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Neuroimaging studies have implicated a relationship between skin picking disorder and structural abnormalities within the brain. This study was the first to evaluate the association between neurocognitive function and structural abnormalities in the neural structures, specifically with those who have a primary diagnosis of skin picking disorder (SPD).

Men and women between the ages of 18-65 years old were recruited for this study. The main criteria of participants with SPD was a current diagnosis of SPD, engagement in skin picking behaviors for at least 30 minutes a day consistently during the past 12 months and a score of >16 on the Yale-Brown Obsessive-compulsive Scale modified for Neurotic Excoriation. Each participant was put through a clinical assessment and evaluation by a practicing psychiatrist to develop a baseline and validate a primary diagnosis of skin picking disorder with no co-morbidities. Participants underwent structural brain MRIs which focused on identifying cortical thickness and volume of subcortical structures.

Compared to the control groups, participants with SPD displayed significantly higher levels of depression and anxiety as well as a significantly lower quality of life. Scores of cognitive flexibility and response impulsivity, also measured during the evaluation, proved not to differ from the control groups. Within the SPD groups, the study identified a relationship between response inhibition and cortical thickness.

During the study, MRI results did not survive multiple testing correction using a false discovery rate. This could be a result of having a small sample size. Although participants scored well below the threshold for clinically significant mood disorders and anxiety, it is worth noting that the SPD group scored generally higher on these tests than the control groups. More studies are needed to solidify the correlative data from this study.

In conclusion, this study suggests that greater motor impulsivity in individuals with SPD relates to structural variation, particularly within the insular cortex and parietal and occipital regions of the brain, a finding which is consistent with previous studies of OCD and OCD-related disorders. Results suggest that cortical thickness in these regions of the brain may play a role in the pathophysiology of SPD.

Neuroanatomical Correlates of Impulsive Action in Excoriation (Skin-Picking) Disorder

Participants underwent brain MRIs to identify...
- Cortical thickness
- Volume of subcortical structures

Compared to the control groups, participants with SPD displayed:
- higher levels of depression
- higher levels of anxiety
- lower quality of life

Results suggest that cortical thickness in the brain may play a role in the pathophysiology of SPD.

Men and Women between the ages of 18-65 were recruited for this study

To qualify for the study, participants must have engaged in skin picking for at least 30 minutes per day over the last 12 months.
Telepsychotherapy has shown promise in treating a wide range of mental illnesses. Given its ability to reach populations who normally can’t access quality treatment, as well as its convenience for people who may be too ashamed or busy to attend traditional psychotherapy, the authors of this paper wanted to examine the utility of telepsychotherapy for trichotillomania. They conducted a randomized controlled trial using remote Acceptance and Commitment Therapy (ACT) -enhanced behavior therapy, which uses both conventional behavioral techniques for hair-pulling and techniques for improving psychological flexibility (meaning, the ability to prioritize central goals over temporary thoughts and impulses).

12 adults were randomized into 10 sessions of active treatment, and 10 into a waitlist condition, meaning they had the option to receive the same treatment as the active group after 12 weeks, and the authors predicted not only significant improvements in hair-pulling severity, but also in quality of life, psychological flexibility, and shame. Of note, all participants had to reside in Utah, because regulations on telepsychology practice vary in different states, and all remote sessions used a video conferencing software compliant with HIPAA (Vsee). Additionally, measures were taken to assess therapeutic alliance and patient satisfaction with the treatment, in order to determine the viability of the remote treatment. Hair-pulling scores were significantly lower in the active treatment group compared to the waitlist group, and over half of the active group saw clinically meaningful improvement in their symptoms.

After all the participants received treatment, a combined analysis was done to observe change over time in both groups: of the 12 patients seeing clinically significant improvement at the final session, 7 of them kept their treatment gains 3 months after treatment ended. Psychological flexibility improved over the course of treatment and stayed stable until follow-up, but neither quality of life nor shame showed demonstrable improvement over time. The nature of the telehealth treatment was well-received, with many participants confirming that remote treatment overcame many of the barriers they faced with conventional treatment, and demonstrating high levels of treatment satisfaction and therapeutic alliance.

