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# A systematic review and meta-analysis of self-help therapeutic interventions for obsessive–compulsive disorder: Is therapeutic contact key to overall improvement?

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ABSTRACT

*Background and objectives:* The presence of obsessive-compulsive disorder (OCD) can result in low quality of life, with significant impairments in social and occupational functioning. An increase in the dissemination of self-help programs has been observed in the treatment of OCD, and has provided improved accessibility to treatment. The present study examined the efficacy of self-help interventions for OCD in the context of therapeutic contact.

*Methods:* Randomised controlled trials and quasi-experimental studies were identified through computerised database searches. Self-help format (bibliotherapy, internet-based, computerised), and therapeutic contact were examined for their effect on treatment outcomes.

*Results:* Eighteen studies targeting self-help for OCD met inclusion criteria with 1570 participants. The average post-treatment effect size (Hedges' g) of self-help interventions on primary outcomes was .51 (95% CI: .41 to 0.61). Subgroup analysis revealed large effect sizes for minimal-contact self-help (g = 0.91, 95% CI: 0.66 to 1.17), moderate effect sizes for predominantly self-help (g = 0.68, 95% CI: 0.40 to 0.96), and small effect sizes for self-administered self-help (g = 0.33, 95% CI: .18 to 0.47).

*Limitations:* A large variation of treatment approaches, amount of therapeutic contact, and risk of bias within each study may account for the large magnitude in effect sizes across studies. Additionally, the long-term follow-up effects of treatment approaches were not examined.

*Conclusions:* A growing body of literature supporting to the use of self-help treatments for OCD is evident, however, further investigation through use of randomised controlled trials is required, particularly the use of stepped care and long-term effectiveness.



## 1. Introduction

Obsessive-compulsive disorder (OCD) can result in a low quality of life, with significant impairments in social and occupational functioning (Moritz, Jelinek, Hauschildt, & Naber, 2010). The availability of effective treatment is therefore highly important. Cognitive-behavioural therapy (CBT) with exposure and response prevention (ERP) has been recognised as the most effective treatment for OCD (Abramowitz, 2006; Whiteside, Brown, & Abramowitz, 2008). Unfortunately, many barriers exist to the accessibility of ERP, including high cost, restricted access in rural areas, and restricted access to trained clinicians. Consequently, the exploration of alternative treatment methods is essential. Several studies have investigated self-help for OCD (e.g., Herbst et al., 2012; Wootton & Diefenbach, 2015). Self-help is useful for increasing access for those in rural and remote areas, for patients on waitlists and those who cannot afford treatment (Newman, Szkodny, Llera, & Przeworski, 2011). Research has investigated the use of stepped care by first providing clients with lower levels of treatment (i.e. self-help) or in order to reduce subsequent therapist time in face-to-face treatment (Gilliam, Diefenbach, Whiting, & Tolin, 2010; Nakagawa et al., 2000; Tolin, Diefenbach, Maltby, & Hannan, 2005).

Although self-help treatments may be less time-intensive and more cost-efficient than face to face, guided self-help is a more intensive treatment than pure self-help due to the provision of therapist assistance through email or telephone (Coull & Morris,

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2011). Unguided pure self-help however utilises no professional guidance, aside from email or SMS reminders (Nordgreen et al., 2012).

Therapeutic contact has been identified as an important factor in self-help that may improve treatment outcome and reduce drop out (Marrs, 1995; Mataix-Cols & Marks, 2006). In a review the NICE Guideline Development Group (2005) found a relationship between number of contact hours and outcome in OCD treatment, with effect sizes of .93 for low intensity, 1.44 for medium and 1.65 for high intensity. Given the recent proliferation of self-help programs for OCD there are limited up to date reviews available to determine if different levels of therapist contact (guided vs unguided) have an impact on treatment outcome and drop out.

A systematic review by Mataix-Cols and Marks (2006) found dropout rates for OCD varied between 17 and 57%, and self-help for anxiety has a trend towards higher dropout than face to face therapy. Herbst et al. (2012) found in a review of telemental interventions for OCD (e.g. computerised and internet-based) high dropout (59–74%) across studies with no therapeutic contact, however dropout rates reduced significantly when minimal therapeutic contact was provided. Kenwright, Marks, Graham, Franses, and Mataix-Cols (2005) in a randomised controlled trial of self-help, found that those who received greater therapeutic assistance in 'scheduled' phone support had higher reductions in OCD symptoms than those who were in a 'requested' phone support group who had no significant improvement (effect size .85 compared to .3). Dropout rates also differed significantly between groups (14% compared to 59% in the requested group). Dropout rates and treatment outcomes have not been actively assessed across all OCD self-help studies (including bibliotherapy, internet-based treatment, and computerised treatment) with and without therapeutic contact.

