"THEY WOULD THINK THAT I WAS A FREAK OR SOMETHING": IMPRESSION MANAGEMENT IN TRICHOTILLOMANIA, A HAIR-PULLING DISORDER

by

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A thesis submitted to the Faculty of the University of Delaware in partial fulfillment of the requirements for the degree of Master of Arts in Sociology

Fall 2015

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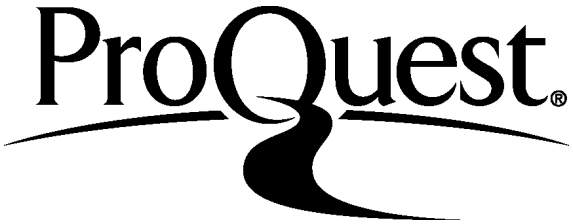

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ACKNOWLEDGMENTS

First, I would like to give a very special thanks to Dr. Asia M. Friedman for being an incredibly helpful advisor and resource on this project.. Second, I would like to thank Dr. Ann V. Bell and Dr. Barret Michalec for both agreeing to be members on my thesis committee and for their insightful feedback that encouraged me to think critically about my work. Thank you to Dr. Victor W. Perez for being a sounding board for my ideas and attending my thesis defense.

I would also like to thank the Trichotillomania Learning Center for their support in helping me recruit participants for this project. I would like to give a huge thanks to Em Rowe for taking notes at my thesis defense and being a wonderful emotional support. A special thanks to Melissa Archer for assisting with formatting my thesis and for providing bond paper. Thank you to other members of my cohort who have been supportive and willing to answer questions and listen to my frustrations: Tom Albert, Ava Carcierieri, TaLisa J. Carter, Ashley Mancik, Jen Snyder, and Bri Van Arsdale,

Last but not least, I would like to thank my friends and family who have been nothing short of amazing through this whole endeavor: Josh Kelley, my wonderful husband, who provided the emotional support I needed to get through this project, Vinny Cataudella, who has been supportive of me and my research for 13 years, and Dr. Stephen T. Slota, without whom I would probably never have considered a career in academia.

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ABSTRACT

The present study examines how individuals with Trichotillomania (TTM), a hair-pulling disorder, use impression management techniques to avoid stigmatization and maintain their social identities. Using in-depth interviews with 25 participants and grounded theory analysis, five areas of impression management are distinguished: Concealment of hair loss, concealment of the cause of hair loss, disclosure as preventative telling, knowing vs. seeing, and public awareness. Participants used a combination of concealment and selective disclosure situated within their social roles of race and gender to perform impression management. This study underlines the importance of impression management and stigma avoidance in understanding the negative psychosocial outcomes associated with TTM.

Chapter 1

INTRODUCTION

> So it's almost like you have two sets of problems—one that you're making yourself look bad, so there's that, and two, the fact that you're doing it to yourself, so I think there's a certain—where people think, 'Oh my god, what is wrong with her?' – Anya, 28

Anya has Trichotillomania (TTM), a condition in which individuals compulsively pull hair from one or more parts of the body (APA 2013). Previous literature suggests negative psychosocial impacts of TTM on individuals, including low self-esteem, social avoidance, and decreased ability to develop and maintain intimate relationships (Casati, Toner, and Yu 2000; Diefenbach et al. 2005; Novak 1997; Soriano et al.1996; Stemberger et al. 2000; Woods et al. 2006). However, the social mechanisms that lead to or protect from these psychosocial issues are often overlooked, particularly stigmatization and impression management.

As hair is important to assessing attractiveness (Gimlin 2002, 2007; Weitz 2001, 2004), people with TTM must navigate the space where two types of stigma exist: deviation from mental health norms and deviation from appearance norms. In order to avoid stigmatization, individuals with TTM engage in various forms of impression management (Goffman 1959, 1963), such as concealing visible hair loss, making up excuses when asked about hair loss, and avoiding social situations where their hair loss might be discovered, such as going to a hair dresser or doctor.

Individuals with TTM often feel isolated (Casati, Toner, and Yu 2000), as they may feel something is "wrong" with them for making them want to pull their hair.

The present study focuses on the impression management techniques of individuals with TTM living in the United States by answering the following questions: (1) How do individuals with TTM perform impression management on a daily basis to avoid stigmatization? (2) What influences their impression management techniques? and (3) How are stigmatization and impression management related to the negative psychosocial impacts of TTM described in previous literature? I argue that for those with TTM, a mental health condition with visible symptoms that directly affect perceived attractiveness, impression management has two layers: concealing the hair loss itself and concealing the cause of the hair loss. Concealing the hair loss allows them to avoid stigmatization from being perceived or labeled as "unattractive." By concealing the cause of the hair loss—TTM—they avoid stigmatization from being perceived or labeled as mentally unstable. For many with TTM, even once "discredited" (Goffman 1963) through discovery of hair loss, they remain "discreditable" (Goffman 1963) as to its cause. I argue that the stress of being discreditable may be a factor in the psychosocial issues identified in previous literature.

For many, the process of impression management can be stressful to the point where a "bad hair day" can lead to avoiding friends or social events, or contribute to low self-esteem. Additionally, the impression management techniques tend to fall within what the individual feels is acceptable for their social role. Salience of gender

identity and racial/ethnic identity are represented particularly in concealment techniques, as individuals wish to preserve their social identities in a society that values attractiveness (Gimlin 2002) and stigmatizes mental illness (Overton and Medina 2008).

Chapter 2

BACKGROUND

Theoretical Frameworks

As social beings, we give meanings to ourselves, others, and situations through performance, or "impression management" (Goffman 1959). We manage the impression we give off in hopes that others will interpret our actions in the way we intended. We attempt to maintain our positive social identity, or "face" (Goffman 1967), during our interactions with others. Maintaining face "is a condition of interaction, not its objective" (Goffman 1967:12). Face maintenance reflects the norms of interactions within social groups, so we must follow the rules or risk having our positive social identity replaced with a negative one. Impression management and face are strongly connected to social identities—such as race and gender—as we attempt to present ourselves in a way where the identities we wish to project are readable to those with who we interact (Goffman 1959).

Stigma occurs when individuals differ from cultural norms in greater society, and when they are "thus reduced in our minds from a whole and usual person to a tainted, discounted one" (Goffman 1963:3). Stigmatized individuals, or those who live in fear of being stigmatized, may alter their impression management techniques in order to avoid stigmatization, lessen its consequences, or adapt to their stigmatized

identities. Though stigma may come from other individuals, it can also come from within. Individuals internally evaluate and judge themselves through self-stigma (Corrigan 2002; Overton and Medina 2008; Thoits 1985), leading to decreased self-esteem and self-efficacy (Blankertz 2001). Stigma may also be structural, as a process of culture and systems (Overton and Medina, 2008).

