UNDERSTANDING THE COMPLEXITIES OF TRICHOTILLOMANIA: WOMEN’S RECOLLECTIONS OF THE ROAD TO DISCOVERING TRICHOTILLOMANIA AND THE JOURNEY THAT FOLLOWED

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
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Abstract

This study examines the childhood and social experiences of 10 women with trichotillomania (compulsive hair pulling) and the various pathways that led them to the discovery of trichotillomania. Trichotillomania is a chronic and devastating condition that affects a significant number of women, which has long-term consequences that can be debilitating and psychologically and emotionally scarring. The 10 women participated in semi-structured interviews during which they were asked to describe their childhood and social experiences. This is the first study that has attempted to understand childhood and social experiences from the perspective of women living with trichotillomania. Utilizing a grounded theory approach (Strauss & Corbin, 1998), the interviews were transcribed, coded, and analyzed. A model, based on the core category, The Road to Discovering Trichotillomania: The Issue of Control, was developed to reflect the experiences of these women. The model is constructed on five major themes: Looking Back: How It All Began; Childhood Environment; Relationship Between Specific Experiences and the Discovery of Hair Pulling; The Role of Hair Pulling; and The Journey of Hair Pulling. The women identified the events (both internal and external) that precipitated the first episode of hair pulling. The underlying theme of these events was the perception that things were out of their control. The discovery of trichotillomania came about as a result of the women’s attempts to regain control of their experiences and environment. The findings of this study make an important contribution to
the current literature on trichotillomania by attempting to understand the complexities of the factors involved in the discovery of this condition. In presenting the lived experiences of these 10 women, this study moves the discussion beyond the pathology and towards a richer understanding of trichotillomania. The study’s limitations, implications for future research, and final thoughts are also discussed.
Acknowledgements

Writing a thesis seems at times to be a solitary journey. But the opposite is true. A thesis is the culmination of several years of hard work by both the writer and those around her. It begins with developing a research project, conceptualizing how the research will be conducted, gathering and analyzing the data, and finally, writing it up in a coherent manner. My journey involves the efforts of a number of people who have been instrumental in helping me realize my dream of completing a doctorate. First, I would like to thank my thesis supervisor, Dr. Mary Alice Guttman, whose encouragement and guidance were unwavering. Though trichotillomania was not your area of interest, you graciously agreed to supervise my research and for this I am grateful. Second, I would also like to thank my committee members, Dr. Niva Piran and Dr. Brenda Toner, who reviewed the various drafts of my thesis and provided helpful suggestions. I am fortunate to have had an opportunity to work with all of you. You’ve provided me with exceptional support. Third, I would like to thank Dr. Charles Chen, who attended my oral defense and provided thoughtful questions. I would also like to thank my external reviewer, Dr. Jennifer Mills, who offered insightful questions, comments, and suggestions. You both made the task of defending my thesis a painless and overall enjoyable endeavor.

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This thesis is dedicated to the women who generously and selflessly participated in this study. Without you, this thesis would not have been possible. I thank you for your participation in this study and for helping to bring this relatively understudied condition out into the open.

As long as you are breathing, there is more right with you than there is wrong, no matter how ill or hopeless you may feel.

(Jon Kabat-Zinn, as cited in Allen, 1995, p. 137)

On a personal note, I would like to dedicate this thesis to my mother, Carla Casati. Words cannot express how much I miss you. You’ve left behind a silence that will never be filled. Though you were not able to see the final result of my many years of hard work, I hope that you are proud of what I have achieved. I would never have been able to accomplish what I did without your encouragement, love, and support.

I love you. You will forever have a place in my thoughts and my heart.
Chapter 1:  
Introduction

I often wonder what my life would be like if I didn’t have this shameful secret.

When people look at me, they don’t see what I think is so obvious; or maybe they do and they don’t comment because they are too polite. I’ve lived with this secret for over 25 years. At times I feel shame and self-loathing, thinking that I am the only one that engages in this behavior. At other times, I accept who I am and the consequences of my behavior. Although I have accomplished much in my professional life, on a personal level, I still spend a great deal of time making sure that family, friends, and co-workers don’t know my secret. What is my secret? I am a hair puller!