Improving the effectiveness of telepsychotherapy, which this study has highlighted to be a practical potential alternative to face-to-face treatment for trichotillomania, requires optimizing the technology and noting technical errors over the course of treatment, strengthening external validity by trying telepsychology with more diverse groups of individuals, and reassessing psychological variables like shame and quality of life with larger samples.
Remote treatment of sleep-related trichotillomania and trichophagia

Trichotillomania and trichophagia (ingesting of hair follicles) at bedtime hours often prove difficult to treat due to the inability to create relevant stimulus conditions in a clinical setting. An alternative that can be used instead is remote monitoring of patients. In this case, a DropCam Pro video camera was placed in the room of Kari, a 3-year-old girl with autism spectrum disorder and trichotillomania/trichophagia. Kari’s caregiver was coached to implement biobehavioral treatment for Kari that included administering melatonin before bedtime and standardizing Kari’s sleep and wake times.

The camera had night vision capabilities and resolution great enough to capture Kari’s hand movements while she was in bed. The videos from each night were screened and coded by trained observers. Videos were scored on the basis of two requirements: that Kari was in her own bedroom and remained there throughout the night and that the caregiver followed the instructions for standardized bed times within 10 minutes. The videos were randomized and distributed to data collectors. Data was collected starting when the caregiver left the room and ended when Kari was woken up in the morning. Data was only collected when Kari’s head was entirely visible. Videos where view of her head was obstructed for 50% or more of the time were excluded. Since the resolution of the camera was not strong enough to score true hair pulling and ingestion activity, counts of head and mouth touches were scored when Kari was awake throughout the night. Sleeping activity was determined if Kari did not move and her eyes were closed for more than 10 consecutive 1-minute intervals. Baseline included standardized sleep hygiene methods and standardized sleep and wake times. Dosage of melatonin was prescribed to Kari based on her age, weight, and height, and was increased from 1 mg to 4 mg throughout the course of the study. Melatonin was delivered by the caregiver to Kari approximately an hour before bedtime every night. Follow up occurred one month after the treatment, and efficacy was measured indirectly by taking photos of Kari’s head both pre- and post-treatment.

Introducing and then increasing dosage of melatonin decreased the number of intervals of head and mouth touches (averaged 1%) compared to baseline (averaged 6.2%, lowest level at 3mg of melatonin). Returning to baseline followed with a sharp increase in number of head and mouth touches (averaged 6.7%). Percentage of head and mouth touches were also analyzed per hour of the night, which showed that higher numbers of touches occurred in the early or late hours of the night, and that titrating melatonin dosages decreased the number of touches at both of these time points. Some limitations to the study include failure to demonstrate functional control over Kari’s sleep regarding the final treatment procedure and assessing treatment integrity.

Lichtblau et al. (2018) : Remote treatment of sleep-related trichotillomania and trichophagia

The pathophysiology of trichotillomania remains poorly understood. Obsessive-Compulsive Disorder (OCD) and trichotillomania are both classified as Obsessive-Compulsive Related Disorders, and thus have high comorbidity and possible overlapping neurocircuitry. PET imaging of OCD patients showed that translocator protein, which increases in presence when microglia aid in neuroinflammatory processes, was significantly higher in several areas of the brain, suggesting neuroinflammation present in the circuitry of OCD. Few studies have investigated the possible role of inflammation in trichotillomania, and this one is the first to study salivary cytokines to better understand the pathophysiology of the disorder.

The study included data from 31 participants, mostly female (n = 27), aged 10-66 years. Participants were excluded if they had prior or current diagnosis of bipolar disorder or psychosis or a substance use disorder. All subjects had a primary diagnosis of trichotillomania, determined by the DSM-5. Several questionnaires were used to assess severity of trichotillomania, as well as impulsivity, depressive symptoms, and psychosocial dysfunction. Of the total number of participants, 10 had co-occurring skin picking disorder, four had histories of major depressive disorder, and nine reported taking antidepressants. Saliva was collected from all participants and levels of specific cytokines (IL-1β, IL-6, IL-8, and TNF-α) were measured.

Compared to controlled data, trichotillomania patients had low levels of salivary inflammatory markers (Z scores: IL-1β Z = −0.26, IL-6 Z = −0.39, IL-8 Z = −0.32, and TNF-α Z = −0.83). Furthermore, inflammatory cytokine levels correlated significantly with age, but did not appear to differ as a function of gender. The first finding is the most interesting, since previous studies showed that some trichotillomania patients have reduced autonomic response to painful stimulation. A possible explanation for the lower inflammatory cytokines in patients could be dampened inflammatory pathways in trichotillomania patients, although further studies, particularly using blood samples, need to be conducted. Some limitations to this study include the lack of a control group and that saliva samples may not represent central inflammation responses well.
According to the dual process model, automatic processes drive behavior until more controlled, conscientious cognitive processes take over – in trichotillomania, this means someone may successfully inhibit an urge to pull with little effort until an obstacle, like fatigue or stress, gets in the way. Among these automatic processes that characterize behavior, certain cognitive biases are characteristic of mental illnesses like trichotillomania: approach bias (approaching rather than avoiding a stimulus); attentional bias (paying attention rather than directing attention away from a stimulus); and positive evaluation bias (positively rather than negatively viewing a stimulus).