Stigma is dependent on power, as power is essential to the production and reproduction of stigma (Link and Phelan 2001). Stigma allows people to "keep others down" through exploitation, "keep others in" by regulating norms, and "keep others away" through avoidance (Phelan, Link, and Dovito 2008). Link and Phelan (2014) describe "stigma power" as a resource people use to exploit, manage, control, or exclude others. Often, this is achieved though labeling. When individuals are labeled, they are linked with negative stereotypes (Link and Phelan 2001).

Stigmatization often has devastating effects, particularly for those with mental illness. Some individuals with mental illness feel that dealing with the stigma of the illness was more burdensome than dealing with the illness itself (Karp and Sisson 2001:7). Labeling individuals with mental illness leads to categorization and separation from the rest of society and the restriction of opportunities (Link and Phelan 2001).

The modified labeling approach (Link et al. 1989) explains how individuals given an "official label" (403) of a mental illness feel threatened by stigmatization. They may choose to conceal their treatment history to avoid rejection, withdraw from social interaction or limit it to only those who know and accept their condition, or

attempt to educate others to mitigate negativity. The anticipation of negative responses from others may result in withdrawal from social and professional situations (Alexander and Link 2003, Link et al. 1989, Overton and Medina 2008). Individuals with a concealable stigmatized identity who anticipate social devaluation and rejection from being discovered are likely to feel greater salience of that identity (Quinn and Chaudoir 2009). In this sense, those with TTM who anticipate rejection if their condition is discovered may feel that the TTM is more salient or central to their overall identity.

TTM exists in the intersection of two types of stigma: the stigma of mental illness, and stigma that occurs when individuals deter from socially acceptable physical appearance. Individuals with TTM must navigate both of these types of stigma, using impression management techniques to avoid being "discredited" (Goffman 1963) in terms of appearance and mental health. I argue that individuals with TTM first navigate in regards to appearance norms, and then once visible hair loss is discovered, navigate the stigma of mental illness.

Social Construction of Illness

The experience of illness is shaped by culture and systems. Conrad and Barker (2010) explain how certain illnesses or conditions have particular social or cultural meanings embedded in them. Some are stigmatized, some are contested, and some are considered disabilities. "What is important about these distinctions is that they exist for social rather than purely biological reasons" (2010:S69).

Individuals may have the same disease or condition yet experience it differently. This could be due in part to individual personality, race, class, sex, gender, ethnic, or national differences (Brown 1995). These differences in experience may also stem from broad social norms and perceptions, interactions, support from friends and family, or perceived interference with work, physical activity, or social activity (Zola 1966). Personal experience can affect treatment and outcomes, such as choices for care and compliance (Conrad 1987). I argue that individuals experience their TTM differently due in part to their race and gender, and develop impression management techniques based on these social identities.

Appearance Norms

As noted by Gimlin, the identity that is enacted through the body is a social construction as well as an individual possession, meaning "the body is one critical point at which the social meets the individual and from which a self is created" (2002:3). The body is indicative of who an individual is, their habits, and their social value. The body is central to modern conceptions of gender, especially the dichotomies of strength and weakness, activity and passivity, sexuality and neutrality. Individuals in the United States, especially women, would find it difficult to ignore their physical appearance, lest they be "stigmatized as unfeminine or socially unaware" (2002:4). Gimlin further explains that men also face social pressure to face certain kinds of physical standards, though they are allowed greater variation in their appearance.

"Body work" (Gimlin 2002) refers to the work individuals do on their bodies to "transform them from their 'natural' state to one that is more explicitly 'cultural'" (Gimlin 2007). Most if not all societies require some type of body work in order to fit their norms. "Beauty work" (Kwan and Trautner 2009) is a specific type of body work which occurs within social systems in which appearance partially affects how rewards and sanctions are distributed.

Physical attractiveness is associated with many positive outcomes in personal, social, and employment spheres of life. Studies show that beauty brings advantages in work (Frieze et al. 1991), education (Clifford and Walster 1973; Felson 1980), marriage (Elder 1969; Udry and Eckland 1984), and various other aspects of life (Kwan and Trautner 2009). Perceptions of physically attractive people are generally positive, associating beauty with talent (Landy and Sigall 1974) and desirable personality traits (Schneider 1973). Attractiveness is also correlated with greater peer acceptance (Dion and Berscheid 1974). Advantages of beauty start in early childhood, as adults perceive attractive babies as having more positive qualities than unattractive babies (Stephan and Langolis 1984), and attractiveness is positively correlated with teachers' perceptions of students (Clifford and Walster 1973).

For both men and women, hair plays a major role in appearance norms and identity (Synnot 1987). Hair is a public symbol that is open to interpretation by others. It provides an indication of age, gender, race, political standing, and social class (Gimlin 2002; Weitz 2004). It allows for the expression of individuality, and affects

the perception of attractiveness (Franzoi, Anderson, and Frommelt 1989; Kranz 2011; Weitz 2004).

Historically, studies on men's hair and identity generally centered around male pattern balding or alopecia. In a study of the perception of balding in men, Cash (1990) found that when compared to their matched, non-balding counterparts, bald or balding men were perceived as less physically attractive, less self-assertive in personality, less socially active, less likely to be successful in personal life and career, and less personally liked by the respondents themselves. Szymczak and Conrad (2006) explain that the medicalization of baldness by some pharmaceutical companies pathologizes hair loss as a treatable disease, rather than a natural phenomenon. Several studies suggest that a full head of hair is an essential characteristic of the successful, hegemonic, and normative man, a symbol of dominance (Connell 1995; Gill et al. 2005; Ricciardelli 2011).

In many ways, hair is even more essential to American women's identity and the assessment of women's attractiveness (Weitz 2001, 2004). Many American women agonize and obsess over how to style their hair and balance their hairstyle desires with the desires of their family members, partners, and employers. Women with hair loss have more social anxiety and poorer self-esteem, well-being, and body image than women without hair loss (Cash 2001). After studying women with alopecia areata, Weitz (2004) conceptualizes hair loss in women as "losing one's very self" (2004:134). Though most studies on hair loss focus on scalp hair, studies show that

those who lose eyebrows and eyelashes through alopecia or chemotherapy may have problems with identity and identity change (Hunt and McHale 2005).

Hair is a key factor of the presentation of gender and racial identity, particularly in African-American women's lives (Prince 2009). For African-American women, hair can be a marker of cultural pride, an expression of style, or a "medium to maintain the status quo or go against it" (Banks 2000:147). African-American women spend a lot of time and money on their hair, and often feel that their hair is a part of their identity. Even within the African-American community, women identify each other and are identified by the ways they style their hair (Banks 2000; Prince 2009). The hegemonic culture in our society is Eurocentric, and the beauty paradigm promotes European features, including straight, smooth hair. In the words of Tracey Owens Patton, "Beauty is subject to the hegemonic standards of the ruling class" (2006:24). As such, African-American women's natural hair is often undesirable, while flat-ironed hair is considered "good" (Banks 2000; Patton 2006; Prince 2009).

