

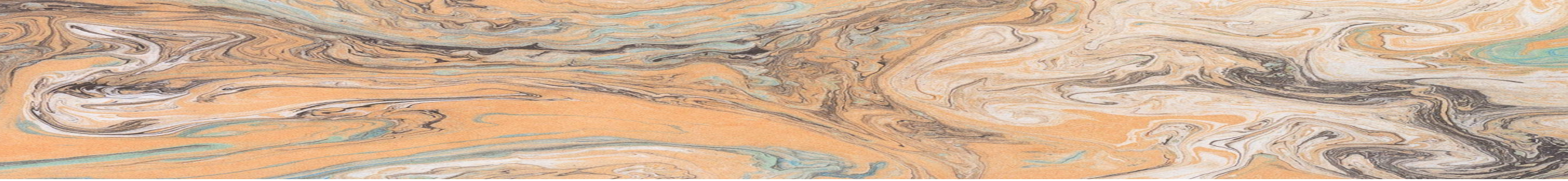
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Professional Ethics, Responsibility & Humility in EBP for OCD

Molly Martinez, PhD, Eric Storch, PhD,
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IOCDF Conference 2023, San Francisco, CA



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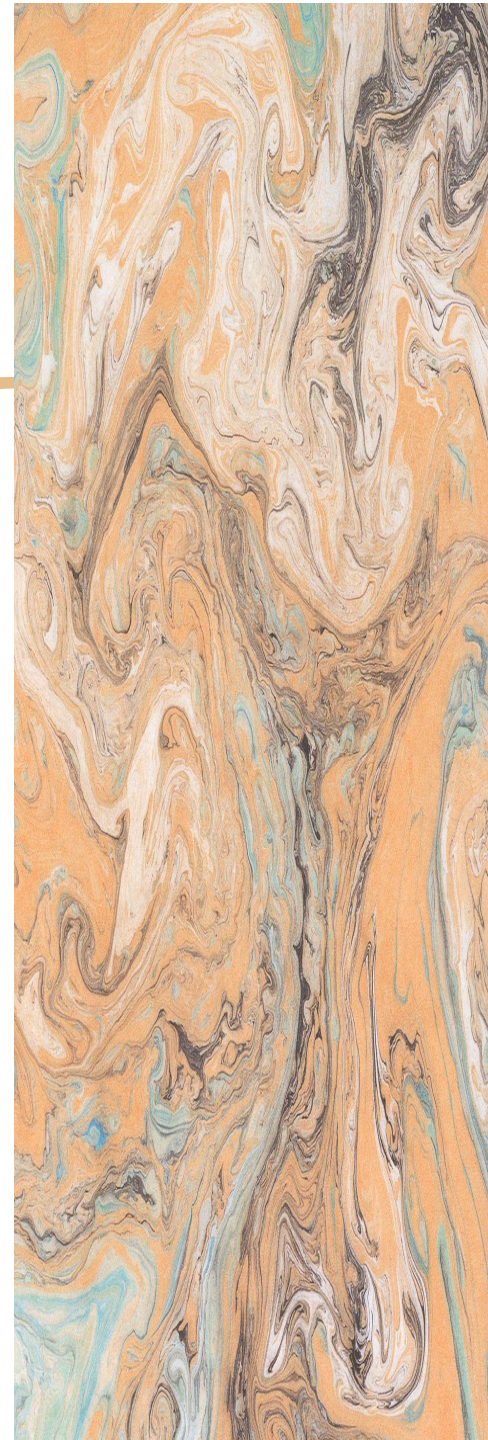
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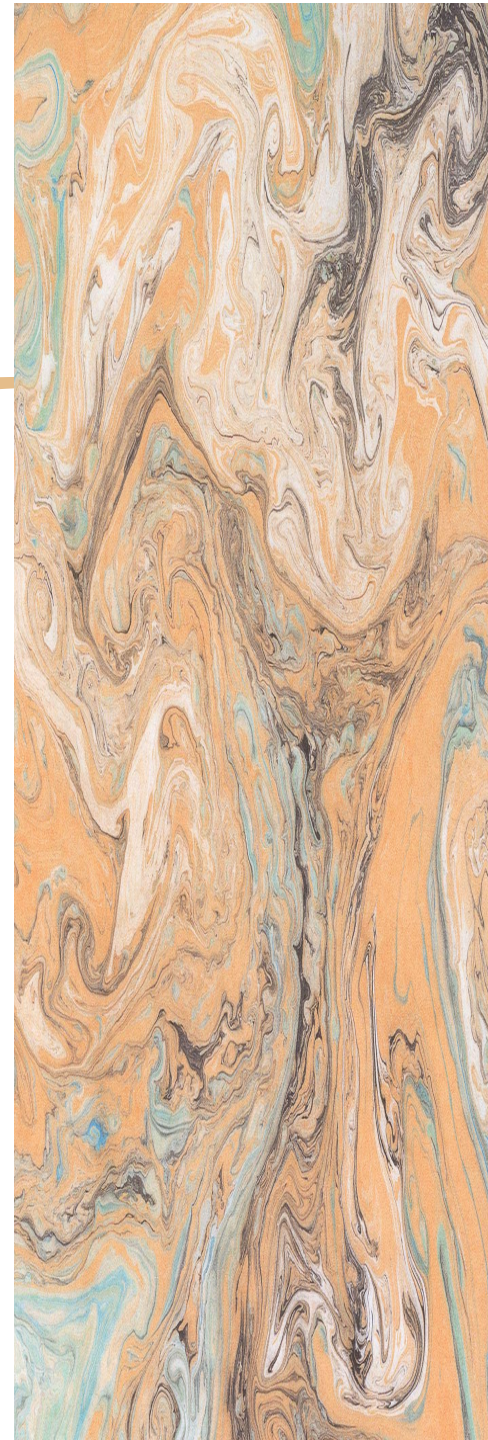
Objectives

1. Discuss ethical implications of treatment choice, equipoise, and professional communication in the field
2. Overview of research available on OCD treatments:
 - Exposure & Response Prevention (ERP)
 - Acceptance & commitment therapy (ACT)
 - Inference-Based Cognitive Behavioral Therapy (I-CBT) for OCD
3. Promote critical thinking about treatment selection with regard for
 - Research
 - Clinical expertise and experience
 - Patient values and autonomy
4. Foster humility & respect



Topics Not Covered

1. Details of the treatments & protocols
2. Delineating or debating the details of each therapy
3. Personal & passionate offenses & defenses but instead:
 - Sit with discomfort
 - Check your privilege

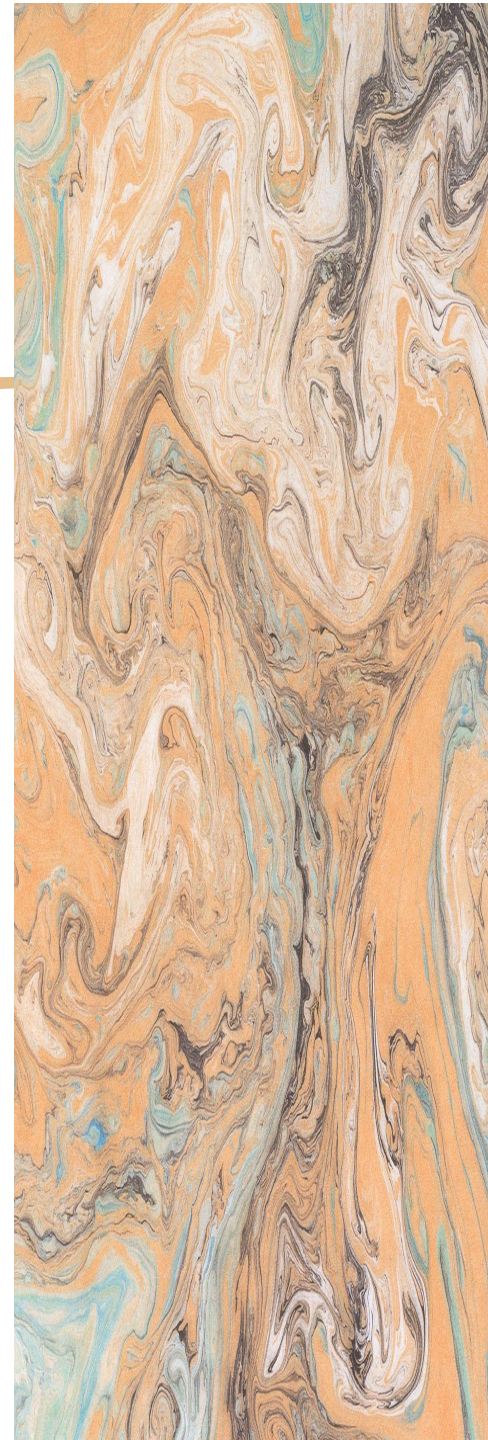


Privilege Check!

- White
- Male
- Cisgender
- Heterosexual
- SES
- Age
- Disability
- Education/degree
- Role (attendee, presenter, family)
- Lived experience
 - Street cred?
 - Stigma?
- Years of professional experience
 - Respect & leadership
 - Tx allegiance

Overview

- Questions on comment cards, please
- Review ethical principles & relevant questions
- Review research methods & statistics
- State of the research: ERP, ACT, I-CBT
- Discuss basis for treatment selection
- Discussion



Why is this an Ethics talk?

Ethical Principles

- Nonmaleficence
- Beneficence
- Autonomy
- Justice

(Beauchamp and Childress, 1979)

Nonmaleficence - “First, do no harm”

Prudent treatment selection, healthy skepticism, productive debate, and standards of care can help us avoid doing harm...

1. ...to patients
2. ...to other professionals
3. ...to the field

Beneficence - Patient's best interest

- How do we choose the best treatment for each patient?
- How can we advance the field to offer more and better treatment options?
- How do professionals challenge & support one another effectively to promote common goals & the best interest of patients?

Autonomy - Independent decision-making

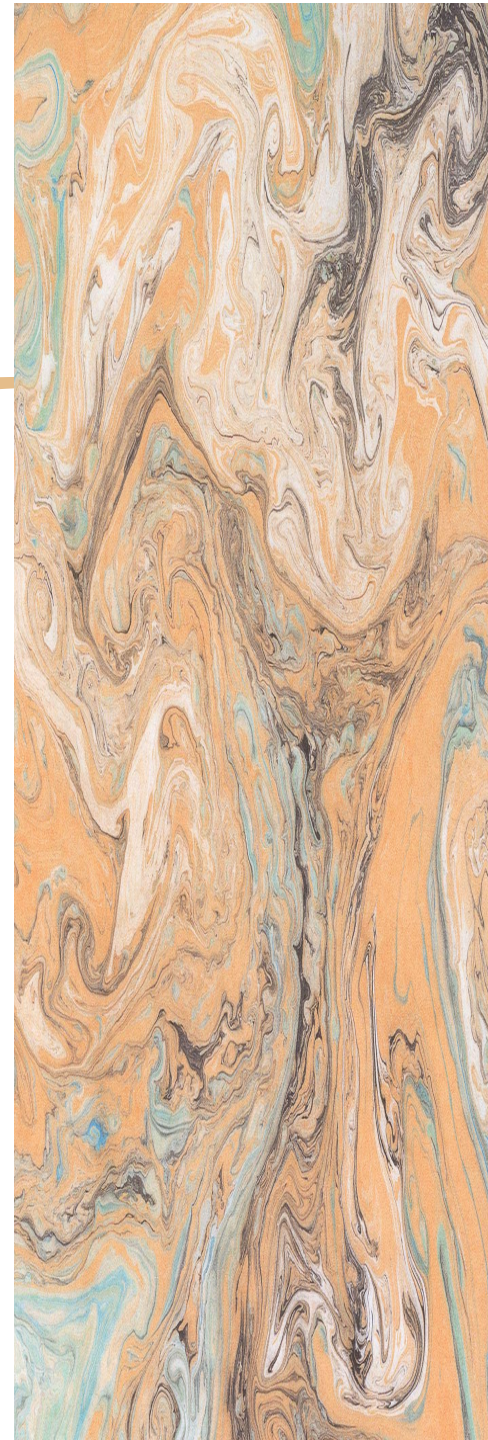
- What role does the patient have in treatment choice?
- To what degree (and in what way) is it appropriate for a clinician to influence that choice?
- Shared decision-making (Ubel et al 2017):
 - Clinicians educate patients about tx options
 - Help patients align their choices with their values

Justice - Fair, equitable, appropriate

- Need to choose a treatment that fits the individual (eg, diversity considerations, past experience in tx)
- Need to make effective treatment available to everyone, not just an elite group
- How do we make EBT more available through training and education?
 - When & how is it appropriate to disseminate a particular treatment?