This study aimed to test these three biases in trichotillomania, especially since there is previous evidence that patients with trichotillomania actually disengage (the opposite of attentional bias) from hair-pulling stimuli, suggesting a pattern of cognitive ‘ambivalence’ where the person isn’t sure whether to engage or disengage their attention when faced with a stimulus related to hair-pulling. The authors expected that the trichotillomania patients would show avoidance tendencies, a negative evaluation bias, attentional disengagement, slow response times indicative of the ‘ambivalence’ pattern, and a positive relationship between the cognitive biases and symptom severity. 54 patients with trichotillomania in the Netherlands completed computer tasks with words and images that were either neutral or related to hair-pulling, and two different measures of symptom severity. Methodological strengths of this study included using hair-pulling stimuli tailored to the area the patient most often pulled from (e.g., images of tweezing brows for brow/lash pullers, etc.), using both words and pictures as stimuli, including words and pictures related to resisting hair-pulling urges, and asking patients to touch or scan their hair prior to the experiment to make the stimuli more realistic. However, one of their computer tasks, the dot probe task, was found unreliable in the broader literature, and one of the severity measures was newly developed for the study, so it was unvalidated.

The results were mixed – none of the biases were consistently demonstrated, but in a few of the tasks, patients had slower response times for hair-pulling related stimuli than neutral stimuli, although in one task, the response time toward hair-pulling stimuli was actually faster than for neutral stimuli, demonstrating the ambivalence pattern slightly. There was also one significant positive correlation between the slower response times on one task and one measure of symptom severity, but since it was the only significant correlation of this kind, the authors acknowledge the possibility that it was a chance finding. No strong conclusions could have been drawn from this data, but to grow the evidence of these cognitive biases or attentional ‘ambivalence’ in trichotillomania, other types of highly-studied biases, more varied stimuli, control groups, and more diversified samples ought to be incorporated.

Skin-picking disorder (SPD), which was added to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in 2013, usually involves scratching or picking of one’s own skin, generally with the fingernails and occasionally with tools such as tweezers and needles. This study aims to look at the relationship between SPD and disgust. Specifically, pathogen disgust, defined as urge to dispel dirt or parasites from the body, moral disgust, usually stimulated by moral transgressions and closely related to other moral emotions such as guilt, anger/indignation and shame/embarrassment, and self-disgust.

The Questionnaire for the Assessment of Disgust Proneness (QADP; Schienle et al. 2002), The Scale for the Assessment of Disgust Sensitivity (SADS; Schienle et al. 2010), The Questionnaire for the Assessment of Self-Disgust (QASD) and Three Domain Disgust Scale (Tybur et al. 2009) were all used to evaluate the participants and collect data on levels of disgust observed in the test groups. The Skin-picking Scale Revised (SPS_R, German version, Gallinat et al. 2016) was used to evaluate the severity of SPD displayed in the test group. Independent-samples t-tests were conducted in order to compare questionnaire scores between SPD patients and controls.

Forty-six SPD patients (24 women, 22 men) and 36 control participants (19 women, 17 men) were studied. The SPD diagnosis according to DSM-5 was obtained by a board-certified clinical psychologist. The participants were on average 36.8 years old (SD=15.7).

The findings of this study indicate that SPD patients display a higher level of disgust as measured by the questionnaires listed above and more importantly, the degree of their SPD could be predicted based on two specific traits: moral disgust and disgust sensitivity. From these findings, it can be assumed that disgust may play a crucial role in SPD, especially in patients who display a heightened level of disgust sensitivity. More research in the area of SPD in relation to disgust is warranted, and may be of value in understanding the origins of SPD.
A new cluster of disorders has been identified in the DSM-V called obsessive-compulsive and related disorders (OCRDs), including OCD, hair-pulling disorder (HPD), skin-picking disorder (SPD), hoarding, and body dysmorphic disorder. Oftentimes, OCD, SPD and HPD develop simultaneously, but very few studies have investigated these disorders together and the physical consequences of them in children and adolescents. OCD is characterized by the presence of many recurrent thoughts, images, or impulses, as well as actions that a person frequently performs in response to obsessions. SPD includes symptoms such as chronically scratching and picking at the skin. The prevalence of both disorders is large, for OCD between 1-4% in children and adults, and for SPD between 1.4-5.4% in the population. This study sought to determine if OCD is a significant predictor of SPD among primary school children.