Prince (2009) explains that although women of all races use extensions and weaves in their hair, African-American women's hair will often not grow past a certain length. As our society idealizes long hair, it is acceptable and at times even encouraged for African-American women to add extensions to make their hair longer. Additionally, the chemical and flat-ironing processes African-American women often use to straighten their hair may leave it damaged, forcing women to wear braids or wigs until their hair is healthy enough to straighten again. These practices may make concealing visible hair loss easier for African-American women, as extensions,

weaves, and wigs are acceptable and even encouraged in the African-American community.

What is TTM?

Given the centrality of hair to attractiveness, studies find individuals with TTM report strong feelings of shame and embarrassment, and disguise hair loss using wigs, elaborate hairstyles, makeup, or head coverings (Diefenbach et al. 2005; Swedo and Rapoport 1991). The time and financial cost of disguising or covering the results of TTM may be significant (Wetterneck et al. 2006). Individuals with TTM may pull hair from a single area or multiple areas, and may change over time. Most commonly, pull areas include the scalp, eyebrows, eyelashes, beard, and pubic area (Flessner et al. 2008).

Previous TTM literature focuses largely on treatment, namely reducing or stopping the pulling through therapeutic strategies (i.e. pharmacotherapy, cognitive behavioral therapy, or alternative methods of therapy). Much of the current research on TTM that is focused on the impact of the disorder on the individual is based on small-scale interview or case studies (Casati, Toner, and Yu 2000; Wetterneck et al. 2006). Larger-scale research tends to be focused on pulling styles and severity (Begotka, Woods, and Wetterneck 2004; Flessner et al. 2008), or the impact of TTM on an individual level in terms of emotion, self-esteem, and social avoidance (Diefenbach et al. 2005; Stemberger et al. 2000).

In our society, we idealize attractiveness and mental stability. A flaw in either can be detrimental to how others perceive our character, so a mental illness that detracts from the perceived attractiveness of an individual may put them at great risk for stigmatization. The purpose of this study is to focus on the social phenomena surrounding TTM, and to understand the ways individuals use impression management techniques—concealment and selective disclosure—to preserve their social identities and avoid stigmatization. By tying the psychosocial impacts of TTM to stigma and impression management, we may be able to better understand how individuals with TTM and other mental illnesses with visual components manage their conditions within a social context.

Chapter 3

METHOD

Procedure

Participants for this study were recruited through the Trichotillomania Learning Center and two social media-based TTM Internet support groups. The Internet is a place where individuals with stigmatized illnesses may find social support, a way to cope with the illness, and means of self-expression (Yeshua-Katz and Martins 2013). In a study of Internet support groups for TTM, Bruwer and Stein (2005) found that group members found it useful to interact frequently with someone who had experienced the same problem. I chose two Internet support groups of which I was already a member. Although I had only once started a new discussion myself, I had occasionally commented on other members' posts with words of support or encouragement. In this sense I had some established presence, and I hoped that group members would recognize my name and have a positive—or at least neutral—opinion of me.

I created a recruitment letter that disclosed my TTM status and asked for US-based individuals ages 18 and older to contact me through private message or e-mail. The language in the recruitment letter was fairly informal in the hopes of increasing the comfort level of potential participants, asking individuals to take part in a study

regarding TTM, beauty standards, and stigma. I posted the recruitment letter in two social media-based Internet groups, with periodic updates to bring it back to the top of the message board. One of the groups had over 4,500 members at the first posting, so the letter would frequently be buried below the newer posts in the group. Twice, group administrators agreed to "pin" the recruitment letter to the top of the message board so that it would not be buried. However, only one message can be "pinned" at a time, so my recruitment letter was not always the top priority. The Trichotillomania Learning Center (TLC) also posted my recruitment letter on the research section of their website and posted links to it on two social media outlets following approval from their scientific advisory board. Additionally, one participant was referred to me by a family member through word of mouth.

Initially, most of the individuals who contacted me with interest in participating in my study were white women. As I wished to have a more diverse sample due to the varying appearance norms related to race and gender, I re-posted my letter in both Internet groups with a header emphasizing my desire to include more women of color and men. A few more women of color contacted me after that, however, I did not hear from any more men. Several weeks in to my recruiting, a man who was relatively new to the larger of the two groups posted a message asking if there were other men in the group. As a targeted recruiting effort, I sent private messages to all of the U.S.-based men who responded to his post, and managed to recruit a few more men for my study.

I conducted semi-structured interviews with 25 participants between December 2014 and January 2015. Thirteen of the interviews were via phone, 10 via video chat, one via Facebook chat (at the participant's request), and one in-person at a cafe. Interviews ranged from 30 to 90 minutes, with an average of 55 minutes. Prior to the interviews, participants were provided informed consent forms to either sign and return via e-mail, or to respond to with oral consent at the start of the interview. To ensure participants' confidentiality, I use pseudonyms throughout the article.

I began each interview with a brief explanation of my history with TTM, including my current age, age of onset, and pull areas. During the interview, I asked participants to describe various experiences with TTM, including perceived impetus to pulling, the age of onset, disclosure and non-disclosure to others, and treatment. I also asked about history with other mental health diagnoses or issues, the visibility and management of their pull areas, goals related to TTM, and self-confidence. I took notes on each interview shortly after they occurred, and transcribed the interviews verbatim. During the transcription process, I highlighted passages and kept notes on emerging themes. Using NVivo software, I then employed qualitative coding techniques to identify patterns in the participants' answers (Saldaña 2012).

As a largely inductive study, I used grounded theory (Charmaz 2006) for my analysis, which allowed me to use my own data to engage an area not previously studied. I coded each transcribed interview using NVivo for Mac (2014). Initially, I did line-by-line coding, using some *in vivo* coding when specific language used by participants was important to the concept (e.g. "crazy" or "weakness"). While coding,

I also made memos regarding some of the themes I began to notice. After initial coding, I had 170 nodes, which I then condensed through focused coding based on the memos I had made. To do this, I printed a list of nodes and placed them into a total of 18 groups by hand before placing them into categories in NVivo. After focused coding, I completed theoretical coding based on themes from the data, and then compared that to the impression management literature.

Though the 25 participants interviewed for this study are certainly not representative of all individuals with TTM, it provides a distinct view into the interactions many adults with TTM experience in the United States and the meanings they construct. By examining the social mechanisms faced by individuals with TTM, I hope broaden the understanding of psychosocial issues found in previous studies. Participants are from 16 different states across the US. Ages range from 18 to 60, with a median age of 28. The sample included six white men, 10 white women, six African-American women (one answered "African-American," but said she preferred to identify as "American," and two identified as "predominantly African-American") two women of mixed race/ethnicity (one white and Japanese, one white and Arabic), and one white transgender woman. Table 1 includes participants' demographics and pull areas.