Overview of the Science

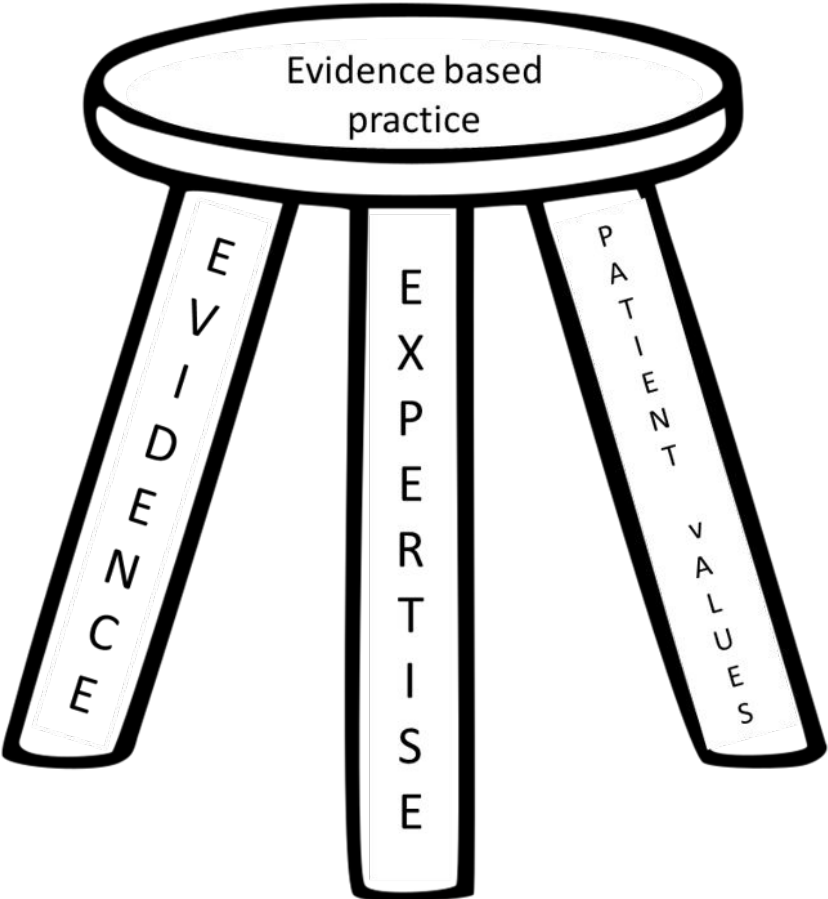
- Basics of interpreting research & statistics
- What is the state of the literature on:
 - Exposure & Response Prevention (ERP)
 - Acceptance & commitment therapy (ACT)
 - Inference-Based Cognitive Behavioral Therapy (I-CBT)



Empirically-Supported Tx (EST) vs. Evidence-Based Practice (EBP)

There's a difference.

Evidence-Based Practice/Tx (EBP/EBT)



Evidence-Based Practice/Tx (EBP/EBT)

- “Three-legged stool” (Institute of Medicine, 2001; APA, 2006)
 1. Best available research evidence (ESTs)
 2. Clinical expertise & experience
 3. Patient characteristics (eg, demographics, values, preferences)
- Informs Best Practice Guidelines
- Example from medicine: cancer treatment
 - ESTs: Chemotherapy, radiation, surgery
 - Oncologists offer chemo or radiation or refer to surgery; Surgeons offer surgery

Empirically-Supported Tx (EST)

- Barlow et al (APA Task Force, 1993)
 - Coined the term “empirically supported treatment”
 - Moved research away from theory to procedure Broad statement on efficacy of a given treatment
- EST status is not binary, but rather a “degree”
- Set standards for research methods, outcomes, & accumulation of evidence

Empirically-Supported Tx (EST)

Criteria Adopted by APA

- Many proposed methods of determining EST status*
- Adopted by APA over time (Div. 12: Society of Clin. Psych.)
 - Chambless & Hollon, 1998
 - “Well-designed” studies; independent investigators
 - Tolin et al, 2015:
 - More stringent criteria and review process (eg, systematic review/meta-analysis; effectiveness/non-research sample)

APA Division 12: Society of Clinical Psychology

EST Status of ERP, CBT, & ACT for OCD

APA Division 12: Society of Clinical Psychology
(<https://div12.org/diagnosis/obsessive-compulsive-disorder/>)

PSYCHOLOGICAL TREATMENTS

- Exposure and Response Prevention for Obsessive-Compulsive Disorder **NEW CONTENT**

2015 EST Status: Strong research support

1998 EST Status: Strong research support

- Cognitive Behavioral Therapy for Obsessive Compulsive Disorder **NEW CONTENT**

2015 EST Status: Treatment pending re-evaluation research support

1998 EST Status: Strong research support

[Text](#)

- Acceptance and Commitment Therapy for Obsessive-Compulsive Disorder **NEW CONTENT**

Note: Other psychological treatments may also be effective in treating Obsessive-Compulsive Disorder, but they have not been evaluated with the same scientific rigor as the treatments above. Many medications may also be helpful for Obsessive-Compulsive Disorder, but we do not cover medications in this website. Of course, we recommend a consultation with a mental health professional for an accurate diagnosis and discussion of various treatment options. When you meet with a professional, be sure to work together to establish clear treatment goals and to monitor progress toward those goals. Feel free to print this information and take it with you to discuss your treatment plan with your therapist.

ERP for OCD

Under Chambless & Hollon criteria = Very Strong

Under Tolin criteria = Strong

APA Division 12: Society of Clinical Psychology
(<https://div12.org/diagnosis/obsessive-compulsive-disorder/>)

ERP for OCD: STRENGTH OF RESEARCH SUPPORT

Empirical Review Status	Very Strong	Strong	Weak	Insufficient Evidence
2015 Criteria (Tolin et al. Recommendation)		✓		
1998 Criteria (Chambless et al. EST)	✓	Modest	Controversial	

CBT for OCD

Under Chambless & Hollon criteria = Strong
(Tolin criteria pending)

APA Division 12: Society of Clinical Psychology
(<https://div12.org/diagnosis/obsessive-compulsive-disorder/>)

CBT for OCD: STRENGTH OF RESEARCH SUPPORT

Empirical Review Status			
2015 Criteria (Tolin et al. Recommendation)	Treatment pending re-evaluation		
1998 Criteria (Chambless et al. EST)	Strong ✓	Modest	Controversial

ACT for OCD

Under Chambless & Hollon criteria = Modest

APA Division 12: Society of Clinical Psychology
(<https://div12.org/diagnosis/obsessive-compulsive-disorder/>)

BRIEF SUMMARY

ACCEPTANCE AND COMMITMENT THERAPY FOR OBSESSIVE-COMPULSIVE DISORDER

STATUS: MODEST RESEARCH SUPPORT

What does this mean?

DESCRIPTION

Acceptance and Commitment Therapy (ACT) is a behavioral therapy that is based on Relational Frame Theory, a theory of how human language influences experience and behavior. ACT aims to change the relationship individuals have with their own thoughts, feelings, memories, and physical sensations that are feared or avoided. Acceptance and mindfulness strategies are used to teach patients to decrease avoidance, attachment to cognitions, and increase focus on the present. Patients learn to clarify their goals and values and to commit to behavioral change strategies. This treatment has been applied to a number of conditions, including OCD.

Research Methods: Study Design

- Sample Size (N)
- Randomized Controlled Trial (RCT)
 - Experimental & comparison group
 - Participants are randomly assigned to one or the other
 - Participants &/or researchers are blind to group assignment
 - Most rigorous & robust; time intensive & expensive
- Non-inferiority trial (aka, “equivalence trial”)
 - Compares (new) treatment to existing effective treatment
 - Analyzed to determine if outcomes are unacceptably worse
- Meta-analysis
 - Analysis of study data from several similar studies to develop a single conclusion
 - Statistically stronger than any single study

Research Methods

- Correlation

- *To what degree is a change in one variable associated with a change in another variable?*

- Significance

- *Is the treatment group better than the comparison group? How likely is it that results are by chance?*

- Effect Size ("standardized mean difference")

- *How much more effective is the treatment than the control?*

Interpreting the Statistics

Correlation	Significance	Effect Size
<p><i>r</i> or <i>p</i> (+1 to -1) (ie, Pearson's, Spearman)</p>	<p><i>p</i>-value (set by investigator; smaller is better)</p>	<p><i>d, g, SMD, MD (etc)</i> (eg, Cohen's, Hedges', also others)</p>
<p><i>r</i> = 0 (no relationship) <i>r</i> = 1 (perfect positive correlation) <i>r</i> = -1 (perfect negative correlation)</p>	<p><i>p</i> < .01 = If you ran the study 100 times you are likely to get the same result 99 times</p>	<p>≤0.2 is trivial ≥0.5 is <u>moderate</u> ≥0.8 is <u>large</u> ≥2.0 is 🤖</p> <p>Note: other types of effect sizes are interpreted differently</p> <p>Standardized Mean Difference</p>

The background is a complex marbled paper pattern with swirling veins of orange, teal, and grey. A large, solid orange circle is positioned on the right side of the image, containing the text.

ERP

Eric Storch, PhD

ERP for OCD: Why the haters?

Eric A. Storch, Ph.D.

Professor, Vice Chair, McIngvale Presidential Endowed Chair

Baylor College of Medicine

Baylor
College of
Medicine®

Disclosures

1. Research: NIH, IOCDF, Ream Foundation
2. Royalties: Springer, Wiley, APA, Lawrence Erlbaum, Elsevier, Oxford, NView
3. Talks: IOCDF
4. Consultant: Brainsway, Biohaven

Meta-Analysis of Adult OCD Tx

Results

- 16 Studies
- strong sample size
 - N=73 to 108 in 4
 - N=20 to 53 in 10
 - N≤20 in 2
- Effect sizes
 - 14 studies: Moderate to Extremely Strong
 - 2 studies: ranged from favoring control to Extremely strong

Table 1
Studies included in the meta-analysis.

Study	Conditions	N	Sample	Mean age	# Of sessions	Primary outcome measure	Secondary outcome measure
Anderson and Rees (2007)	CBT vs. WL	51	Adult	33.7	10	YBOCS	BDI
Barratt et al. (2004)	CBT vs. WL	53	Child	11.8	14	CYBOCS	CDI
Bolton and Perrin (2008)	CBT vs. WL	20	Child	13.2	12	CYBOCS	None
Cordoli et al. (2003)	CBT vs. WL	47	Adult	36.5	12	YBOCS	HAM-D
Fals-Stewart et al. (1994)	CBT vs. Psych PL	93	Adult	36.5	12	YBOCS	BDI
Finberg et al. (2005)	CBT vs. Psych PL	47	Adult	39.3	12	YBOCS	None
Foa et al. (2005)	CBT vs. PDI PL	61	Adult	34.3	23	YBOCS	HAM-D
Freeston et al. (1997)	CBT vs. WL	29	Adult	35.8	12	YBOCS	BDI
Jones and Menzies (1998)	CBT vs. WL	21	Adult	35.5	10	MOCI	BDI
Lindsay et al. (1997)	CBT vs. Psych PL	18	Adult	32.8	15	YBOCS	BDI
O'Connor et al. (1999)	CBT vs. WL	26	Adult	37.3	5	YBOCS	None
Simpson et al. (2008)	CBT vs. Psych PL	108	Adult	39.2	17	YBOCS	HAM-D
Twong et al. (2010)	CBT vs. Psych PL	39	Adult	37.0	8	YBOCS	BDI-II
Whittal et al. (2010)	CBT vs. Psych PL vs. WL	73	Adult	31.5	12	YBOCS	BDI
Wilhelm et al. (2009)	CBT vs. WL	29	Adult	33.4	22	YBOCS	BDI
Williams et al. (2010)	CBT vs. WL	21	Child	13.6	10	CYBOCS	CDI

Note. CBT – Cognitive Behavior Therapy, WL – Waitlist, PL – Placebo, CYBOCS – Children's Yale-Brown Obsessive Compulsive Scale, MOCI – Maudsley Obsessional-Compulsive Inventory, YBOCS – Yale-Brown Obsessive Compulsive Scale, BDI – Beck Depression Inventory, BDI-II – Beck Depression Inventory-II, CDI – Children's Depression Inventory, HAM-D – Hamilton Rating Scale for Depression.