This was a descriptive study that followed a correlational design, conducted by Iranian researchers who pulled from a population of Iranian school children. The sample consisted of a total of 381 male and female students, ages 7-11 years old, and a multistage cluster sampling method was used. The Obsessive-Compulsive Inventory-Child Version and Skin Picking Reward Scale were used to assess symptoms and severity of both OCD and SPD in the subjects. Using a Pearson correlation coefficient, researchers found that aspects of OCD had significant relationships with SPD among the children in the sample: doubting (0.17), obsessing (0.22), washing (0.15), ordering (0.19), neutralizing (0.14).

Limitations to this study include lack of geographical diversity of the children in the sample as well as the study’s design, since observed correlations were small. With these findings, the fact that OCD is prevalent among children as well as adults, and that many studies have shown that OCD may be associated with SPD and HPD, it is even more crucial now to determine causes and develop treatments for these disorders for children.
Prevalence rates for BFRBs can vary widely, but the consensus in the scientific community is that BFRBs are moderately common. However, there are gaps in the historical prevalence estimates, because most of them don’t include subclinical levels of symptoms, and most of them only assess 1 BFRB at a time. Based on how similar BFRBs are in clinical presentation and how often they occur together, it is extremely important to obtain a broader, more refined prevalence estimate of BFRBs. The aim of this study was to estimate the prevalence of BFRBs collectively, in both subclinical and pathological forms, in a large sample of college students (n=4,435) with more conservative diagnostic criteria, as well as other features of BFRBs, including how chronic they are and how much impairment they cause.

Participants were asked whether they had engaged in a BFRB in the past month, and were also asked questions about frequency (a BFRB was considered ‘pathological’ if the participant engaged in it 5x/day or more), physical impact, psychosocial distress, functional impact, and whether they ever sought medical attention. The BFRBs assessed included hair pulling, skin picking, nail biting, cheek biting, teeth grinding while awake (diurnal bruxism), and skin biting, but not teeth grinding at night (nocturnal bruxism), and the BFRB definitions were narrowly tailored to prevent participants from the possibility of over-endorsing BFRBs. 71.81% of the sample reported engaging in a BFRB within the past month: 59.55% reported a subclinical BFRB (69.3% female; 30.6% male), and 12.27% reported a pathological BFRB (77.2% female; 22.8% male). Almost three-fourths (73.2%) of people with a pathological BFRB also endorsed at least one subclinical BFRB. The most common BFRB in both categories was cheek biting, suggesting potential merit of including cheek biting in the DSM alongside HPD and SPD.

The sample overall described BFRBs as being more chronic than acute, and they reported a trend of psychosocial distress, but that distress did not appear to be followed by functional impairment, and few people sought medical attention for their BFRB. This study provides support for an idea that clinical-level BFRBs are just maladaptive exacerbations of behaviors that are in large part normal and common. Limitations of the study include: restricting the sample to college students, using a survey design and unvalidated assessment tools, not collecting demographic information, and not using the current DSM-V criteria (including the criterion of having to have made attempts to stop) to assess diagnostic status.
Skin Picking Disorder (SPD) may develop at any age, but the most common age of onset is during adolescence. Defining subgroups of SPD can be the first step to identifying the efficacy of different treatment strategies to provide more effective treatment to those groups. This study aims to identify the differences between people who develop SPD during adolescence versus adulthood.

Final study results include data from 701 adults with quantifiable characteristics of SPD. Latent profile analysis, the process by which you cross-check results to create distinct subgroups from patterns in the data, was used to identify two major subgroups within SPD: (1) an early onset group with average onset in adolescence, and (2) a late onset group with average onset in middle adulthood.

In contrast to the early onset group, the late onset group reported significantly less focused picking, less SPD-related impairment, and lower rates of co-occurring Body-Focused Repetitive Behaviors (BFRBs) like trichotillomania and cheek-biting. Late onset skin-pickers also showed a lack of family history with SPD, and also reported increased comorbidities, such as depression and anxiety.