Table 1: Participants

Pseudonym	Age	Race/Ethnicity	Gender	Pull Areas*
Erica	44	African-American	F	scalp (pubic)
Jasmine	18	African-American	F	eyebrows, eyelashes, pubic (scalp)
Lea	45	African-American	F	scalp
Joy	33	African-American**	F	eyelashes, scalp, pubic
Sasha	31	Predominantly African-American	F	scalp, pubic
Star	26	Predominantly African-American	F	eyebrows, scalp, pubic
Allie	23	White	F	scalp, arms
Emily	60	White	F	eyebrows, eyelashes
Hailey	24	White	F	eyelashes
Lauren	24	White	F	(scalp)
Lisa	26	White	F	eyelashes, scalp (eyebrows)
Lucy	20	White	F	eyebrows, eyelashes
Mary	20	White	F	eyebrows, eyelashes, scalp
Michelle	37	White	F	eyelashes, legs
Olivia	44	White	F	scalp, pubic, upper lip
Rachael	40	White	F	eyebrows, eyelashes, scalp
Sarah	18	White	F/Transgender	eyelashes, scalp
Aaron	41	White	M	eyebrows, eyelashes, beard (pubic, chest)
Ben	25	White	M	eyelashes, eyebrows, beard
Carl	37	White	M	scalp
Justin	22	White	M	scalp
Ken	30	White	M	wrists, chest (hands)
Logan	34	White	M	scalp, beard (legs)
Anya	28	White/Arabic	F	scalp
Hanna	21	White/Japanese	F	scalp, (eyebrows, eyelashes)

* former pull areas are in parentheses ( )

** Gave this as an answer, however, prefers to identify as "American."

Self-Reflexivity

My positionality as a white woman with TTM certainly shaped the interview data (Fonow and Cook 2005). As I had hoped, disclosing my own TTM diagnosis gave some participants the courage and comfort to tell me things they had never talked to anyone else about before. Many of the women I interviewed related to me and assumed we had shared experiences as women and as women with TTM, often saying things like "you know what I mean" when describing a feeling or situation. Most of the African-American women I interviewed referenced "the Black community," and took care to explain particular phrases and hair-related practices such as microbraids, weaves, and the difference between going to a barber and a hair-dresser, with and without my prompting. Because I am white, they may have felt that they needed to be more explicit about these practices, which proved to be beneficial to my understanding during the analysis process.

Additionally, my status as an academic researcher shaped the interview data. Two participants explained that they wanted their particular stories to be included in research, as they felt they were in unique situations with their TTM. Many of the other participants agreed to take part in the study because they felt it would help raise awareness for TTM, or because they feel any research will bring us closer to an effective treatment or cure.

I constantly found myself navigating my roles as researcher and person with TTM during the interview process. Trustworthiness is central to ensuring reliability in qualitative research (Rubin and Babbie, 2008). Many people with TTM feel shame

(Casati, Toner, and Yu 2000; Diefenbach et al. 2005) and keep the pulling secret from friends and loved ones (Stemberger et al. 2000), so I feel that it would create an unfair power dynamic to ask individuals to expose potential vulnerabilities to me while keeping my own experiences private.

Before my first interview, I decided that if participants asked me about my experiences with my own TTM, I would answer them, however I would not offer any advice or opinions on their experiences or the meaning of TTM outside of the inconclusiveness of current literature. When asked my advice or opinion, I tried to offer referrals to resource centers or providers. Though I opened my interviews with a brief explanation of my history with TTM and interest in its research, several participants asked questions about my experiences toward the end of the interviews, which I answered. Often after offering a little more information about myself, the participants opened up about more of their experiences they had not mentioned before. Only during one interview did I find myself needing to seriously consider the ethical implications of my answers before I gave them.

Joy, a 33-year-old woman who had only recently found out that her hair-pulling had a name, had only ever talked to a few other people about it. I interviewed her via video chat, and when I asked her how visible her hair pulling was, she removed her scarf to show me the pull areas on her scalp. I was grateful to her for being comfortable enough to show me her pull area, which she had never shown anybody before. However, I was caught off-guard when she asked me, “Is that bad? Cause if it’s bad, be honest. Do you think that’s bad?” I told her that between my own history

of TTM, my participation in Internet support groups, and reviewing research, I have seen many examples of pull areas all over the body. Severity of pulling varies greatly, and I had certainly seen much larger pull areas than hers. Joy also asked me about medications late in the interview, after she had told me earlier that she had been on several psychotropic medications before and did not like their side effects. "Now, medications that are offered, is that something you can get from your family doctor, or would I have to see a psychiatric doctor for that?" I referred her to her family doctor, and explained they might refer her to a psychiatrist or therapist.

Researching a disorder that I have myself opens up the potential for bias and ethical implications in both data collection and analysis. Some participants shared stories that mirrored my own, and some shared stories that were very different from mine. However, I understand that I am not outside the population I research; I too am an individual with TTM, and I too perform impression management within my own interactions. In my analysis I took a social construction of illness perspective, examining how their experiences of TTM and in turn their impression management techniques are shaped by social processes and culture (Conrad and Barker 2010).

The TTM community uses some words and phrases that I incorporated into the interviews and are reflected in both quotes and analysis. Many individuals, myself included, refer to TTM as "trich" (pronounced "trick") for short. As the sexually transmitted infection trichomoniasis may also be referred to as "trich," some participants reported that when they used the word "trich" to explain TTM to their friends or family, it was sometimes assumed that they were talking about the infection

and not the hair-pulling disorder. Additionally, use of the word "pulling" may refer to the TTM-related pulling of hair from any pull area. Some participants also use the words "plucking" or "picking" to describe their pulling, which may reflect their perception of their particular pulling method and process.

Limitations

All participants (except for the one referred by a family member) in this study were recruited from TTM support groups, or through TLC. As a result of my recruiting techniques, nearly all participants feel their hair pulling is problematic enough that they need support or information in order to stop. All participants are therefore aware that hair pulling is named and framed as a disorder, and have read information about it, and/or have read others' posts and opinions in the support group. In addition, research indicates that regardless of socioeconomic status, African-American individuals who are experiencing emotional difficulties are less likely than white individuals to seek help from traditional mental health sources (Neighbors et al. 1994; Neal-Barnett et al. 2000). With my recruiting techniques, I may have limited my access to potential African-American participants.