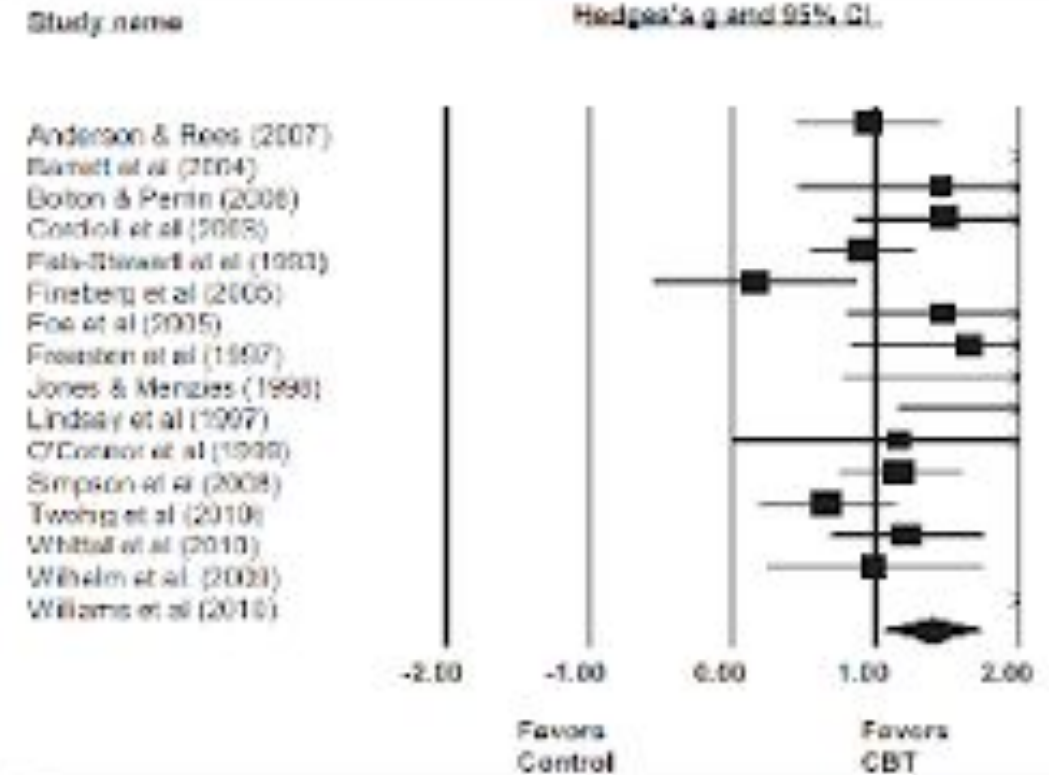


Fig. 2. Effect size estimates (Hedges' g) for the efficacy of CBT compared to control conditions on OCD symptom reduction.



Evidence Base Supporting ERP

State of the Literature

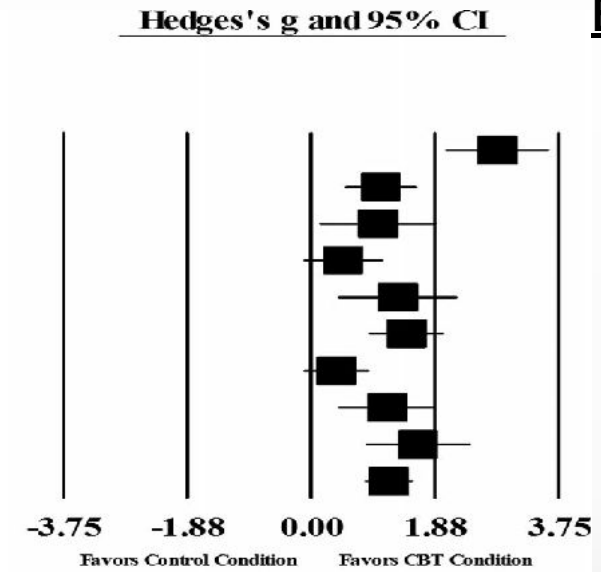
1. Consistently strong and similar effects
2. Superior to active and inactive treatments
3. Safe
4. Acceptable
5. Effective for more refractory patients
6. Partial response common
7. 25-30% do not respond meaningfully
8. Some people don't want ERP

Meta-Analysis of Peds OCD Tx

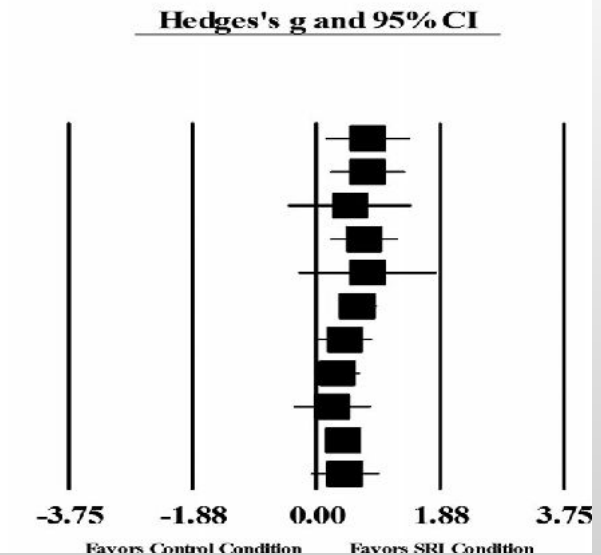
(McGuire et al., 2015)



Study name	Statistics for each study		
	Hedges's g	Lower limit	Upper limit
A			
Barrett et al. 2004	2.82	2.03	3.61
POTS, 2004b	1.06	0.51	1.61
Bolton & Perrin 2007	1.02	0.12	1.91
Freeman et al. 2008	0.49	-0.12	1.09
Williams et al. 2010	1.31	0.40	2.23
Bolton et al. 2011	1.45	0.87	2.02
Piacentini et al. 2011	0.38	-0.12	0.88
Storch et al. 2011	1.15	0.41	1.89
Lewin et al. 2014	1.62	0.82	2.42
Freeman et al. 2014	1.18	0.80	1.55



Study name	Statistics for each study		
	Hedges's g	Lower limit	Upper limit
B			
Flament et al. 1985	0.78	0.13	1.43
Leonard et al. 1989	0.78	0.20	1.36
March et al. 1990	0.51	-0.43	1.45
DeVaugh-Geiss et al. 1992	0.73	0.21	1.24
Riddle et al. 1992	0.78	-0.28	1.84
March et al. 1998	0.62	0.33	0.92
Geller et al. 2001	0.44	0.02	0.85
Riddle et al. 2001	0.31	-0.04	0.67
Liebowitz et al. 2002	0.24	-0.35	0.83
Geller et al. 2004	0.40	0.13	0.68
POTS, 2004a	0.43	-0.09	0.96



Cervin et al, 2023

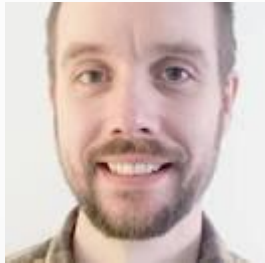
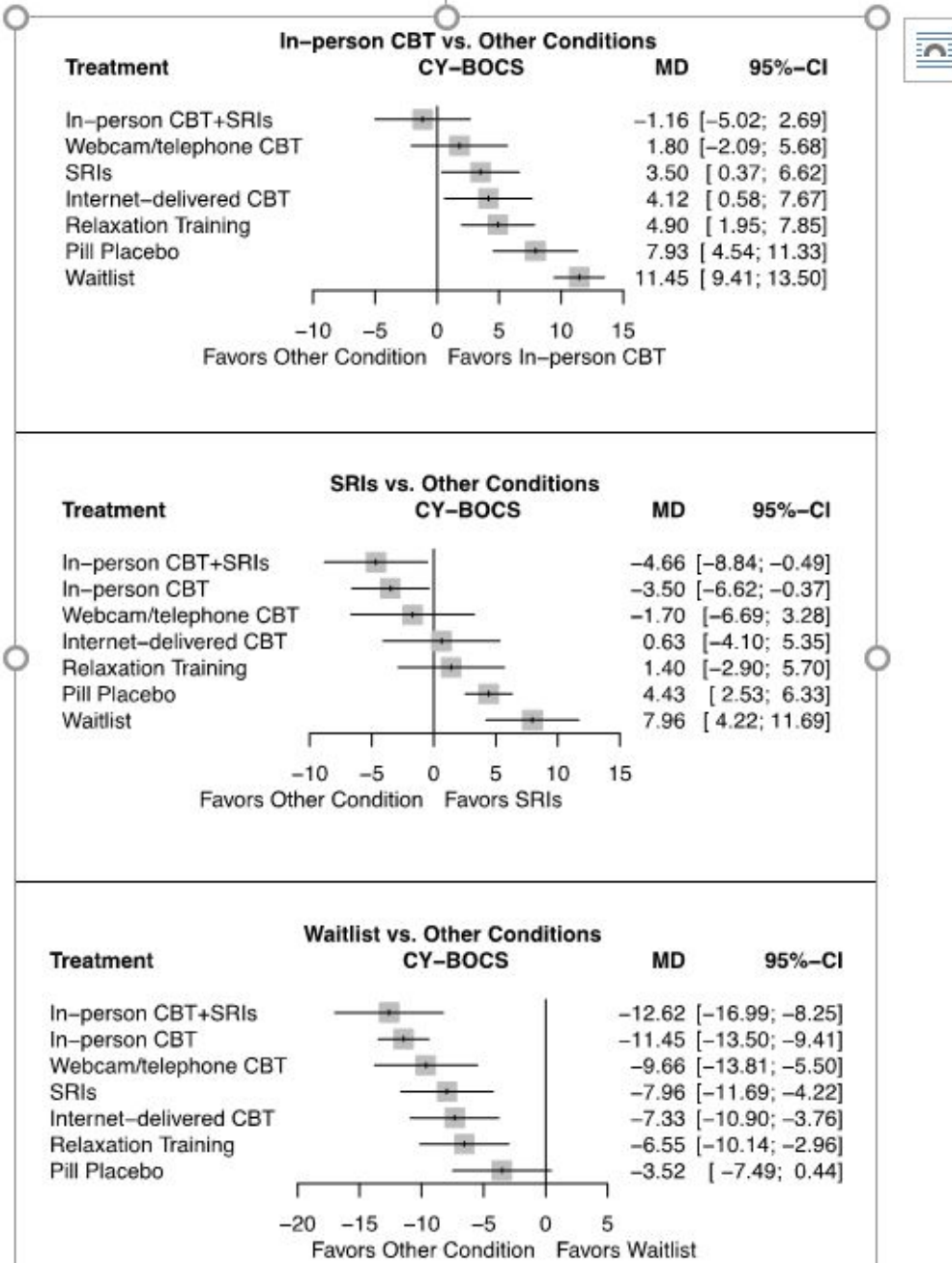


Figure 2. Effect comparisons for in-person CBT (top panel), SRIs (middle panel), and waitlist (bottom panel) for the CY-BOCS at post-intervention.



MD=mean difference (effect size)

But certainly not perfect...

