online in a self-report format. Participants were required to confirm the presence of obsessions and/or compulsions over the past month, as well distress and/or impairment in functioning. The DIAMOND has demonstrated good to excellent test-retest reliability and convergent validity when administered in a clinician-administered format (Tolin et al., 2018).

### Yale-Brown obsessive compulsive scale – self report version (Y-BOCS-SR; Baer, 2012)

The Y-BOCS-SR is a 10-item self-report measure of OCD symptom severity. The Y-BOCS-SR includes two subscales corresponding to items that measure the severity of obsessions and compulsions over the past week, including time spent on symptoms, associated distress,



**Figure 1.** Participant flow.

interference on functioning, degree of resistance, and control over symptoms. Total scores range from 0 to 40, and a score of 16 is considered to be clinically relevant (Baer, 2012). A cut-off score of 14 was employed for eligibility in the ICBT open trial as it has been found to indicate moderate symptoms of OCD (Storch et al., 2015). The self-report version is similar to the clinician-administered version, with a moderate to high correlation being demonstrated between both (Federici et al., 2010). The Y-BOCS-SR has good internal consistency, ranging between  $\alpha = 0.87$  and 0.92 (Ólafsson et al., 2010), and has demonstrated good divergent validity (Ólafsson et al., 2010) in previous samples.

#### **Dimensional obsessive-compulsive scale (DOCS; Abramowitz et al., 2010)**

The DOCS is a 20-item self-report measure that evaluates the severity of four symptom dimensions of OCD, including contamination obsessions and associated cleaning compulsions, responsibility obsessions and associated checking compulsions, need for order/symmetry obsessions and associated ordering/arranging compulsions, and unacceptable obsessional thoughts

and associated mental rituals (Abramowitz et al., 2010). Each symptom dimension includes 5 items, with each measured on a 5-point scale. Total scores range from 0 to 80, and subscale scores range from 0 to 20, with higher scores indicating greater severity of symptoms. The DOCS has demonstrated good psychometric properties in previous samples (Abramowitz et al., 2010).

#### **Patient health questionnaire (9-item) (PHQ-9; Kroenke et al., 2001)**

The PHQ-9 is a 9-item self-report measure of depressive symptom severity. Items measure the frequency of symptoms over the past 2 weeks on a scale from 0 ("Not at all") to 3 ("Nearly every day"). Total scores range from 0 to 27 (Kroenke et al., 2010). The PHQ-9 has demonstrated high internal consistency, ranging between  $\alpha = 0.74$  to 0.89 (Kroenke et al., 2001), and good convergent and divergent validity (Beard et al., 2016).

#### **Data analysis**

Data from the three face-to-face comparator studies (Abramowitz et al., 2010; Launes et al., 2019; Steketee et al., 2019) were extracted and entered into a pre-

defined Microsoft Excel sheet to compute differences between the face-to-face treatment group and ICBT group. The first comparator study was the Steketee et al. (2019) mega-analysis which examined predictors and moderators of face-to-face CBT for OCD across eight international outpatient research clinics. Three-hundred and fifty-nine participants completed CBT and data pertaining to their age, gender, and pre-treatment Y-BOCS-SR total score were extracted. Additionally, medication status from a subset of the sample ( $n = 268$ ; 70.0%) was also extracted. The second comparator study was the Abramowitz et al. (2010) psychometric evaluation of the DOCS. In this study, 315 participants presented for face-to-face CBT and data from 68 participants who had been administered the DOCS at pre-treatment were extracted. The third comparator study was a randomised controlled trial examining the efficacy of concentrated face-to-face CBT amongst participants attending an outpatient clinic in Norway. Sixteen participants completed CBT and their pre-treatment depressive symptom data, as measured by the PHQ-9, was extracted.