As I asked participants to discuss memories of past interactions, some of the data collected is retrospective. In this sense, the stories they tell are representations of what they remember, rather than exactly what happened. According to Levine and Pizarro, "The primary function of memory may be to guide future behavior rather than keep an exact record of the past" (2004:534). In light of this, rather than taking the

memories strictly at face value, I also try to understand their role in the meanings the participants have constructed over time.

Additionally, the sample is limited in terms of race and gender diversity. Initially, I planned to complete an intersectional analysis looking at raced and gendered influences on both the interactions and meanings of TTM. However, with only six men (all white) and eight women of color (six of whom identify as African-American), I am unable to make robust between-group comparisons. Though I make some observations in the areas of gender and race, all findings are preliminary and will require further investigation with a more diverse sample.

Chapter 4

FINDINGS AND DISCUSSION

Impression management is critical to participants' daily management of their TTM. Participants attempt to avoid stigmatization by maintaining a socially acceptable appearance largely defined by their gender and race, generally with concealment of visible hair loss. For those whose hair loss is discovered, however, they often conceal the cause by using something they feel is more socially acceptable as an explanation. Concealment of hair loss allows participants to avoid being labeled and stigmatized as "unattractive," while concealment of TTM as the cause allows them to avoid being stigmatized as having a mental illness. When individuals do choose to disclose their TTM, it is generally to those they feel will be the least likely to stigmatize them.

In the following sections I will discuss the multiple layers of stigma avoidance through impression management in the areas of concealment and disclosure. As many individuals with TTM do not seek treatment (Diefenbach, Reitman, and Williamson 2000), it is important to note that several participants are self-diagnosed through Internet research and discovery, rather than by a medical professional (Duchan and Kovarsky 2005). However, all participants identify as having TTM, and the self-labeling of the condition does not change the way it is studied (Giles and Newbold 2011; Moses 2009; Thoits 1985).

Concealing the Hair Loss

Goffman (1963) uses the term *passing* to describe when a potentially stigmatized or discreditable individual manages their identity in order to pass as "normal." For most participants, this means concealing their visible hair loss. Nearly all participants conceal their hair loss as a result of pulling in some way, often with makeup, wigs or hair extensions, head coverings, or a particular hairstyle (including shaven). Lisa, 26, pulls her eyelashes: "I always wear eye makeup to cover—to make it seem like I have eyelashes. Like a black eyeliner, and stuff like that." By concealing her "differentness," that is, lack of eyelashes, she remains "discreditable" (Goffman 1963:42). She is not stigmatized, but could be if her lack of eyelashes were discovered.

Emily, 60, pulls her eyebrows:

> I'm always using an eyebrow pencil to fill in, and then mascara or something like mascara to um, try and make it look—try and make the hairs that are there look more prominent.

Emily, who is an athlete with a prestigious, public occupation, keeps an eyebrow pencil with her at all times and re-touches her brows throughout the day, particularly after exercising. Even with all of her life and career accomplishments, she considers her TTM a weakness, and does not want to show her weakness to others.

Ken had only ever spoken to his wife about his TTM before our interview. He worries about the consequences that might follow if he decided to go into politics:

> I do get concerned that if—that people are going to notice and I almost feel like I'm gonna have to stop at some point if I get you know—a job that's more high-profile and more closely-scrutinized, or if I ever go into politics or anything like that… I'd obviously have to explain it, and I think that in that arena, especially in the political arena, mental health

> issues are not—people are not as accepting or understanding. Um, I mean just as a fairly political matter. I think that political opponents would certainly make an issue out of it.

Ken is generally able to hide his pull areas by wearing long sleeves and ties at work, but feels that in a highly scrutinized public arena such as politics, his TTM could be highly discrediting.

The methods of concealment used by participants generally align with their social roles. Although some individuals discussed their occupation, age, or location as a factor in their concealment methods, participants generally spoke about the importance of gender, and for African-American women, gender and race.

Often, participants feel that their TTM hinders their gender performance, and so gender appropriate concealment is required. Men's hair is a reflection of their sense of self and is indicative of the masculinity they hope to achieve (Ricciardelli 2011). Five of the six men who participated in this study pull from their scalp, beard, or both. All five shave those pull areas, and either keep them shaved all the time, or shave them once the pulling becomes noticeable. Carl explains how he knows when it is time to shave his head again:

> Usually my wife will give me a heads up, saying "Your pulling is really bad" or you know, "There's hair all over your desk," or one of my coworkers actually who I used to live with, he got used to living with me, and he saw it, and he'll give me a heads up as to when I need to shave my head.

Carl shaves his head to retain his masculinity, as he feels it is more acceptable to be completely bald than partially bald. All of the male scalp pullers in this study, and many of the women as well, feel that shaving one's head is more socially acceptable

for men than it is for women. Across many cultures, social norms require women's hair to be different from men's hair, a rule only abandoned when the culture's need to differentiate themselves from other cultures trumps the need to differentiate between genders (Weitz 2004). The four women who have shaved their heads make sure to wear makeup, big earrings, or other accessories. Sasha reflects on her femininity while having a shaved head in public:

> I'd make sure I wore like earrings, and eyeliner, and makeup, just to kinda, you know. Like, "Hey I'm feminine." I don't want, you know, to be unsensitive, but I'm not like, a butch. I don't want people to be like, "Oh my god, is she butchy or something?" It's just like, "Mm-mm, I'm wearing my big earrings and makeup and jewelry" just to kinda show my femininity, you know what I mean?

Sasha's resistance to being considered "butch" might be a result of the norms surrounding gender enactment. For women, hair is a part of gender enactment, confined by the appropriate ways to wear it (Gimlin 2002). Wearing feminine accessories makes up for wearing her hair shaved, which is often associated with men and masculine women. Carl and Sasha each have a sense of self-blame for the ways their TTM hinders their gender performance. Carl would like to have a masculine full head of hair, and loses confidence when he realizes he has a "ginormous bald spot" that he caused to himself. Sasha says her goal is to be able to go to a hair salon to have her hair done. She wants to spend time with women at a hair salon, rather than "sit with a bunch of guys" at the barbershop. Though Sasha wears wigs, scarves, accessories, and makeup to preserve her femininity, she realizes that she is denying herself this way to connect with other women.

Though several women participants like Emily and Mary use makeup to conceal their missing eyebrows or eyelashes, some participants do not conceal their visible hair loss in their eyebrows or eyelashes and hope that others do not notice or comment. Women feel that using makeup would draw too much attention to their eyes, while men feel that for them, wearing makeup to fill in eyebrows or eyelashes would be socially unacceptable. Ben, a 25-year old man, went out with his friends to see how strangers would react to him wearing realistic false eyebrows.