11

Cognitive behavioural therapy with exposure and response prevention in the treatment of obsessive-compulsive disorder: A systematic review and meta-analysis of randomised controlled trials



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ARTICLE INFO

Keywords:

Cognitive behavioural therapy
Exposure and response prevention
researcher allegiance
Meta-analysis
Obsessive compulsive disorder

ABSTRACT

Background: Cognitive behavioural therapy (CBT), incorporating exposure and response prevention (ERP) is widely recognised as the psychological treatment of choice for obsessive-compulsive disorder (OCD). Uncertainty remains however about the magnitude of the effect of CBT with ERP and the impact of moderating factors in patients with OCD.

Aim: This systematic review and meta-analysis assessed randomised-controlled trials of CBT with ERP in patients of all ages with OCD. The study was pre-registered in PROSPERO (CRD42019122311). The primary outcome was end-of-trial OCD symptom scores. The moderating effects of patient-related and study-related factors including type of control intervention and risk of bias were examined. Additional exploratory analyses assessed the effects of treatment fidelity and impact of researcher allegiance.

Results: Thirty-six studies were included, involving 2020 patients (537 children/adolescents and 1483 adults) with 1005 assigned to CBT with ERP and 1015 to control conditions. When compared against all control conditions, a large pooled effect size (ES) emerged in favour of CBT with ERP ($g = 0.74$; 95% CI = 0.51 to 0.97; $k = 36$), which appeared to diminish with increasing age. While CBT with ERP was more effective than psychological placebo ($g = 1.13$; 95% CI 0.71 to 1.55, $k = 10$), it was no more effective than other active forms of psychological therapy ($g = -0.06$; 95% CI = 0.27 to 0.16, $k = 8$). Similarly, where CBT with ERP was significantly superior when compared to all forms of pharmacological treatment ($g = 0.36$; 95% CI 0.7 to 0.64, $k = 7$), the effect became marginal when compared with adequate dosages of pharmacotherapy for OCD ($g = 0.22$; 95% CI = 0.00 to 0.64, $k = 6$). A minority of studies ($k = 8$) were deemed to be at low risk of bias. Moreover, three quarters of studies ($k = 28$) demonstrated suspected researcher allegiance, and these studies reported a large ES ($g = 0.95$; 95% CI 0.60 to 1.2), while those without suspected researcher allegiance ($k = 8$) indicated that CBT with ERP was not efficacious ($g = 0.02$; 95% CI = 0.20 to 0.33).

Conclusions: A large effect size was found for CBT with ERP in reducing the symptoms of OCD, but depends upon the choice of comparative control. This meta-analysis also highlights concerns about the methodological rigour and reporting of published studies of CBT with ERP in OCD. In particular, efficacy was strongly linked to researcher allegiance and this requires further future investigation.

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E/RP Attrition and Drop Out



Attrition and Drop Out: State of the literature



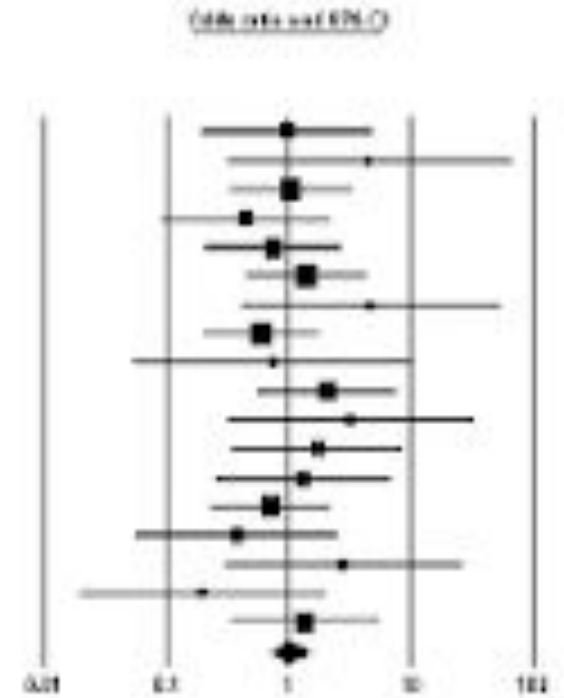
• Youth:

- Attrition rates were relatively low for ERP (10.24%) compared pharmacotherapy (17.29%), active control conditions (e.g., relaxation, meta-cognitive therapy, treatment-as-usual; 20.63%), pill placebo (23.95%) and waitlist conditions (4.5%).

• Adults:

- ERP dropout was 14.7% (24.6% in depression)
- Refusal rates 4.8% and 3.4%

Study, year	Comparison	Statistics for each study				
		Odds ratio	Lower 95% CI	Upper 95% CI	Z-Value	p-Value
Dunnkamp et al., 2011	CBT	1.001	0.181	5.241	0.003	1.000
Feldman et al., 1981	Waitlist	4.579	0.299	90.971	1.112	0.266
van Oort et al., 1992	ET	1.001	0.207	3.730	0.009	0.303
van Balkom et al., 1991	Waitlist	0.144	0.001	17.101	-0.001	0.997
Hasan et al., 2008	ERP+vsua	0.764	0.213	2.740	-0.413	0.680
Calamari et al., 2001	ET	1.301	0.143	4.232	0.071	0.285
Kochanska et al., 2001	ET	4.711	0.185	21.336	1.229	0.216
Poa et al., 2000	ERP+vsua	0.081	0.283	1.792	-0.010	0.985
Ullmann et al., 2006	Waitlist	0.718	0.059	10.771	-0.154	0.880
Ullmann et al., 2005	CBT	2.089	0.547	7.824	1.083	0.275
Levitt et al., 2006	ERP+vsua	3.182	0.570	22.130	0.981	0.327
Anderson & Rees, 2007	GroupCBT	1.729	0.340	9.796	0.669	0.511
Lee et al., 2007	ERP+vsua	1.313	0.259	6.880	0.394	0.691
Singh et al., 2009	ActiveControl	0.714	0.221	2.330	-0.071	0.480
Ullmann et al., 2008	ERP+vsua	0.381	0.069	2.230	-0.982	0.321
Salovey et al., 2006	GroupCBT	0.761	0.287	20.087	-0.087	0.930
Stephan et al., 2010	ERP+vsua	0.104	0.019	0.617	-1.309	0.171
Vanman et al., 2014	ET	1.301	0.337	5.427	0.417	0.670
		1.041	0.721	1.481	0.213	0.832



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Fig. 2. Forest plot for dropout rates of ERP vs. other conditions. Note: Higher odds ratios indicate greater likelihood of dropout in the ERP condition relative to the comparison condition.

Important to Challenge Existing Paradigms

- But, do so with equipoise and patience.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66*(1), 7–18. <https://doi.org/10.1037/0022-006X.66.1.7>

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REVIEW ARTICLE OPEN

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Barriers to clinical adoption of pharmacogenomic testing in psychiatry: a critical analysis

Catherine B. Wahlberg^{1,2,3}, Ajayash G. Sekhri^{1,2,4} and James L. Kennedy^{1,2,3}

in The Archives 2024

Pharmacogenomics (PGx) is the study of genetic influences on an individual's response to medications. Improvements in the quality and quantity of PGx research over the past two decades have enabled the establishment of commercial markets for PGx tests. Nevertheless, this testing has yet to be adopted as a routine practice in clinical care. Accordingly, policy regarding the commercialization and reimbursement of PGx testing is in its infancy. Several papers have been published on the topic of challenges or barriers in clinical adoption of this healthcare innovation. However, none do not include severe evidence from randomized controlled trials, economic utility studies, and qualitative assessments of stakeholder opinions. The present paper reports the most cited barriers to adoption of PGx testing: evidence for clinical utility, evidence for economic effectiveness, and stakeholder awareness. We consider these barriers in the context of reviewing PGx literature published over the past two decades and synthesize data from comments: PGx testing companies, where they have published the largest datasets. We conclude with a discussion of existing inhibitors to PGx testing and recommendations for progress.

Translational Psychiatry (2024) 13:1040 | <https://doi.org/10.1038/s41229-024-01600-7>

Things are getting strange

LETTERS TO THE EDITOR

Little Doubt That CBT Works for Pediatric OCD



To the Editor:

We write with great concern in response to the recent systematic review and meta-analysis of cognitive-behavioral therapy (CBT) in pediatric obsessive-compulsive disorder (OCD) by Ullrich et al.¹ Although the authors' main conclusion supports the clinical efficacy of CBT for pediatric OCD, we regret that much like ourselves, readers will be confused by the discussion and inappropriate conclusions that they present. These conclusions stem from the authors' application and interpretation of their particular qualitative methods, which could lead to inappropriate conclusions (eg, parents, patients, clinicians, and patients) to wrongly discount clear evidence for what is known to be the best evidence-based therapy for pediatric OCD.

Across nearly 20 randomized controlled trials (RCTs) of pediatric OCD conducted around the world, CBT has produced consistently large effect sizes (Hedges' $d = 0.82$)^{2,3} with low risk of bias and lower attrition rates than any other psychological or pharmacological approach.⁴ Even when these findings were subjected to stringent sensitivity analysis, Ullrich et al.¹ still replicated previous findings that CBT demonstrated a large effect size. Further, the fact that all participants in the OCD studies enrolled in active intervention (ie, CBT versus relaxation therapy) and that all outcome measures were blinded should mitigate concerns about overall risk of bias, especially given the low risk effect associated with CBT, which also serves to minimize measurement bias.

We were therefore surprised to see Ullrich et al.¹ conclude that they are "very uncertain about the effect compared" produced by CBT. Our main concern with their evaluation of the evidence is their problematic application of qualitative approaches to the quantitative clinical trial data. The Cochrine risk of bias tool by the authors is known to be unreliable, a fact that was not acknowledged as a limitation. Indeed, a new strategy to address widely recognized problems was recently released.⁵ For example, the main issue Cochrine review on pediatric OCD rated the Pediatric OCD 239 treatment study (POTS) study as low overall risk of bias, while the approach used by Ullrich et al.¹ used POTS as

having a high risk of bias. Furthermore, the authors' approach carries risk of bias with regards to bias. A study rated at high risk of bias could show bias that influences results 19% or 100%, but given that their sensitivity analysis showed little difference despite a very stringent sensitivity position, the large effects observed appear to be robust.

We also highlight inappropriate use of grading of Recommendations Assessment, Development and Evaluation criteria. Ullrich et al.¹ rate the certainty of evidence for CBT efficacy versus no intervention as low, which corresponds to "a large enough difference that it might have an effect on a decision."⁶ However, it is highly unlikely that comparing those with existing studies would impact the status of CBT as a gold standard intervention, given that the authors' sensitivity analysis returned similar conclusions to the original analysis, and CBT efficacy is supported by both definitive meta-analysis and large trials that are rated at low risk of bias by authoritative sources.

We were also struck by the reportedly narrow focus of Ullrich et al.¹ study of 29 studies (6/26 included), including no CBT, CBT as well as pharmacotherapy only trials. In addition, some of the included CBT studies were inappropriately grouped despite clinically different protocols (eg, versus CBT groups with minimal in-person contact and treatment dose). Furthermore, we were confused that Ullrich et al.¹ seem to suggest that CBT may have significant risk effect in children. Our data and review suggest that adverse events happened in less than 0.05% of treated cases,⁷ which would be clinically common in this pediatric cohort.

In short, Ullrich et al.¹ bias their conclusions on a flawed process. They rely on unreliable qualitative methods, which they subsequently and inappropriately, if their approach were adopted broadly, clinicians would be effectively prevented from recommending their patient evidence-based therapies. Indeed, their conclusions could permit us to unfairly deny domains of pediatric and most cases of medicine. For example, Ullrich et al.¹ highlighted cognitive problems with participatory bioterror. Yet, many medical procedures that are considered a low risk for bias are similarly difficult to blind, such as medication trials in which common side effects may lead to unblinding or other surgical interventions when blinding is not possible.