Data from the ICBT open trial were entered into the Statistical Package for Social Sciences (SPSS) version 28.0. Analyses were performed to obtain means and standard deviations for the continuous demographic and clinical variables (i.e., age and symptom severity), and frequencies and proportions for the categorical demographic variables (i.e., gender and medication status). Differences between samples were analysed using Microsoft Excel. Chi-square tests were used to assess the difference between samples on categorical demographic variables (i.e., gender and medication status), and independent  $t$ -tests were used to assess the mean difference between samples on continuous demographic and clinical variables (i.e., age and symptom severity). The  $p$ -value was adjusted for multiple comparisons and set at .005 to reduce the rate of Type I errors. For continuous variables, effect sizes were calculated using Cohen's  $d$  whereby .20 indicates a small effect size, .50 a medium effect size, and  $> .80$  a large effect size (Cohen, 1992). As the characteristics of the ICBT group were compared to published data on the characteristics of individuals in the face-to-face treatment group, some participants in the ICBT group were not included in the analyses. Specifically, six

participants from the ICBT group who identified as gender diverse were not included in the analysis for gender in order to correspond to its comparison face-to-face group, which only included females and males in their analyses.

## Results

### Demographic characteristics

Participant demographic characteristics for the ICBT group and its comparison face-to-face group (Steketee et al., 2019) are outlined in Table 1. There was a significant difference in age between the groups, with those in the ICBT group being significantly younger than those in the face-to-face group. There was a significant difference in gender between the groups, with more females in the ICBT group than in the face-to-face group. There was a significant difference in medication status between the groups, with those in the face-to-face group being more likely to take psychotropic medication for their OCD symptoms than the ICBT group.

### OCD symptom severity

The mean YBOCS-SR total score for the ICBT group was in the moderate range ( $M = 23.74$ ,  $SD = 5.20$ ) while the mean Y-BOCS-SR total score for the face-to-face group (Steketee et al., 2019) was in the severe range ( $M = 24.33$ ,  $SD = 5.67$ ). The difference between the ICBT group and face-to-face group on the YBOCS-SR was not statistically significant,  $t(680) = 1.42$ ,  $p = .16$ ,  $d = 0.11$ .

The means and standard deviations of the severity of OCD symptom as measured by the DOCS for the ICBT group and its comparison face-to-face group (Abramowitz et al., 2010) are outlined in Table 2. There were no statistically significant differences between the groups on the DOCS total score, contamination subscale, responsibility subscale, unacceptable thoughts subscale, or symmetry subscale, when using the adjusted  $p$ -value.

### Depression severity

The mean PHQ-9 total scores for the ICBT group ( $M = 12.60$ ,  $SD = 6.39$ ) and face-to-face group (Launes et al.,

**Table 1.** Demographic characteristics.

	ICBT		Face-to-face (Steketee et al., 2019)		Test Statistic	$p$ -value
	N	M (SD)/%	N	M (SD)/%		
Age	323	33.27 (12.22)	359	35.93 (11.14)	$t = 2.96$	<.001
Gender (% female)	317	74.1%	359	60.0%	$\chi^2 = 15.12$	<.001
Medication status (% yes)	323	44.9%	268	59.0%	$\chi^2 = 11.60$	<.001

**Table 2.** Mean and standard deviation of Dimensional Obsessive-Compulsive Scale (DOCS) total and subscale scores by group.

	Group		Test Statistic	<i>p</i> -value	Cohen's <i>d</i>
	ICBT	Face-to-face (Abramowitz et al., 2010) <sup>a</sup>			
DOCS Total Score	32.63 (13.49)	30.06 (15.49)	<i>t</i> = 1.27	0.20	0.18
<i>Contamination</i>	6.96 (6.18)	6.53 (6.40)	<i>t</i> = 0.51	0.61	0.07
<i>Responsibility</i>	9.52 (5.21)	7.54 (5.84)	<i>t</i> = 2.59	0.01	0.36
<i>Unacceptable thoughts</i>	9.78 (5.64)	9.73 (6.20)	<i>t</i> = 0.06	0.95	0.01
<i>Symmetry</i>	6.36 (5.72)	6.13 (5.50)	<i>t</i> = 0.31	0.76	0.04

<sup>a</sup>Based on a subset of OCD patients (*n* = 68).