A number of systematic reviews exist evaluating internet-delivered psychological treatments, and self-help treatments for anxiety and depression, however to date few systematic reviews exist that include all self-help treatments with and without therapeutic contact for OCD. Furthermore, many reviews exist which include only evidence based treatments (Lovell & Bee, 2011; Mataix-Cols & Marks, 2006; Rosa-Alcázar, Sánchez-Meca, Gómez-Conesa, & Marín-Martínez, 2008) however only one review exists (Sarris, Camfield, & Berk, 2012) that includes all available self-help treatments for OCD. Barlow, Ellard, Hainsworth, Jones, and Fisher (2005) conducted a review of clinical and cost-effectiveness of self-help in anxiety, however, only one study was in OCD. Herbst et al. (2012) reviewed telemental approaches for OCD, however only included articles to 2011. Wootton and Diefenbach (2015) conducted a review on the efficacy of iCBT for OCD reviewing 4 open trials, and 3 RCTs for guided interventions, and 2 open trials for self-guided interventions, however, excluded other self-help treatments. Given the recent numerous studies published there is a need for an up-to-date review, including all available self-help treatments for OCD with a particular focus on therapeutic contact in order to inform therapists.

Many different types of self-help treatment for OCD have been investigated throughout the literature. CBT focuses on challenging irrational beliefs and cognitive distortions (catastrophising, personalisation, jumping to conclusions) and as such is focused on the content of intrusive thoughts. The focus of Metacognitive Therapy (MCT), on the other hand is on the meaning and significance of intrusive thoughts. MCT challenges the client's belief that their thoughts are important or powerful (Wells, 2009). Exposure and Response Prevention (ERP) involves exposure to thoughts, images, objects, and situations that are perceived as threats. This exposure results in an increase in anxiety and ritual prevention is then encouraged to ensure that the client does not engage in compulsive rituals to reduce anxiety. Over time through exposure, habituation occurs where anxiety levels naturally reduce, challenging the need for compulsive rituals. An example of the use of self-help ERP has been found in BT Steps, which is a computer-guided behaviour therapy self-help system (Griest et al., 2002; Kenwright et al., 2005; Nakagawa et al., 2000). The system is accessible via a touch-tone telephone and involves an interactive voice response computer system, which guides the client through a workbook and self-ERP. Daily self-exposure and self-imposed ritual prevention are incorporated within the treatment phase to reduce the urge to perform rituals/compulsions, as well as relapse prevention.

Other alternative treatment methods such as meridian tapping, attention training and association splitting have also been investigated. Meridian tapping is concerned with releasing energy blockages by using a technique of tapping on acupuncture points, which are believed to alleviate obsessive thoughts (Moritz, Aravena, et al., 2011). Attention training is focused on minimising dysfunctional attention biases by shifting attention from internal to external events, and as such, improving flexibility and control of attention (Moritz, Wess, Treszl, & Jelinek, 2011). Association splitting, on the other hand, is a technique aimed to reduce obsessive thoughts by diffusing associations with obsessions and furthermore, related compulsions (Moritz & Rassu, 2013).

The current review will critically evaluate the literature on all self-help treatments for OCD (mainstream and alternative treatment studies using randomised controlled trials and quasi-experimental designs) to provide an up-to-date synthesis. Both evidence-based and alternative treatments have been included within the current review in order to determine the impact of the amount of therapist contact on outcomes for OCD, irrespective of the specific treatment type. We aim to expand on existing reviews in order to establish whether self-help treatment is effective in reducing OCD symptoms in adults. We further aim to examine whether therapeutic contact at differing intensities has an impact on treatment outcome. The results may assist time-poor clinicians in understanding the amount of therapeutic contact required to achieve satisfactory outcomes through self-help treatments as a first step of care.

The objectives of this meta-analysis were to identify all randomised controlled and quasi-experimental trials of self-help treatment in OCD to determine whether self-help treatment is effective at reducing symptoms of OCD in adults. In order for the current review to be comprehensive, all identified self-help treatment types were included. Furthermore, we aimed to examine if therapeutic contact has an impact on treatment outcome and dropout.

## 2. Method

The meta-analysis was conducted in accordance to the PRISMA statement criteria (Liberati et al., 2009; Moher, Liberati, Tetzlaff, Altman, PRISMA Group, 2009). Pre-specified inclusion and exclusion were determined prior to screening.

### 2.1. Eligibility criteria

Studies included within the meta-analysis were randomised controlled trials and quasi-experimental designs that provided evidence for or against the efficacy of self-help interventions (bibliotherapy, computerised, and internet-based). Case series, single-case designs, and uncontrolled repeated measures designs (open trials) were excluded. The review included both therapy assisted self-help, and pure self-help, however, studies were organised into a framework of differing amounts of therapist contact, as categorised by Newman, Erickson, Przeworski, and Dzus (2003). To be included studies had to provide sample