LETTERS TO THE EDITOR

This work by Ullrich et al.¹ raises several other key questions and concerns. What burden of proof do we require to establish a treatment as recommended? Moreover, when damage is done when a published, peer-reviewed article diminishes the overwhelming weight of the past 15 years of cumulative evidence from RCTs designed to promote rational science? The quality of research in CBT that we observe that is many areas of biomedicine. Virtually all OCD investigators have achieved consensus regarding the efficacy of CBT for pediatric OCD and its place as a frontline intervention.^{8,9,10} Certainly, the highest priority for research and practice as well as the most pressing challenge we face in reducing OCD burden in the community is increasing the dissemination and implementation of treatments that work. To support this, our doubts on the evidence base could reduce chances of dissemination of one of the best tools currently at our disposal, to the detriment of children and families. Yet, flawed operationalization of the risk of bias and Grading of Recommendations Assessment, Development and Evaluation tools and a narrow scope of studies reviewed unquestionably will not question well-established and empirically supported practice.

Our group of clinician reviewers first completed to report because the risks are high. The meta-analysis by Ullrich et al.¹ presents grave potential harm to children and families because it employs an approach that misrepresents the state of the evidence, in an era where there are unlikely to be additional RCTs of CBT relative to other interventions for OCD. Ullrich et al.¹ state studies are "unclear" their flawed findings have the potential to draw clinicians from using treatments that work, reduce child-parent support for existing necessary care, and cause ongoing and unnecessary stress burden for children and families. We appreciate the authors' willingness to take a clear look at its evidence base supporting CBT, but to arrive at disparate conclusions via questionable methods is perhaps more problematic than they realize. As Ullrich summarizes, "This paper is the enemy of the good," and in this case, seeking the good or evidence is reinforced by 1) poor of diagnostic accuracy – they used parents' reports who have no perfect option available to them from assessing a treatment likely to provide substantial and lasting relief.

Eric A. Storch, PhD
David J. Finkel, PhD
Alexander B. Nevo, PhD
Julia P. Fombonne, PhD
Michael Altsch, MD

Mark Gillies, PhD
Joseph McGuire, PhD
David J. Finkel, PhD
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Susan Ann Wagner, PhD
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Kate D. Fergusson, MD
Wayne C. D'Arment, MD

Author Disclosures

The authors, advisors, authors, and reviewers are affiliated with the College of Physicians (University of Pennsylvania) and the University of Pennsylvania School of Medicine (University of Pennsylvania) and the University of Pennsylvania School of Medicine (University of Pennsylvania). Dr. Storch is affiliated with the University of Pennsylvania School of Medicine (University of Pennsylvania). Dr. Finkel is affiliated with the University of Pennsylvania School of Medicine (University of Pennsylvania). Dr. Nevo is affiliated with the University of Pennsylvania School of Medicine (University of Pennsylvania). Dr. Fombonne is affiliated with the University of Pennsylvania School of Medicine (University of Pennsylvania). Dr. Altsch is affiliated with the University of Pennsylvania School of Medicine (University of Pennsylvania).

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3. Fergusson KD, Fergusson KD, Fergusson KD, et al. Cognitive-behavioral therapy for pediatric obsessive-compulsive disorder: a systematic review and meta-analysis. *JAMA Psychiatry*. 2018;175(11):1001-1010.
4. Fergusson KD, Fergusson KD, Fergusson KD, et al. Cognitive-behavioral therapy for pediatric obsessive-compulsive disorder: a systematic review and meta-analysis. *JAMA Psychiatry*. 2018;175(11):1001-1010.
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6. Fergusson KD, Fergusson KD, Fergusson KD, et al. Cognitive-behavioral therapy for pediatric obsessive-compulsive disorder: a systematic review and meta-analysis. *JAMA Psychiatry*. 2018;175(11):1001-1010.
7. Fergusson KD, Fergusson KD, Fergusson KD, et al. Cognitive-behavioral therapy for pediatric obsessive-compulsive disorder: a systematic review and meta-analysis. *JAMA Psychiatry*. 2018;175(11):1001-1010.
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10. Fergusson KD, Fergusson KD, Fergusson KD, et al. Cognitive-behavioral therapy for pediatric obsessive-compulsive disorder: a systematic review and meta-analysis. *JAMA Psychiatry*. 2018;175(11):1001-1010.

“Why Can't We Be Friends?” - War



<https://youtube.com/clip/UgkxVf87R65Uy0gj7-cUxZ7wrum0EgaRgdZO>

The background is a complex marbled paper pattern with swirling veins of orange, teal, and grey. A large, semi-transparent orange circle is positioned on the right side of the image, containing the text.

ACT

Michael Twohig, PhD



Acceptance And Commitment Therapy for OCD

Michael P. Twohig, Ph.D.

Professor

Utah State University



Disclosures

1. Research: Ream Foundation
2. Royalties: Oxford University Press, New Harbinger, Praxis CET

What is ACT?

1. Model of psychotherapy not a protocol
2. Processes based intervention
3. Broad applicability
 - a. Including within OCD and related disorders

Journal of Contextual Behavioral Science 18 (2020) 181–192

Contents lists available at [ScienceDirect](#)

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Journal of Contextual Behavioral Science

journal homepage: www.elsevier.com/locate/jcbs



Review Articles

The empirical status of acceptance and commitment therapy: A review of meta-analyses[☆]

Andrew T. Gloster^{a, *}, Noemi Walder^a, Michael E. Levin^b, Michael P. Twohig^b, Maria Karekla^c

^a University of Basel, Division of Clinical Psychology and Intervention Science, Switzerland
^b Utah State University, U.S.A
^c University of Cyprus, Cyprus



Support for the model

- Psychological Inflexibility predicts OCD, $r=.36$



Contents lists available at ScienceDirect

Journal of Obsessive-Compulsive and Related Disorders

journal homepage: www.elsevier.com/locate/jocrd



Experiential avoidance in the context of obsessions: Development and validation of the Acceptance and Action Questionnaire for Obsessions and Compulsions



Ryan J. Jacoby^{a,b,*}, Jonathan S. Abramowitz^a, Jennifer Buchholz^a, Lillian Reuman^a, Shannon M. Blakey^a

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^b Massachusetts General Hospital / Harvard Medical School, 185 Cambridge St, Boston, MA 02114, United States

Journal of Contextual Behavioral Science 12 (2019) 234–242



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Journal of Contextual Behavioral Science

journal homepage: www.elsevier.com/locate/jcbs



Empirical research

Assessing psychological inflexibility in hoarding: The Acceptance and Action Questionnaire for Hoarding (AAQH)



Jennifer Krafft^{*}, Clarissa W. Ong, Michael P. Twohig, Michael E. Levin

Psychiatry Research 220 (2014) 356–361



Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres



Measuring the role of psychological inflexibility in Trichotillomania



David C. Houghton^a, Scott N. Compton^b, Michael P. Twohig^c, Stephen M. Saunders^d, Martin E. Franklin^e, Angela M. Neal-Barnett^f, Laura Ely^g, Matthew R. Capriotti^h, Douglas W. Woods^{a,*}

^a Department of Psychology, Texas A&M University, 4235 TAMU, College Station, TX 77843, USA

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^c Department of Psychology, Utah State University, Logan, UT, USA

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^e Department of Psychiatry, Perelman School of Medicine, University of Pennsylvania, Philadelphia, PA, USA

Journal of Anxiety Disorders 28 (2014) 612–624

Contents lists available at ScienceDirect

Journal of Anxiety Disorders

Review

Acceptance and commitment therapy for anxiety and OCD spectrum disorders: An empirical review

Ellen J. Bluett, Kendra J. Homan, Kate L. Morrison, Michael E. Levin, Michael P. Twohig^{*}

Utah State University, United States



Psychiatry Research 220 (2014) 356–361

Contents lists available at ScienceDirect

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Measuring the role of psychological inflexibility in Trichotillomania

David C. Houghton^a, Scott N. Compton^b, Michael P. Twohig^c, Stephen M. Saunders^d, Martin E. Franklin^e, Angela M. Neal-Barnett^f, Laura Ely^g, Matthew R. Capriotti^h, Douglas W. Woods^{a,*}




^a Department of Psychology, Texas A&M University, 4235 TAMU, College Station, TX 77843, USA

^b Department of Psychiatry and Behavioral Sciences, Duke University School of Medicine, Durham, NC, USA

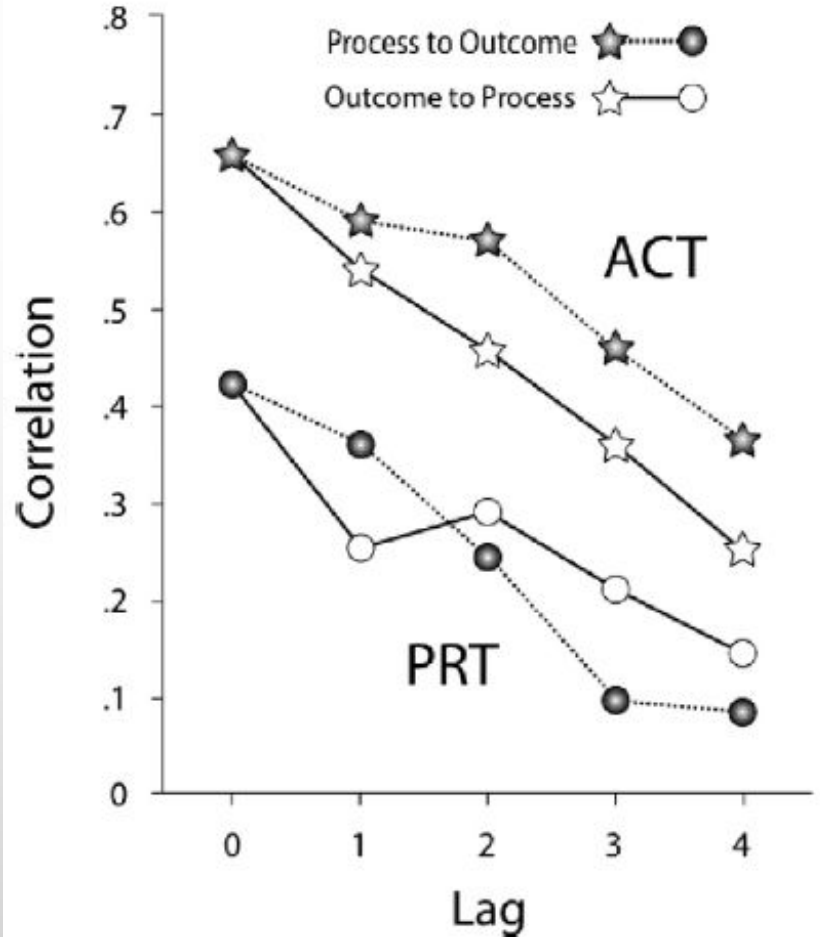
^c Department of Psychology, Utah State University, Logan, UT, USA