As with any study, there were some limiting factors. Although this study aims to identify different subgroups of SPD including one which develops during adolescence, all survey results included in this study are from participants over the age of 18, eliminating results from those who are displaying SPD and are currently adolescent. Since the surveys were conducted online, those without internet were unable to access them. Sample size was also a limiting factor, which should be considered in future studies.

In conclusion, based on the latent profile analysis results, it can be said with relative confidence that there are two clearly identifiable subgroups within the world of SPD: those with early onset SPD, and those with late onset SPD that develops later in life. Based on the results, further studies to identify difference in treatment efficacy for the subgroups identified are warranted.
Sensory Over-Responsivity in Trichotillomania

This study explored the relationship between sensory over-responsivity (SOR) to external experiences and hair-pulling behavior.

People with TTM displayed higher levels of SOP on the hearing and touch scales.

Researchers concluded that SOR is related to higher levels of “focused” hair-pulling and perfectionism.

This study is the first to show that SOR influences hair-pulling behavior.

Falkenstein et al. (2018): Sensory over-responsivity in trichotillomania (hair-pulling disorder)

Recent studies have begun to explore the relationship between OC-related disorders and sensory over-responsivity (SOR), which is an extremely intense over-reaction to sensory stimuli. Sensory aspects of trichotillomania (TTM) have been shown to differ among the main subtypes of hair-pulling. Individuals with OCD face challenges when encountering experiences that are “not just right” (NJREs), which present as similar situations that trigger “focused” pullers to behave. “Focused” pullers tend to be aware of the behaviors they exhibit, rather than pulling out hair in a subconscious manner. The intersection between NJREs, sensory phenomena, and perfectionism has been studied in OCD patients, but not in TTM patients. This study explores the relationship between over-responsivity to external experiences and hair-pulling behavior.

Individuals with TTM were recruited from the TLC Foundation for BFRBs (n = 609), and non-affected subjects for comparison were recruited online from Amazon Mechanical Turk (n = 268). All participants completed an online self-reported survey, which included measures that assessed severity of hair-pulling symptoms, symptoms of TTM-by-proxy, subtype of hair-pulling, perfectionism, degree of SOR, and severity of misophonia (hatred of sound). In patients with TTM, mild SOR symptomatology was observed on the SOR-touch and SOR-hearing subscales. On both these subscales, TTM patients scored significantly higher on average (M = 4.47 for touch, M = 4.29 for hearing) compared to non-affected participants (M = 2.55 for touch, M = 2.74 for hearing). A small but significant correlation was found between TTM symptom severity and SOR-touch, and there was a small but significant correlation between SOR-hearing and scores for focused pulling subtype. SOR in general was also positively associated with impairment in the TTM sample, and there were also significant correlations between SOR and perfectionism, but no significant associations between SOR and hair-pulling by proxy.

The researchers overall concluded that SOR is related to higher levels of “focused” hair-pulling and perfectionism, but recognize limitations to the study include self-reported TTM diagnoses, the novel nature of the measure of SOR, and that only auditory and tactile sensory modalities were measured. One important implication of the study is that patients with SOR and TTM may make up a specific phenotype that requires a different treatment than that for TTM alone.

Midface toddler excoriation syndrome (MiTES) can be caused by autosomal recessive biallelic mutations in a gene for congenital insensitivity to pain, PRDM12

Midface toddler excoriation syndrome (MiTES) is a condition that involves habitual scratching from the first year of life that results in deep, chronic scarring wounds around the nose and eyes. The goal of this study was to take a closer look at five recently-reported cases of MiTES, as well as three previously-reported cases, particularly in their relation to the PRDM12 gene that plays a factor in the congenital insensitivity to pain.

All of the subjects in this study were identified as having MiTES by a credentialed medical institution. Four of the cases were presented at the Indira Ghandi Institute of Child Heath in Bangalore, India. The fifth case was presented to Our Lady’s Children’s Hospital in Dublin, Ireland. Molecular analysis, particularly the measurement of alanine amino acid residues, was used in this study to identify the mutation. In healthy people, the PRDM12 gene measures 14-15 residues. In four out of the five children in this study, the alanine residues were expanded to 18, indicating a mutation. In a previously reported case study of three individuals, a father and his two children, a mutation was found in the SCN11A gene, suggesting this disorder is genetically heterogenous. In seven out of eight of the total presented cases, iron deficiency anemia and thrombocytosis have been present, it is unclear whether this is an identifying factor of MiTES or not.