> I went far away from my normal hangout so I wouldn't see anybody that I knew. And my friends were very supportive and everything, and they started saying as the night went on "they're growing on me, they're growing on me." And I'm like "oh cool." We ended up at this one bar, and the bartender, you know like, kept looking at me, and I'm like "Uh oh, is this a good look or a bad look?" And then my buddy's like "Oh no, she's just like, she's probably wondering like, if you get your eyebrows waxed and she wants to know where you go." And I'm like "Oh alright." So then she ended up coming over, and she was like, "What's up with your eyebrows?" I'm like, "What do you mean?" And she's like, "I don't know, they're like, weird. Are they fake?" And then my buddy started laughing, and I'm like, "Yeah, they are." And she's like, "Why would you do that?"

Ben experienced first-hand what other brow pullers said, that it is socially acceptable for women to use makeup to fill in eyebrows and eyelashes, while for men it is not. As any behavior "can be assessed as to its womanly or manly nature" (West and Zimmerman 1987), using makeup to conceal missing eyebrows or eyelashes would be considered un-manly. All of the participants discussed ways that they manage their impressions (Goffman 1959) to fit within the acceptable range of appearance norms based on their gender and race. For each participant, gender is a salient part of their identity, and they experience TTM from the standpoint of gendered normativity.

For African-American women, hair is an important part of culture and identity. Nearly all of the African-American women I interviewed described the importance of hair to African-American culture. Lea reflects on the importance of hair to beauty and identity:

> Black women, that's our crown, you know what I mean? We spend a lot of money on our hair. We spend thousands and thousands and thousands of dollars on our hair. And I was raised like, my mother was like, "You know your hair is an extension of your beauty."…That's what I was told, your hair is an extension, you know, of your beauty. You know, hair texture, um, yeah it is. Yeah, it's definitely part of my identity. It's part of your character, um, men judge you on your hair. There's expectation of how your hair is supposed to look from your family. People talk about you if your hair doesn't look good.

The African-American participants all alluded to the use of wigs or extensions in the African-American community as being normative. Sasha says she had never really put much thought into it, because it is so ingrained: "It's like, 'Oh you've got a wig? Where'd you get that? What store?' Like, nothing else. No questions asked."

All of the African-American participants pull or have pulled from their scalp, and each wears wigs, scarves, or extensions daily, explaining that these practices are normative for African-American women in general. Several of these women mentioned the prevalence of damaged hair and bald patches due to the hair practices of African-American women, and the normalized (and even expected) use of wigs, scarves, and extensions to cover them.

For those that pull hair from their scalp, men participants seem to have similar experiences to the African-American women participants, in that they have a method for concealing visible bald spots that is widely used, and often for hair loss unrelated

to TTM. For men in general, being completely bald seems to be preferable to having bald spots, while for African-American women, using a wig or extensions is preferable to having thin or damaged hair. The few non-African-American women participants that wore wigs often discussed the quality of the wigs themselves, and whether or not they looked "natural." Hanna explains the quality of her wigs:

> I would wear my wig at work, and people would never tell. Because I'm talking—I've paid probably more than 5,000 dollars total on wigs alone. Um, yeah. So they're super high quality, they're custom fit to my head, and um, it's like taking care of a designer dress. So, people can't tell.

Conversely, Lisa reflects on her experiences with lesser quality wigs:

> I guess the most hurtful thing would be like when I was working, and I was still new to the wig community, so I had cheap bad ones, and there would be people that I would work with that would like snicker and say things about me like, "There she goes with that nappy hair." They would like, tell my boss he needed to tell me to get better hair, and stuff like that.

Hanna's high-quality wigs allow her to remain discreditable, while Lisa is discredited for having low-quality, unnatural-looking wigs. Quality of wigs did not come up as an issue for the African-American participants, though for the non-African-American women, having natural-looking hair seems central to the ability to remain discreditable.

Concealing the Cause

For participants whose visible hair loss has been discovered, many want to keep the cause concealed, lest they be discredited for having a mental illness (Goffman 1963). Several participants explained that if others found out they were pulling out

their own hair, they would be considered "crazy" or a "freak." Many participants have undergone similar thought processes, and respond by preparing some kind of excuse or reasoning for the hair loss that they feel would be more socially acceptable than TTM (Shott 1979, Thoits 1985). Some participants blame the hair loss on another medical condition that is known to include hair loss, which they may or may not actually have. For some, this may be a thyroid condition, alopecia, or cancer. Lea, a recent cancer survivor, reflects on why she keeps her TTM a secret:

> I would feel like they would think that I was a freak or something—a weirdo. Or um, I would think that they would think that I'm unstable, like a freak or something. It's embarrassing, I don't—you know what I mean? They would think less of me, they would think I'm a weirdo or a freak or some—that's why I avoid telling people what the real situation is.

Lea's avoidance of telling people the "real situation"—her TTM—allows her to blame previous aggressive chemotherapy for her hair loss. She already has the stigma of having cancer and the hair loss that goes with it, but she feels that it is less damaging to her identity than having TTM. With aggressive chemotherapy, hair loss is accepted as a consequence Lea would have no control over. With TTM, however, Lea believes that she would be seen as a "freak" or mentally unstable as she is causing her own hair loss. Because of this, Lea has low self-esteem, and does not feel she can trust anybody enough to tell them about her TTM without them judging her.

Sasha spent her childhood and adolescence making up excuses for why she was missing hair. As a child, someone in her neighborhood asked her if she had

cancer, and she went along with it. Once her neighbors thought she was sick, they defended her when she was made fun of:

> If even one of the neighbors, or if an older, older neighbor heard one of the kids like, talking junk, it'd be, "oh really? Really?" I remember this older white lady, she like literally pulled—took the kid's ear, old school, and brought him to his house…And she was like, "Your son is not gonna talk about that little girl that's sick." And then the mom was like "Oh my god, you're talking about her? What's wrong with you?"

Sasha understood that hair loss due to chemotherapy would be accepted as something that was not her fault. However, if the children in her neighborhood knew that she was pulling her eyebrows and scalp hair out herself, she would have been made fun of for that. However, if her neighbors believed she had cancer, she would receive their pity. For Sasha, like Lea, the stigma of having cancer was far less damaging than the stigma of having TTM.

Some participants' excuses are more accident-related, as if the hair loss was a result of an acute accident. Mary reflects on her experiences at work:

> A couple of time, customers/other employees will notice my eyelashes and ask what happened to my eyelashes and I will make up an excuse like "I was taking off my makeup and I must've rubbed to hard on my eyelashes since some came out" or "I tried fake eyelashes and the glue got stuck to my eyelashes and pulled them out."

Ken has a similar excuse prepared, although he has never had to use it:

> I think I am able to hide it very well, you know, and if anyone were to ask me about it, I'd probably just say it was an old chemistry injury or something, or something like that…Sort of like cause where it is, if you were to have your hands on either side of a Bunsen burner, and it blew out, that's where it would get you.