^d Department of Psychology, Marquette University, Milwaukee, WI, USA

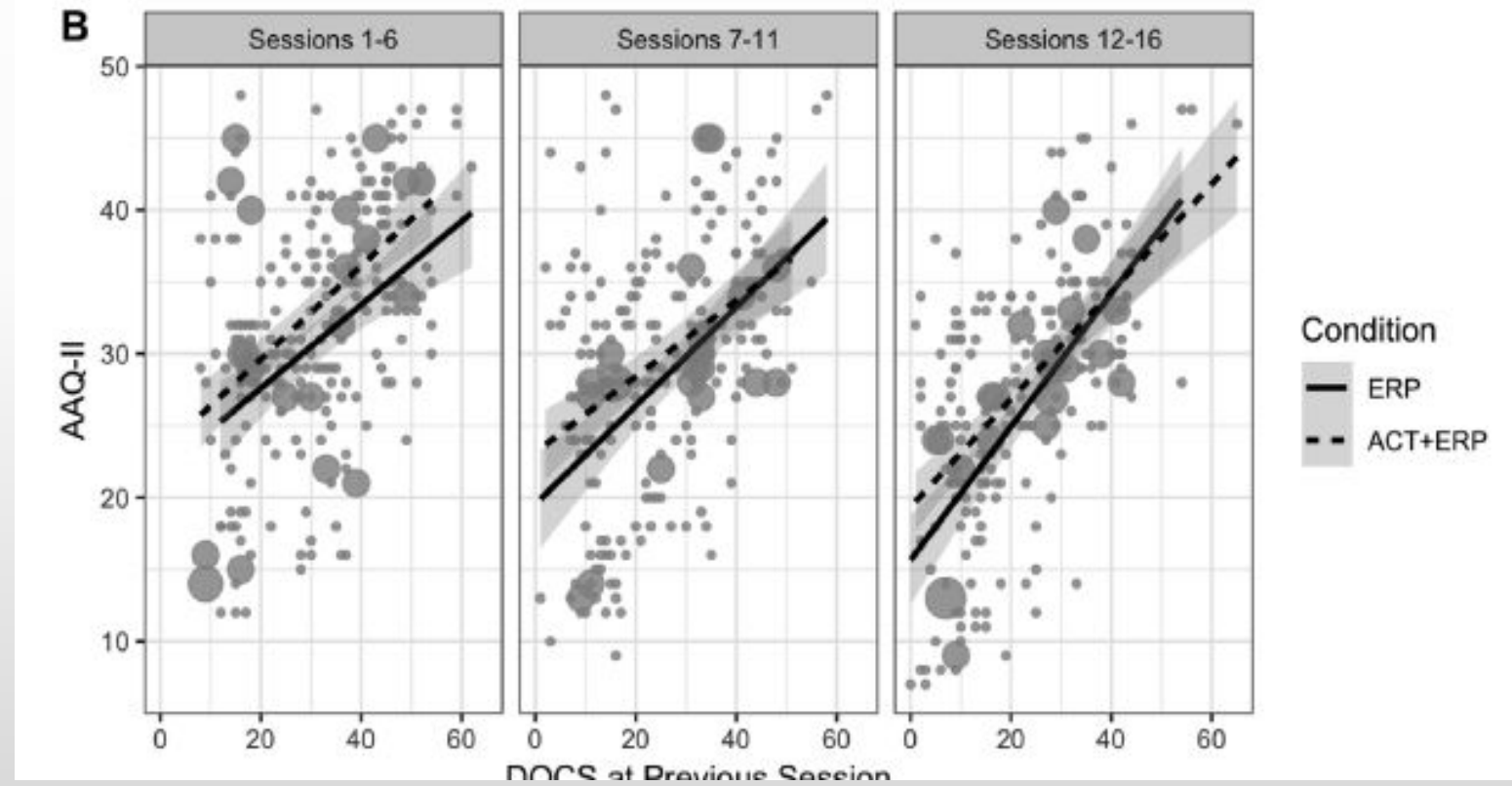
^e Department of Psychiatry, Perelman School of Medicine, University of Pennsylvania, Philadelphia, PA, USA



Is Psychological Flexibility a relevant Process?

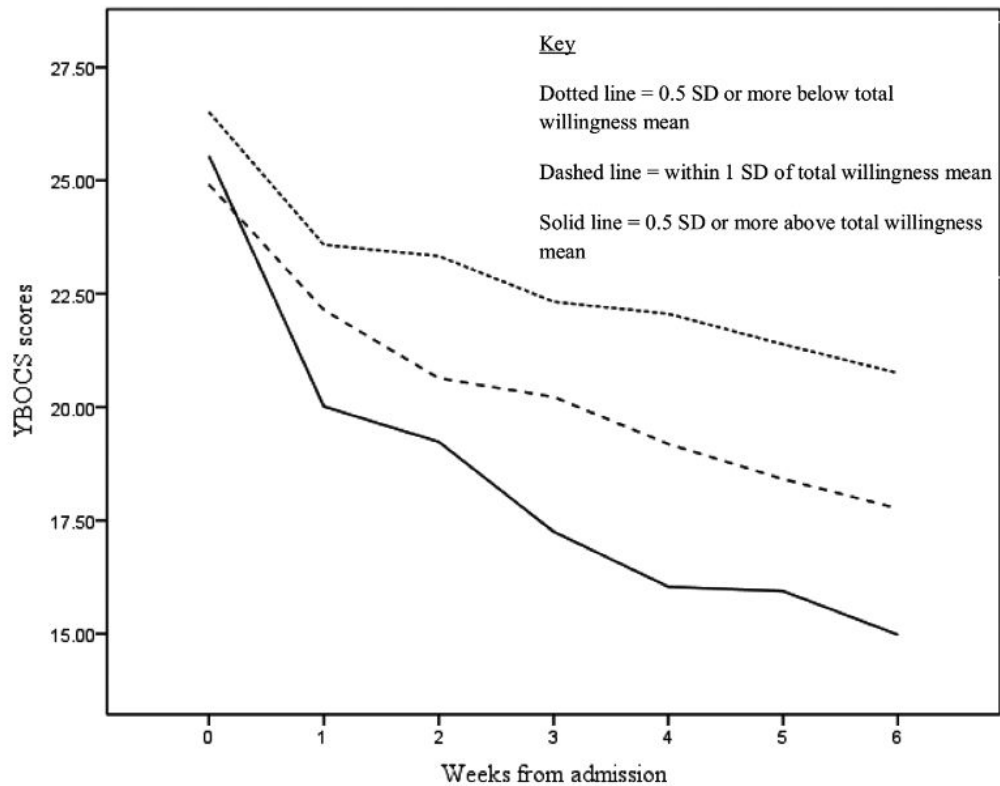


Twohig et al., 2015



Ong et al., 2020

Relevant across Interventions



Reid et al, 2017



Contents lists available at ScienceDirect

Journal of Contextual Behavioral Science

journal homepage: www.elsevier.com/locate/jcbs



The “how” of exposures: Examining the relationship between exposure parameters and outcomes in obsessive-compulsive disorder

Clarissa W. Ong^{a,b,*}, Julie M. Petersen^a, Carina L. Terry^a, Jennifer Krafft^a, Jennifer L. Barney^a, Jonathan S. Abramowitz^c, Michael P. Twohig^a

^a Utah State University, Logan, UT, USA

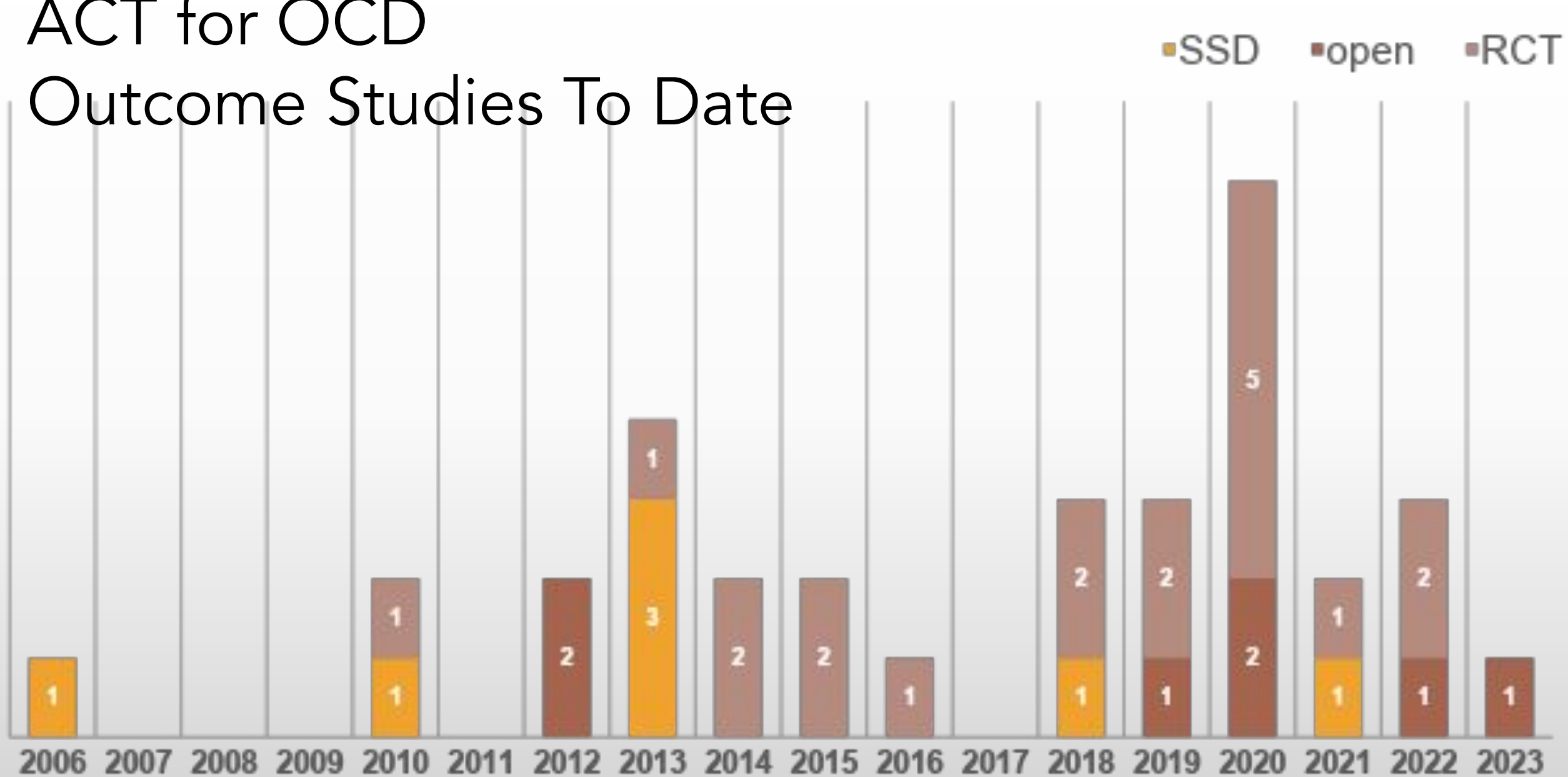
^b Center for Anxiety and Related Disorders, Boston University, Boston, MA, USA

^c University of North Carolina at Chapel Hill, Chapel Hill, NC, USA

- Solid delivery of acceptance/tolerance model was associated with more homework, less inflexibility, and lower OCD.

ACT for OCD

Outcome Studies To Date



SSD=Single Subject Design, RCT=Randomized Controlled Trial



Review

Acceptance and commitment therapy for anxiety and OCD spectrum disorders: An empirical review



Ellen J. Bluett, Kendra J. Homan, Kate L. Morrison, Michael E. Levin, Michael P. Twohig*

Utah State University, United States



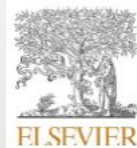
Review

Acceptance and commitment therapy in the treatment of Obsessive-Compulsive Disorder: A systematic review

Joel Philip^{a,*}, Vinu Cherian^b

^a Neurocenter Kochi, India

^b Department of Community Medicine, Sree Narayana Institute of Medical Sciences, Chalakka, Kochi, India



The current status of acceptance and commitment therapy (ACT) in Iran: A systematic narrative review

Mehdi Akbari^{a,*}, Mohammad Seydavi^a, Carter H. Davis^b, Michael E. Levin^b, Michael P. Twohig^b, Elahe Zamani^a

^a Department of Clinical Psychology, Faculty of Psychology, Kharazmi University of Tehran, No.43. South Mofatteh Ave., Tehran, Iran

^b Department of Psychology, Utah State University, Logan, USA



A Systematic Review of the Use of Acceptance and Commitment Therapy (ACT) to Treat Adult Obsessive-Compulsive Disorder (OCD)

[Kelsey J. Evey](#) , [Shari A. Steinman](#)

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<https://doi.org/10.1016/j.beth.2022.02.009> ↗