2019) ( $M = 10.06$ ,  $SD = 4.60$ ) were in the moderate range. The difference between the ICBT group and face-to-face group on the PHQ-9 was not statistically significant,  $t(390) = 2.11$ ,  $p = .04$ ,  $d = 0.46$ , when using the adjusted *p*-value.

## Discussion

The aim of this study was to compare the demographic and clinical characteristics of a large international sample of individuals who were enrolled in an ICBT course for OCD to a large sample of individuals who enrolled in face-to-face CBT for OCD. It was hypothesised that the ICBT group would demonstrate similar demographic, OCD symptom severity, and depression severity profiles to those who engaged with face-to-face CBT. The hypotheses were partially supported.

Overall, the results indicated that the demographic characteristics were significantly different between those who commenced ICBT and those who commenced face-to-face CBT. In terms of gender distribution, women with OCD symptoms appear to be more likely to engage with ICBT than face to face treatment (74.1% vs 60.0%). This finding is consistent with the existing literature on OCD (e.g., Wootton et al., 2011). Similar findings have also been observed in other anxiety and related disorders such as generalised anxiety disorder (Hobbs et al., 2017), and PTSD (Ivarsson et al., 2014). While preliminary, these findings suggest that females may be more likely to engage in ICBT than males, however a sizeable proportion of males are still likely to undertake this treatment approach.

Contrary to the existing literature in OCD (Wootton et al., 2011) and anxiety disorders (Titov et al., 2010), individuals in the ICBT group were slightly younger ( $M = 33.26$ ) than the face-to-face CBT group ( $M = 35.93$ ). This finding is consistent with other studies that have identified that younger participants are more likely to enrol in ICBT treatments than their older counterparts (Mewton et al., 2013). This may be due to younger patients having increased comfort with technology (Soucy & Hadjistavropoulos, 2017). However, despite this, older participants enrolled in ICBT treatments

have been found to have higher rates of treatment completion (Hobbs et al., 2017; Mewton et al., 2012; Newby et al., 2014) as well as greater improvements in symptoms of generalised anxiety (Mewton et al., 2012) and social anxiety (Newby et al., 2014), compared to their younger counterparts. Therefore, ICBT for OCD may be beneficial for adults across the lifespan and older participants may be more likely to take up internet-delivered therapy as it becomes more common and widespread over time. However, it is important to acknowledge that although statistically significant differences were found between the ICBT and face-to-face treatment groups on age, the magnitude of these differences do not appear to be clinically significant (i.e., 33 years versus 35 years).

While the rate of psychotropic medication use in this study is consistent with previous ICBT studies for OCD (Mahoney et al., 2014; Wootton et al., 2021), the results indicate that individuals in the ICBT group were less likely to be medicated for their symptoms compared with those who engaged in face-to-face CBT. This may indicate that individuals who enrol in ICBT are potentially using it as their first step in accessing treatment. Further research is required to understand whether there are differences in medication use amongst individuals who choose different forms of therapy and whether it has an impact on treatment outcomes. However, with the growing evidence for its efficacy, ICBT shows promise as a first step in a stepped-care approach to treatment for OCD, where the second and more intensive treatment may be face-to-face or pharmacological treatments.

Finally, the results of the current study indicated that the clinical characteristics were similar between the ICBT group and the face-to-face CBT group. Consistent with the existing literature (Wootton et al., 2011), the ICBT group had similar severity of OCD symptoms as the face-to-face treatment group, as measured by the total score on the Y-BOCS-SR and DOCS. Additionally, the ICBT group had similar severity of depressive symptoms as the face-to-face treatment group, as measured by the total score on the PHQ-9. These findings indicate that individuals who seek ICBT

have non-trivial symptoms and the severity of their symptoms are comparable to those who seek face-to-face treatment. However, in addition to examining severity of symptoms, future research would benefit from examining clinical characteristics of distress and disability and whether these factors have any influence on the form of treatment individuals choose to undertake, and whether they have an impact on treatment outcome.