(Personal journal, May 25, 2008)

The preceding excerpt describes feelings typical of someone with trichotillomania. An estimated 1 in 50 individuals (Trichotillomania Learning Centre Inc, n.d.) or 2 to 4% of the American population have a shameful and psychologically devastating secret obsession: a chronic need to pull out their hair (Anders & Jefferson, 1994). This is a condition that strikes women disproportionately. For every man with trichotillomania there are 15 women (Christenson, Mackenzie, & Mitchell, 1991). Hair pulling, clinically referred to as trichotillomania (TTM), is considered by most TTM investigators to be not a new condition but rather one that is slowly emerging out of the shadows. It was not officially listed in the handbook of psychiatric and psychological disorders, the Diagnostic and Statistical Manual of Mental Disorders (DSM-IIIR) until 1987 (American Psychiatric Association, 1987) although trichotillomania was first described by Hallopeau in 1894 (cited in Christenson & Mansueto, 1999). A recent study by Woods et al. (2006) demonstrates just how emotionally
painful and significant trichotillomania is for its sufferers. Given the level of psychosocial disability experienced by those with trichotillomania, this condition represents a major cost to society. As noted by Woods and Twohig (2008), “nearly 1 million work days are missed per year due to TTM symptoms, and nearly 73,000 working age adults may have ended their employment because of TTM (Woods, Flessner, et al., 2006a)” (p. 3).

The understanding and treatment of trichotillomania has been and continues to be a challenge. Despite how common this condition is and its significant psychosocial complications, not to mention the continued suffering of the individuals affected, it has only been in recent years that the literature has expanded to include the personal accounts of individuals with this condition. For example, Cheryn Salazar’s 1995 book, You Are Not Alone: Compulsive Hair Pulling, the Enemy Within, recounts the author’s personal struggles with trichotillomania and her journey towards acceptance and recovery. In the past 10 years, numerous books and articles have been written that address the phenomenology, conceptualization, and treatment of trichotillomania, significantly advancing what we know about this condition. More recently, the reality show “Obsessed” has provided a firsthand account of what it is like to live with obsessive compulsive disorders. One episode chronicles the struggles and challenges of a woman named Mandi as she attempts to address her trichotillomania. Despite the sensationalism of reality shows and the criticisms directed towards them, these televised accounts reach large numbers of people. These accounts offer hope to those suffering with the condition and help to dispel the notion that they are the only ones with these symptoms. In addition, a web site program, StopPulling.com (Mouton-Odum, Keuthen, & Stanley, 2003) was developed in response to the needs of individuals with trichotillomania to assess and address their hair-pulling symptoms in a private and cost-
effective manner. The developers of the program, Drs. Mouton-Odum, Keuthen, and Stanley, have given those suffering from trichotillomania an alternative method of assessing and treating this condition by allowing individuals to address it in the privacy of their own home and at their leisure. Using a cognitive behavior therapy approach, it is an interactive self-help program. For a monthly fee, participants can create individualized treatment plans to deal with their hair-pulling behaviors (Mouton-Odum, Keuthen, Wagener, Stanley, & DeBakey, 2006). This web site has brought more awareness to the condition and more access to assessment and treatment. Finally, the Trichotillomania Learning Centre (TLC), a non-profit organization devoted to disseminating clinical and research information and providing resources to individuals with trichotillomania, their families, and the general public, has further advanced understanding of this condition. Yet there is much that is still unknown.

The conceptualization of trichotillomania, or how we think theoretically about this condition, has received much attention in the literature, generally from one of two perspectives, the biological and the psychological. The biological perspective suggests that it is an impulse control disorder (American Psychiatric Association, 2000) or an obsessive compulsive spectrum disorder (Swedo & Leonard, 1992) and strongly emphasizes the role that biological factors may play in its development. In contrast, the psychological perspective suggests that trichotillomania is a habit disorder and emphasizes the role of psychological factors such as stressful life events (Azrin & Nunn, 1977). Family dynamics and environmental antecedents have also been proposed as possible factors in the development of TTM under the umbrella of this perspective (Keuthen, Stein, & Christenson, 2001; Penzel, 2003). While these etiological models have advanced the scientific understanding of trichotillomania, empirical research on the development and course of chronic hair pulling is
still at the preliminary stages. This has led some researchers to speculate that the origins of trichotillomania may be found by using a multifaceted approach, suggesting that biological, psychological, and social factors each play a significant role in its development, i.e., that it is unlikely that hair pulling is linked to one and only one factor (Enos & Plante, 2001; Keuthen et al., 2001).