In conclusion, this study builds on the previous study and has taken the first steps in identifying MiTES as a distinct condition, caused by a biallelic PRDM12 poyalanine tract expansion mutation that can be a comorbidity of congenital insensitivity to pain. Although Skin Picking Disorder can result in wounds on the body that resemble those commonly found in MiTES, it is unclear if there is any relation between these two conditions. More steps should be taken to properly identify cases of MiTES as such in the future based on history and the presence of distinct chronic scarring wounds on the face.
Anxiogenic parenting practices as predictors of pediatric body-focused repetitive behaviors

Are parenting behaviors that make children anxious (hovering, arguing) related to development of a BFRB in childhood?

530 parents surveyed
268 children with BFRBs

Researchers found:
1. Parents with anxiety-provoking behaviors slightly increased the risk of their child developing skin-picking or nail-biting specifically.

2. The child’s anxiety played a more functional role in the development of BFRBs.

3 Anxiety may not necessarily be a cause of BFRBs, but targeting anxiety along BFRB symptoms in children could be beneficial.


Murphy et al. (2019) : Anxiogenic parenting practices as predictors of pediatric body-focused repetitive behaviors

Body Focused Repetitive Behaviors (BFRBs) often develop during childhood, but very little research until now has looked at family environment as a risk factor in pediatric BFRBs. Anxiogenic parenting is defined as parenting behaviors that worsen anxiety in a child (including conflict, over-involvement, enabling children to avoid situations that make them anxious, exhibiting their own anxious behaviors in front of their children, and not displaying emotional warmth), and the aim of this study was to evaluate if anxiogenic parenting is related to likelihood, number, and severity of childhood BFRBs.

A group of 530 parents/caregivers of children between the ages of 7-17 were sampled using Amazon MTurk, an Internet survey method. Of this group, 268 reported their child had at least one BFRB, and 262 reported their child did not have a BFRB. The parents answered questions about their child’s anxiety and BFRB symptoms, as well as a survey developed and validated by the authors to quantify anxiogenic parenting practices. The results were slightly surprising; it appears that the child’s anxiety level plays a more consistent role in overall BFRB presence, number of BFRBs, and presence of specific BFRBs than anxiogenic parenting does. There were increased probabilities of specific BFRBs with anxiogenic parents; with every additional point on the anxiogenic parenting survey’s total score, a parent’s child was 1.49 times more likely to develop skin-picking disorder, and 1.28 times more likely to engage in nail-biting, which are relatively minor increases.

The results of this study suggest that much of the risk of developing a BFRB originally attributed to a parent’s anxiety may actually work through the child’s anxiety instead. There are additional questions about whether anxiogenic parenting is only related to specific BFRBs, like skin-picking or nail-biting, if there are additional family factors at play besides anxiogenic parenting, and what the relationship is between parental and child anxiety. The study is limited by only testing the parents once (using a cross-sectional design), using Internet questionnaires instead of interviewing with a clinician, and limiting the number of BFRB questions asked during the survey. There’s no evidence to say whether or not anxiogenic parenting causes BFRBs, but additional support for the role of pediatric anxiety in BFRBs suggests targeting anxiety alongside BFRB symptoms in children could be beneficial.
Professor YAAC’s “Making Sense of Writing about Research”

“Professor YAAC, what’s IMRD?”
“Great question! Let’s review…”

Intro: What were the researchers trying to test? Why should I care?
Methods: What did the researchers do to test this?
Results: What did the researchers find through their testing?
Discussion: How does this study apply to the real world? What’s next?

“What are the levels of evidence?”
“Recall, some of these are better than others!”

BEST
- Claims are based on RCT and treatment works for reasons developer thinks it works.
- Claims are based on results of a randomized controlled trial (RCT).
- Claims are based on good data with a lot of cases, but are uncontrolled.
- Claims are based on data, but it is of poor quality and/or from a few isolated cases.
- Claims are based on theory, and theory alone.

WORST
- “Worked for me!”

“What will a good article tell us?”
“Good articles will do the following…”

1) Separate the story from the data
2) Define terms you need to know
3) Talk about the study’s flaws
4) Not make claims that are too strong
5) Raise more questions to think about

The TLC Foundation for BFRB’s Young Adult Action Council

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