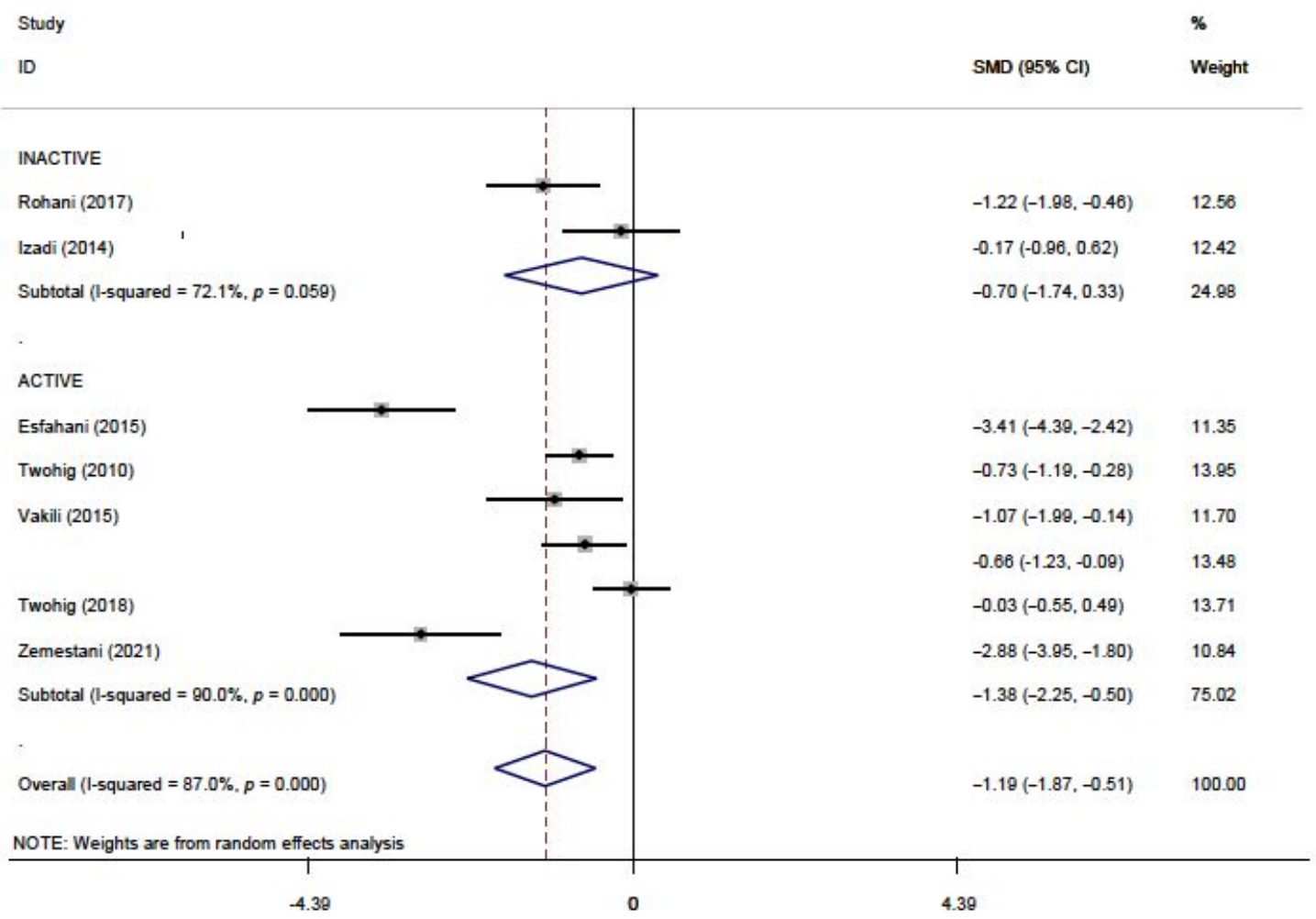
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Review
The Applicability of Acceptance and Commitment Therapy for Obsessive-Compulsive Disorder: A Systematic Review and Meta-Analysis

Tamini Soondrum ^{1,2}, Xiang Wang ^{1,2,3} , Feng Gao ^{1,2,3}, Qian Liu ^{1,2,3}, Jie Fan ^{1,2,3} and Xiongzhaoh Zhu ^{1,2,3,*}

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² Medical Psychological Institute of Central South University, Changsha 410011, China
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 * Correspondence: xiongzhaohzhu@csu.edu.cn; Tel.: +86-135-7485-232

SMD=standardized mean difference (effect size)



Limitations

- Unfunded projects
 - Small sample size
 - Poor designs in some

Strengths

- Theory based
- Supported across disorders
- Process of change based

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I-CBT

Molly Martinez, PhD

Origins & Theory of I-CBT

Inference-Based Model

- Designed specific to OCD thought process
- Developed specifically to treat OCD
- Inference-based model
 - Inferential confusion
 - Feared-self

I-CBT: Publication Type & Timeline

<https://icbt.online/publications/>

2023 - 4 theoretical papers (feared self, etc)

2022 – 1 multi-center RCT of ICBT paper; 6 papers on theoretical concepts, assessment

2021 – 7 papers on theoretical concepts

2020 – 1 paper on Spanish language questionnaire, 11 theoretical papers

2019 – 6 papers on theoretical concepts

2018 – 3 theoretical paper; 1 psychometric study of questionnaire

2017 – 1 open trial of ICBT across subtypes of OCD paper; 1 theoretical paper

2016 – 1 open trial of ICBT for hoarding paper; 1 literature review, 2 theoretical papers

2015 – 1 RCT comparing “IBA” v CBT in OCD with poor insight, 1 German translation of questionnaire, 1 study of ICBT self-help, 5 theoretical papers

...

2009 – 1st conceptual & empirical basis for “an inference-based approach”

Theoretical Basis of I-CBT: Inferential Confusion

Construct	Studies
Inferential Confusion – predicts OC Sx independent of other cognitive domains & mood	Emmelkamp & Aardema, 1999 Aardema et al 2006, 2018 Goods et al, 2014 Wu et al, 2018
Task-based measures of Inferential Confusion	Aardema et al., 2009 Wong et al, 2016 Baraby, 2021a, 2021b
Inferential Confusion Elevated in OCD	Baraby, 2016
Inferential confusion as mechanism for change	Aardema, 2005, 2011, 2017 Baraby et al, 2007

Theoretical Basis of I-CBT: Feared Self

Construct	Studies
Feared self-perception theme of dangerousness predicts OC Sx in clinical & non-clinical samples	Aardema et al, 2013 Nikodijevic et al, 2013 Aardema et al, 2021 Melli et al, 2015
Repugnant obsessions score higher on feared self-perceptions than eating d/o, BDD, depression or anxiety	Aardema et al, 2017
Reduction in feared self through tx associated with improvement in repugnant & contamination obsess.	Aardema et al, 2018
Manipulating feared self perception by increasing intensity associated with increased intensity of obsessions	Sauvaguea et al, 2020

I-CBT Case Series

Author	Study Aim	Study Design	Outcome Measures (% Reduction per subject)
Van Niekerk et al, 2014	Integrate I-CBT into CBT Test the I-CBT manual (van Niekerk et al, 2009)	Qualitative N=3	YBOCS (52%, 100%, 97%) OCI-Revised (77%, 89%, 95%) OBQ-44 (17%, 64%, & 61%) DASS-21 (0%, 68%, 65%)

I-CBT Protocol Studies

Author	Study Aim	Study Design	Significance/Effect Size
Taillon, O'Connor, et al, 2011	20 wk I-CBT for BDD	N=10 BDD-YBOCS & BDI-II reduction Not compared to CBT	BDD-YBOCS: $d=2.9$ BDI-II: $d=1.5$
Moritz et al 2015	Self-help with I-CBT	N=37 I-CBT (n=17) Control (n=21)	YBOCS: $p = 0.047$
Blais et al 2017	20 wk I-CBT for hoarding	N-17 VOCI-Hoarding YBOCS Beck Anxiety Inventory (BAI)	VOCI-H: $p < .001$ YBOCS: $p < .001$ BAI: $p < .05$

I-CBT: RCTs

Study Design & Result	Author	Significance (Effect size)
RCT: I-CBT v CBT w/ERP, N=44 20 wks in one tx arm Similarly effective I-CBT better with overvalued ideation	O'Connor, Aardema, et al, 2005	No significant difference b/t groups
Open Trial, N=125 Waitlist control YBOCS outcome measure I-CBT effective on all subtypes of OCD I-CBT better with overvalued ideation	Aardema, O'Connor, et al, 2017	<.001 (1.49 to 2.53)
Multicenter RCT, N=90 24 wks tx I-CBT (n=47) or CBT (n=43) OCD with poor insight	Visser et al, 2015	No significant difference b/t groups
Multicenter RCT: I-CBT (n=38) v Mindfulness (n=34) v appraisal-based CBT (n=39)	Aardema et al, 2022	No significant differences in YBOCS b/t groups

Summary: I-CBT

- Large body of work on theoretical basis of I-CBT (inferential confusion, feared-self)
- >100 peer-reviewed articles over 28-years
- Most have been theoretical, experimental, psychometric
- 4 published open trials/RCTs
- Evidence-based practice, likely does not meet EST standards
- Two RCTs and non-inferiority trials are ongoing

Summary: I-CBT

- RCTs from two separate labs
 - Frederick Aaredema, OCD-RL in the Montreal Mental Health University Institute Research Centre
 - Henny Visser, Innova Research Centre in the Netherlands
- All RCTs have compared I-CBT to CBT with ERP
- OCD, poor insight, over-valued ideation
- BDD, hoarding
- Self-help

Advantages

- Theory based, specific to OCD
- Evidence for non-inferiority to ERP
- Alternative for ERP non-responders/refusers, or patients whose values conflict with ERP
- Good results with overvalued ideation
- Ongoing RCTs

Limits/Concerns

- Larger body of research for theory than procedure
- Small sample sizes
- Need replication studies (research is only from 2 labs)
- Not demonstrated to be better than ERP
- Concern that dissemination may be outpacing established efficacy

Resources on I-CBT Research

- I-CBT website
 - <https://icbt.online/publications/>
- Dr Frederick Aardema – Research Overview
 - <https://www.youtube.com/watch?v=2VTuqb9ZHBY>

Bibliography Inference-based Cognitive-Behavioral Therapy (I-CBT)

The current bibliography contains all peer-reviewed scientific publications related to I-CBT that we are aware of. If you know of any others, contact us and we'll add it to the list.

2023

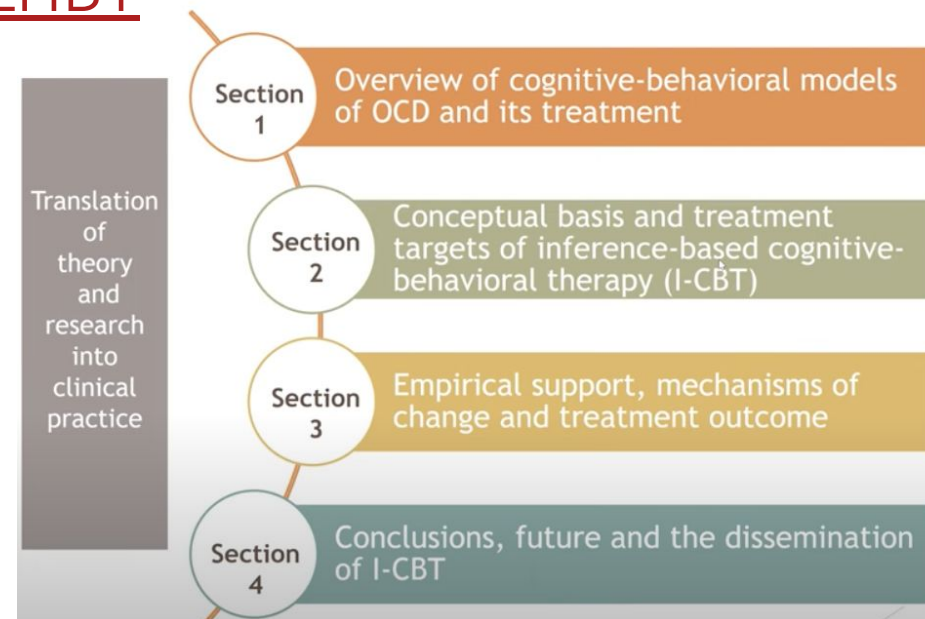
Ashoori, M. & Bazzazian S. (2023). The Mediating Role of Fear of Self in the Relationship between Insecure Attachment Styles and Obsessive Beliefs in a Non-Clinical Population. *Studies in Medical Sciences*, 33, 749-759. [View](#)

Audet, J-S, Kheloui, S, Jacmin-Park, S, Gravel, C., Juster, R.P. & Aardema, F. (2023). COVID-19 related stress and fears of contamination: The implications of feared self-perceptions. *Current Psychology*, 12, 1-12. [View](#)

Baraby, L-P., Bourguignon, L., & Aardema, F. (2022). The relevance of dysfunctional reasoning to OCD and its treatment: Further evidence for inferential confusion utilizing a new task-based measure. *Journal of Behavior Therapy and Experimental Psychiatry*, 101728. [View](#)

Ouellet-Courtois, C., Audet, J-S, & Aardema, F. (2023). The COGINS: A New Measure of Cognitive Insight in Obsessive-Compulsive and Related Disorders.