Once hair loss is discovered, individuals with TTM remain discreditable regarding its cause. Having an excuse prepared allows Mary and Ken to blame the hair loss on something other than themselves, something they cannot control. Blaming the hair loss on an accident frees them of the potential stigma and devaluation (Goffman 1963, Link et al. 1989) of being labeled with a mental illness.

Gender and race may play a part in allowing individuals with TTM conceal the cause of their hair loss once it is discovered. Erica explained how African-American women's hair practices often lead to damaged hair, and how others assume her hair loss is from those practices:

> They think partly because of the use of chemicals in the black community, um, people always think it's from bad relaxer or straightener, or too much heat from a straightening comb, or braids that were too tight… I think there's a lot of women who have damage from other stuff, like I was saying the perms and hot combs and stuff. So bald patches are not such an unusual thing.

For Erica, along with some of the other African-American women participants, the normality of bald patches allows them to conceal the cause of their hair loss with an excuse embedded in their hair culture.

These two layers of concealment show us the complexities of impression management, and the ways they can affect the psychosocial impacts of TTM on the individual. Impression management can cause anxiety, as individuals with TTM not only have to cover their hair loss, but also its cause. Feeling as though they have to cover their visible hair loss around certain people or in public, as well as worrying about how visible their bald spots are can cause low self-esteem and make them want

to avoid social situations in which they worry their hair loss might be seen. Worrying about others discovering the cause of hair loss adds an additional layer to this anxiety, as the idea that the individual is "doing this to themselves" can further decrease self-esteem and increase the avoidance of social situations where the hair loss might need to be explained. In addition, individuals who make up excuses may have to maintain them, or come up with new ones. For example, to preserve her excuse Sasha had to maintain the identity of a cancer patient for a long time when she was younger, for which she says that she now feels guilty.

Disclosure as Preventative Telling

For a stigmatizing condition such as TTM, information control can be very important to maintaining a public identity (Schneider and Conrad 1980). Disclosing a stigmatizing condition can be used as "preventative telling," (Link et al. 1989) which would hopefully enlighten others to the situation and prevent or change negative attitudes about the condition. Schneider and Conrad (1980) discuss this as a management strategy, in which individuals use disclosure to influence others' actions and ideas not only about them, but also about other individuals with the same condition. In previous research, individuals with TTM reported that sharing their experience is helpful in educating others about the diagnosis, however disclosure may lead to an increase in negative social perceptions (Casati, Toner, and Yu 2000; Marcks, Woods, and Ridosko 2005).

Participants fell on a wide spectrum of TTM disclosure, ranging from only telling a few close friends or family to public disclosure using social or mass media. Lauren used to work in a high school, and although she no longer needs to wear a wig, she felt that she needed to disclose her TTM to her coworkers when she began wearing a wig during the school year:

> I had to tell coworkers at one point because I did start wearing a wig, and when you work in an environment like a high school, and everybody sees you every day and you're not just in your own little cubicle, um, so a lot of coworkers knew, and by the end of the year I did tell my students.

Lauren felt a drastic appearance change like beginning to wear a wig would have raised questions and concern from her coworkers, so she explained her TTM to them. Although Lauren had previously felt considerable anxiety regarding talking about her TTM, she felt that the school was a supportive environment, and she could trust her coworkers not to devalue or reject her. She felt supported enough by them to eventually tell her students, who she felt reacted positively toward her. The trust and support Lauren felt were enough to allow her to overcome some of the negative psychosocial impacts individuals with TTM often feel, helping to increase her self-esteem and ability to maintain close relationships with her coworkers.

Though not all participants' disclosure is preventative—some is more therapeutic in nature (Schneider and Conrad 1980)—those who disclose their TTM tend to do so with those who they anticipate will not stigmatize or discriminate against them (Rüsch et al. 2014). Sarah feels that her friends are a great support network for her, and so she feels comfortable disclosing her TTM to them:

> Most of them try to find out more about it. Most of my friends are very sympathetic. My friends like that understand—I rarely ever came across someone who actually knew what it was prior to [telling them].

Educating her friends about TTM and their wish to learn more about it makes Sarah feel accepted, and keeps her from being stigmatized within her social network.

Selective disclosure allows participants to manage their identities and avoid stigmatization by controlling the flow of information. Through preventative telling, individuals can bring up their TTM on their own terms with the intention of dispelling some of the discrimination or devaluation that may come if their hair loss or pulling behavior are discovered accidently. Generally, participants choose to disclose to those they feel will be less likely to stigmatize and more likely to support them, which in turn may have positive psychosocial effects like raising self-esteem and allowing them to feel more comfortable maintaining intimate relationships.

Knowing Vs. Seeing

Disclosure has a second layer. There is a difference between allowing others to know about TTM and allowing them to see the unconcealed hair loss. Nearly all participants have at least one person they feel comfortable enough to disclose their TTM to, and attempt to educate them about the condition. Generally these are parents, close family or friends, and romantic partners, as those are the individuals they will see most often and are most likely to see their visible hair loss. While some participants feel uncomfortable allowing their romantic partner to see their visible hair loss, several feel their partner is a positive support. Having a supportive partner may

have a protective effect against the difficulties initiating and maintaining intimate relationships noted in previous research (Casati, Toner, and Yu 2000; Novak 1997).

Most participants that conceal do not wish to do so at home. They feel most comfortable in their own homes and with those they live with, so they are able to disclose and leave their hair loss unconcealed. Some participants have experiences living with roommates or others not in their immediate family. Hanna reflects on her experience with a foreign exchange student that lived with her and her family:

> She just walked in on me in the bathroom one day and I paid no mind to it, and I told her, "No, this is what I do, this is why I look different, this is what I have, and you're just gonna have—you're just gonna have to see if you're in the house." She had to just accept the fact that this is where she was living, these are the people she was going to live with for one year. So I feel like she has the right to know, I don't wanna have to hide in my own home.

Similarly, Hailey reflects on her experiences living with roommates at college, and allowing them to see her hair loss:

> I'm in college, and I've had many different roommates, and I've actually just told them. "Oh, just so you know I have trich, and I have this and this and this is my routine" and they're usually okay with it.

By explaining their TTM to those they live with, Hanna and Hailey defend themselves against potential stigmatization, which could be likely in these situations. Allowing those they live with to see their visible hair loss gives participants like Hanna and Hailey the ability to reclaim power in a potentially stigmatizing situation, which may in turn be protective against negative psychosocial impacts like low self-esteem or social avoidance.

Public Awareness

Awareness was a common theme throughout many interviews. Several participants discussed being open about their TTM in hopes of generating awareness that could lead to less devaluation and discrimination (Link et al. 1989). Lisa reflects on her openness about her TTM at work:

> Um, I'm fairly open about it. It creates a lot of curiosity at work. I work at a hospital, so they're used to seeing people you know, with wigs and stuff like that. So I just kinda drop little hints to get them asking me about it, you know. Cause I want to tell people, I want people to be aware of the issue, you know? Cause I think not enough people have ever heard of it. I wish it was that abundant. Like, omnipresent and other stuff, you know, that people deal with.