### Limitations

Several limitations of this study should be acknowledged. First, although the sample size in Steketee et al. (2019) study was large and comparable to the sample size of the ICBT group, the sample size in Abramowitz et al. (2010) and Launes et al. (2019) studies were relatively small, consisting of 68 and 16 participants, respectively. As a result, the analyses of the symptom dimensions and to a greater degree, the severity of depressive symptoms need to be considered preliminary.

Second, the selected face-to-face comparator studies (i.e., Abramowitz et al., 2010; Launes et al., 2019; Steketee et al., 2019) precluded the ability to examine some demographic variables (i.e., education level) as they were not included in their analyses. Similarly, despite the current study collecting information pertaining to gender, participants who identified as gender diverse were excluded from the analysis to correspond with the comparative face-to-face study (Steketee et al., 2019). Thus, further research is required to understand whether individuals who identify as gender diverse may be more represented in specific forms of therapy.

Third, the selected face-to-face comparator studies did not provide details of recruitment methods. Thus, it is possible that differences demonstrated between the samples may not be reflective of the type of treatment per se; rather, the method utilised to recruit the sample. Future studies may wish to examine the clinical and demographic profiles of individuals with OCD who are given the option of ICBT or face-to-face CBT in order to address this research question. Similarly, it is important to note that all of the data compared were from research studies rather than routine care settings. It is possible that individuals who choose to engage in research studies may be different to those in routine care. Recently, there have been some studies that have examined the effectiveness of ICBT when it has been delivered in routine care settings within Australia (Li et al., 2022; Luu et al., 2020; Wootton et al., 2021). Whilst the

demographic and clinical characteristics of individuals within these studies were not examined in the present study, they appear to demonstrate similar characteristics. Thus, future research would benefit from examining individuals in routine care settings and comparing them to those in research studies to determine whether they are the same or similar population.

Fourth, approximately 39% of participants in the ICBT group were excluded as they did not fulfil inclusion criteria. Although it is difficult to ascertain what this may indicate about the characteristics of individuals seeking ICBT for OCD, it is possible that they may be experiencing high levels of distress and want to obtain more immediate support or support of a higher intensity. This is evidenced by a large proportion of individuals not completing the online application, possibly due to the length of the application being burdensome on the individuals and acting as a barrier to obtaining support. Thus, as mentioned above, future research would benefit from examining distress levels amongst those who seek ICBT and compare them with those who seek face-to-face treatment to determine whether there are any meaningful differences between the groups and whether this impacts on their engagement in treatment.

Fifth, alternative treatment options such as face-to-face treatment were not discussed with participants in the ICBT group, and it is unknown whether participants in the comparator face-to-face studies were informed of online treatment options. Although it is presumed that individuals who engage in one form of treatment compared to another are “choosing” that form of treatment, it is unknown whether they may have undertaken the mode of treatment if all alternatives were provided to them. Thus, these findings should be interpreted with caution and future research should explicitly discuss all treatment options with potential participants to ascertain whether any differences in characteristics observed between groups are meaningful and correspond to their preferences.

Finally, while participants in this study endorsed OCD symptoms on the DIAMOND in a self-report format, a clinician-administered diagnostic interview was not conducted to confirm a diagnosis of OCD. Therefore, caution should be taken when interpreting the results of this study as they may not be generalisable to those with a diagnosis of OCD. Thus, future research would benefit from administering a diagnostic interview to determine whether there are any similarities or differences in the demographic and clinical profiles between those who engage in ICBT and face-to-face CBT for OCD.



## Conclusion

To our knowledge, this is the first study to examine the demographic and clinical characteristics of individuals with OCD who seek self-guided ICBT for their symptoms. While there were some differences in demographic characteristics between those who engaged with self-guided ICBT compared with those who engaged in face-to-face treatment, the clinical characteristics were similar between the two groups. This indicates that the people choosing to use self-guided ICBT appear to be clinically representative of individuals with OCD in the general population. As such, these findings demonstrate the potential for an entirely remote stepped care treatment model for OCD to improve access to evidence-based treatment for individuals with OCD.

## Disclosure statement

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