Topics and themes



Key Questions

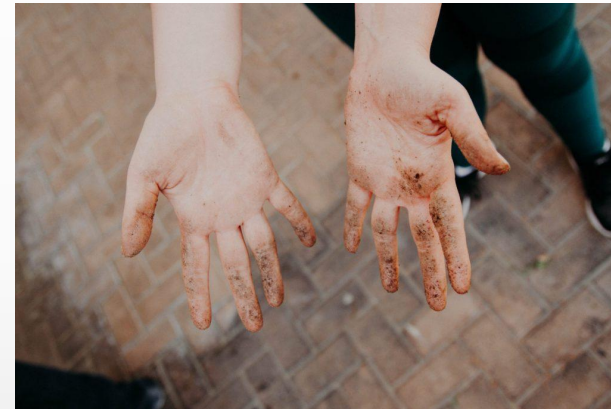
- *Can't we all just get along?*
- Is there a good decision tree in OCD treatment selection?
 - Fail or refuse ERP first?
 - Should ACT and I-CBT be considered first-line OCD tx?
- How can theories/components of models be incorporated?
 - Inference-based model with appraisal-based CBT (van Neikerch et al, 2014)
 - Feared-self or inferential confusion w/ERP?
- How do we train therapists new to treating OCD?
 - Should ERP be a pre-requisite?
- How do we factor in...
 - Clinical expertise/training & patient characteristics
 - Clinician professional/personal (lived) experience
 - Accessibility to OCD treatment

The background is a traditional marbled paper pattern with swirling, organic shapes in shades of orange, teal, and cream. A large, semi-transparent orange circle is positioned on the right side of the image, serving as a backdrop for the text.

Wisdom & Perspective

Jonathan Abramowitz,
PhD

Treatments used for OCD: Criteria and Mechanisms



Treatments used for OCD: Criteria and Mechanisms

- These treatments “work” on a variable interval reinforcement schedule
- Why?
- What contributes to placebo effects
 - Patient hope
 - Credibility of the intervention
 - Provider allegiance
- Allegiance effects in treatment research
- ERP research has been plentiful and very consistent
- The bar for is extremely high in OCD treatment research... and it should be



Conditioning and Extinction are “a Thing”

- The 2-factor theory of fear maintenance (Mowrer, 1947)
- Solomon et al. (1940s and 50s) fear extinction paradigm
- They were researching behavioral principles, not trying to treat OCD
- Vic Meyer, James G. Taylor, Rachman, Marks applied ERP to people with OCD 1960s and 70s because psychoanalysis didn't work
- Conditioning and extinction are scientific facts—there's no debate
- Exposure therapy works to reduce pathological fear—no debate

Behav. Res. & Therapy, 1966, Vol. 4, pp. 273 to 280. Pergamon Press Ltd. Printed in England

MODIFICATION OF EXPECTATIONS IN CASES WITH OBSESSIONAL RITUALS

V. MEYER

Academic Department of Psychiatry Middlesex Hospital Medical School, London

(Received 6 May 1966)

Summary—Some theoretical issues in relation to the nature of obsessional rituals and the most commonly adopted method of behaviour therapy for this disorder are critically considered. On the basis of these con-

fear extinction is essentially a cognitive process (Craske et al.)

- Experience is the best teacher

Adapted by Bronwyn Shroyer from: O'Connor, K., & Aardema, F. (2012).
Clinician's handbook for obsessive compulsive disorder: Inference-based
therapy. Chichester: Wiley-Blackwell.

Module 8 Practice:

Step 1: When a doubt or obsession occurs that takes you beyond the senses, hold still and imagine yourself between worlds – a bridge between reality and the imagination.

Step 2: Focus your attention back on reality, and look at what is there without effort.


Step 3: Look down the bridge between worlds and take note of any feeling that you might not be doing enough. It is the void left behind by not engaging in any rituals.

Step 4: Realize this void is imaginary, and that there is certainty in the world of the senses. Try to feel that ground under your feet. It is common sense.


Step 5: Act on the knowledge from your senses by dismissing the obsession and not engaging in any compulsive behaviors.



- Allegi
- Cogni
- Cog
- Behav
- "Ex



**Face The Things
You Fear**

The image features a background of marbled paper with intricate, swirling patterns in shades of orange, teal, and cream. A large, solid orange circle is positioned on the right side of the frame. Inside this circle, the text "Audience Q&A" is written in a clean, white, sans-serif font, centered vertically and horizontally.

Audience Q&A

The image features a background of marbled paper with intricate, swirling patterns in shades of orange, teal, and cream. A large, solid orange circle is positioned on the right side of the frame. Inside this circle, the word "Conclusions" is written in a clean, white, sans-serif font, centered horizontally and vertically.

Conclusions

Conclusions

- Understanding empirical research is vital to EBP & Tx selection
- Must also consider clinician expertise, client characteristics, & client autonomy
- Current Best Practice for OCD: CBT + ERP (always *evolving*)
- Important to develop new & better treatments; can't always wait for science
- We share common goals & values
 - Want to help patients
 - Invested and passionate
- Ethics, Respect, Humility: with patients & within our community & with professionals outside the OCD community

**She
doesn
't
even
go
here!**

**You
can't
sit
with
us!**

**On
Wednes
days
we wear
pink.**

**Respect. Humility. Ethics.
Don't be Mean Girls.**





THANK YOU!



<https://youtube.com/clip/UgkxVf87R65Uy0gj7-cUxZ7wrum0EgaRgdZO>

The image features a background of marbled paper with intricate, swirling patterns in shades of orange, teal, and cream. A large, solid orange circle is positioned on the right side of the frame. Inside this circle, the text "Extra Slides" is written in a clean, white, sans-serif font.

Extra Slides

Research Methods: Correlation

To what degree is a change in one variable associated with a change in another variable?

- Measures the strength of a linear relationship between two variables
- Represented as r (Pearson Product) [or also ρ (Spearman)]
- Coefficient r (ranges from -1 to +1)
 - $r = 1$ is a perfect positive correlation
 - $r = -1$ is a perfect negative correlation
 - $r = 0$ means essentially no relationship
- Correlation does not equal causation

Research Methods: Significance

Is the treatment group significantly better than the comparison group (placebo/waitlist control or another active treatment)?

How likely is it that this finding occurred by chance?

- p-value (set by investigator, smaller is better; $p < .01$)
- **$p < .01$** means: If you ran the study 100 times you are statistically likely to get the same result 99 times

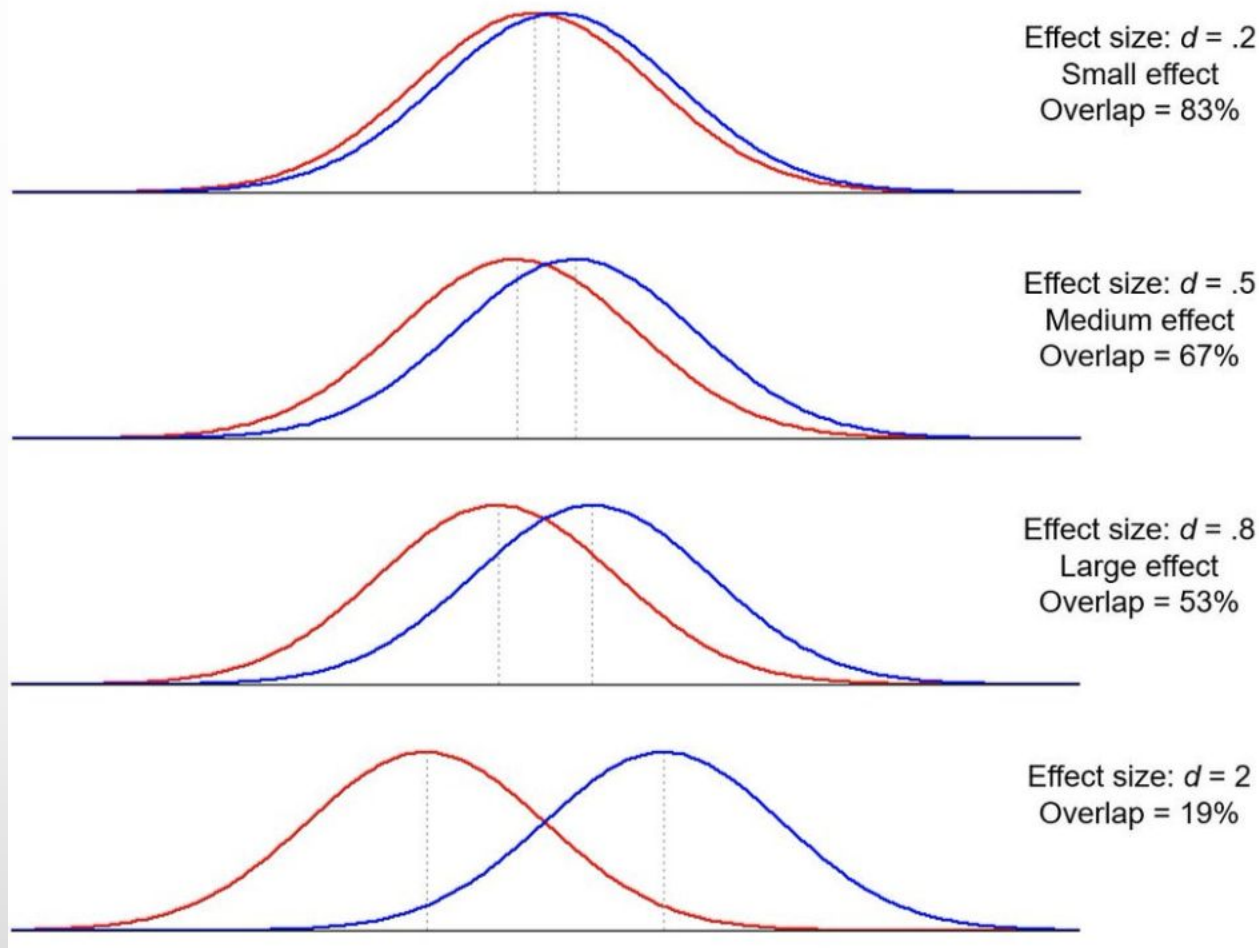
Research Methods: Effect Size

How large are the differences between the two groups?

How much more effective is the treatment than the control?

- Standardized Mean Difference (eg, SMD, MD, Cohen's d , Hedges' g)
 - ≤ 0.2 is trivial
 - ≥ 0.5 is moderate
 - ≥ 0.8 is large
 - Note: other types of effect sizes are interpreted differently

Understanding Effect Sizes



Effect Size
(SDs of ave. person in Group 1 above ave. person in Group 2)

Percentage of Group 2 who would be below average person in Group 1

0.0 50%

0.2 58%

0.4 66%

0.6 73%

0.8 79%

1.0 84%

1.4 92%

1.6 95%

1.8 96%

2.0 98%

2.5 99%

3.0 99.9%

Statology, Effect Size: What It Is and Why It Matters,

<https://www.statology.org/effect-size>

Effect Size in Statistics,
<https://loonylabs.org/2021/03/01/effect-size-in-statistics/>