Other participants have written blogs about their experiences in hopes of raising awareness and helping others with TTM. Rachael has a blog and has taken part in more public projects related to TTM as well. She feels as though she has been able to take on the role of a public figure for TTM, but also feels that her work may affect her dating prospects:

> If you Google me, if you Google my name, that's what's gonna come up. It's just a laundry list of—I rip out my hair—so I notice because I am single, I will not give out my last name, and then I'm like well shit I gotta tell you. Like, either I gotta tell you, or you're gonna Google me, which is really easy to do, so I'd better get it out of the way fast.

Rachael balances the responsibilities of raising awareness as a public figure in the TTM community with her life as a single woman in a world where attractiveness and mental stability are valued. Although Rachael is public with her TTM, she still feels some shame and hesitation in telling prospective dates about it. She worries that she may be rejected or receive judgmental and discriminatory reactions, which may be a

risk of education (Schneider and Conrad 1980). However, she engages in preventative telling to maintain control over the flow of information and hopefully dispel negative reactions.

Participants feel that more awareness and public knowledge about TTM might help normalize and de-mystify it, which would eliminate the need for impression management and stigma avoidance. Although some participants engage in public awareness work, some participants had very little history of disclosure and told me they hoped to help spread awareness of TTM by taking part in this study. A few participants mentioned seeing TTM on television or in a magazine, and it helped them put a name to their behavior. However, other participants felt that media portrayal of TTM sensationalizes it, reinforcing the feeling that others might see them as "crazy" if their TTM was discovered.

Chapter 5

CONCLUSION

Through a combination of concealment and selective disclosure, participants use impression management techniques to avoid stigmatization in the areas of appearance and mental health. Participants may go to great lengths to preserve their social identities in a society that values both attractiveness and mental stability. A flaw in either can be detrimental to how others perceive their character, so a mental illness that detracts from the perceived attractiveness of an individual may put them at great risk for stigmatization.

Concealing visible hair loss is a focus for most participants, and techniques used fall largely under what they perceive to be socially acceptable for their social positioning, particularly gender and race. Women are more likely to use makeup to conceal missing eyebrows or eyelashes, while men feel it would not be socially acceptable to do so. Men who pull from their scalp are more likely to shave their heads, while women will either wear wigs, scarves, or extensions. The few women who have shaved their heads will wear makeup or other accessories to preserve their femininity. African-American women feel that hair loss is common due to the extensive use of chemicals, straighteners, and tight braids, so wearing a wig or weave is accepted and in some cases even encouraged.

For participants whose visible hair loss has been seen or discovered, many wish to hide their pulling as the true reason for the hair loss, and will create an excuse. For some, the excuse may be an acute accident, such as eyelashes getting stuck to false eyelash glue, or using heated styling tools too often. Others may blame a medical condition known to cause hair loss whether or not they actually have the cause, such as cancer or thyroid issues. Both types of excuses remove the cause of the hair loss from the individual's behavior and give the illusion of the cause as something outside their control. Although illness carries its own stigma, participants feel that the stigma related to illness is less damaging than the stigma that would be associated with TTM.

Consistent with mental health literature on disclosure (Rüsch et al. 2014), participants tend to limit the disclosure of their TTM to those who they feel will be less likely to stigmatize them. Many participants disclose their TTM as a preventative measure to those who they think may discover their pulling behavior, hoping to educate them about the condition and deter negative perceptions or judgments about the individual and others with TTM. Some participants even use social and mass media hoping to educate the public about TTM, which is also the motivation to participate in this study for some.

There seems to be a difference between disclosure and actually allowing others to see the visible hair loss. Participants tend to be more comfortable leaving their hair loss unconcealed in their own homes around significant others or very close family members, however some have felt comfortable enough with roommates to allow them to see hair loss. This may be because they feel safer at home, and do not feel they need

to spend as much time managing impressions around those who they feel accept and support them.

By studying the impression management techniques of those with TTM, we learn that concealment of visible hair loss is a primary and immediate goal, with an emphasis on hiding the cause of the hair loss as self-induced. Additionally, we find the influence of race and gender on the impression management techniques used. Understanding TTM as a condition that exists within the space where mental health norms and appearance norms meet may help us to understand other mental illnesses that affect appearance, such as other body-focused repetitive disorders like skin-picking and nail-biting (Stein et al. 2010). There may be some similarities between TTM and eating disorders (ED), as both are classified as mental illnesses (APA 2013) and directly affect the appearance of the body. As disordered eating is also a solitary and isolating experience and a stigmatized illness (Mond, Robertson-Smith, and Vetere 2006; Yeshua-Katz and Martins 2013), studying ED in the space where mental health norms and appearance norms meet may help to understand impression management within it in a different light. Further research in the area of impression management in body-specific mental illnesses would be helpful in understanding the ways individuals avoid stigmatization, but also how the level of comfort varies around different spaces and people.

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Appendix One

IRB Approval Letter

RESEARCH OFFICE

210 Hullihen Hall
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Newark, Delaware 19716-1551
Ph: 302/831-2136
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DATE: December 18, 2014

TO: Andrea Kelley, MSW
FROM: University of Delaware IRB

STUDY TITLE: [670723-2] Trichotillomania: A Sociological Approach
IRB REFERENCE #:
SUBMISSION TYPE: Amendment/Modification

ACTION: APPROVED
APPROVAL DATE: December 18, 2014
EXPIRATION DATE: November 30, 2015
REVIEW TYPE: Expedited Review

REVIEW CATEGORY: Expedited review category # *(6,7)*

Thank you for your submission of Amendment/Modification materials for this research study. The University of Delaware IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a study design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on the applicable federal regulation.

Please remember that informed consent is a process beginning with a description of the study and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the study via a dialogue between the researcher and research participant. Federal regulations require each participant receive a copy of the signed consent document.

Please note that any revision to previously approved materials must be approved by this office prior to initiation. Please use the appropriate revision forms for this procedure.

All SERIOUS and UNEXPECTED adverse events must be reported to this office. Please use the appropriate adverse event forms for this procedure. All sponsor reporting requirements should also be followed.

Please report all NON-COMPLIANCE issues or COMPLAINTS regarding this study to this office.

Please note that all research records must be retained for a minimum of three years.

Based on the risks, this project requires Continuing Review by this office on an annual basis. Please use the appropriate renewal forms for this procedure.

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If you have any questions, please contact Nicole Farnese-McFarlane at (302) 831-1119 or nicolefm@udel.edu. Please include your study title and reference number in all correspondence with this office.

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