Despite the increasing research and clinical interest in trichotillomania, little is known about the etiology of this condition. One theme that has on occasion emerged in anecdotal and clinical descriptions of trichotillomania is the role of early adverse experiences. A recent study by Lochner et al. (2002) compared childhood trauma in female patients with obsessive compulsive disorder, trichotillomania, and a control group. Participants completed the Childhood Trauma Questionnaire (CTQ), a short self-report measure that assesses sexual, physical, and emotional abuse in childhood. Results of the study indicate that women with trichotillomania and OCD have a higher rate of childhood trauma than the control group. While this study does provide some preliminary data to support the notion that early adverse experiences may be associated with trichotillomania, the emphasis of the study was on childhood trauma. To date, there have been no studies that have systematically investigated the childhood environment of women with trichotillomania. Research into the interplay of early life events in the development of trichotillomania can provide valuable information about its course and help facilitate appropriate and effective interventions.

The primary purpose of this study is to explore the childhood environment and experiences of women with compulsive hair pulling. At the present time, little is known about the influence of early life events on trichotillomania. Studies are needed to increase our understanding in this area. This study seeks to contribute to the literature by exploring the
childhood and social experiences of women with trichotillomania and illustrating the various pathways that lead to its onset. Undoubtedly, chronic hair pulling may be attributed to different factors for different individuals. While providing a foundation for future research, findings from this study will help to better define the experiences of women with trichotillomania by naming the condition and naming the various factors associated with discovering trichotillomania. The naming of these experiences is done in the words and the voices of the women who participated in this study. In addition, a secondary purpose of this study is to bring awareness to, and reduce the stigma of hair pulling and to offer support to the millions who continue to suffer in silence.
Chapter 2:
A Review of the Literature

In this chapter, I begin with an overview of the clinical characteristics and presentation of trichotillomania. I then present a review of the research on the childhood environment of women with trichotillomania. The final section of this chapter provides a brief summary of the biological, psychological, biopsychosocial, and other models proposed to explain the development of trichotillomania.

Clinical Characteristics and Presentation of Trichotillomania

Trichotillomania is a mental disorder defined by specific diagnostic criteria. Though hair twirling and hair playing are typical activities that are not of clinical significance for many in the general population, for individuals with trichotillomania these symptoms are extensive and result in a chronic and uncontrollable pattern of behavior. In other words, the diagnosis of trichotillomania is the result of noticeable hair loss and symptoms that significantly interfere with the person’s work and interpersonal relationships (American Psychiatric Association, 2000). Additional diagnostic criteria for trichotillomania include: increasing sense of tension prior to the pulling, relief or gratification after, and a determination that the pulling is not due to a medical or other psychiatric condition (American Psychiatric Association, 2000). This condition is currently classified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV TR) (American Psychiatric Association, 2000) as an “impulse control disorder not otherwise classified,” however, there is much discussion among the trichotillomania community as to whether this current classification is appropriate given its failure to fully
capture the presentation of trichotillomania (Christenson & Mansueto, 1999). “The inclusion of TTM in DSM-IV-TR among a diverse group of impulse control problems such as intermittent explosive disorder, kleptomania, and pyromania has been criticized as conceptually unfounded” (Franklin & Tolin, 2007, p. 13). Continued research in the area of trichotillomania will perhaps result in a shift in how we conceptualize and classify this disorder. But until a more appropriate category is created, trichotillomania will likely remain classified as an impulse control disorder.

Trichotillomania is considered by most researchers to be a prevalent and common condition that is estimated to affect a significant percentage of the US population (Christenson, Pyle, & Mitchell, 1991). Though demographically trichotillomania has been recognized in the Caucasian population (Stanley & Mouton, 1996), several studies have demonstrated the occurrence of trichotillomania among other ethnicities in the US (Christenson, Mackenzie, and Mitchell, 1991; Dubose & Spirrison, 2006; Neal-Barnett, Ward-Brown, Mitchell, & Krownapple, 2000). Trichotillomania has also been shown to cut across socio-economic levels (Christenson, Mackenzie, & Mitchell, 1991; Cohen et al., 1995). However, the stigma and secrecy commonly associated with this condition makes it nearly impossible to know the exact number of those afflicted with it (Penzel, 2003). The studies undertaken that have attempted to address this issue have consistently demonstrated that though it is more widespread than previously thought, it is still very much an understudied and underreported condition. Woods and Miltenberger (2001) note that repetitive disorders are seriously underrepresented in the current clinical literature. More specifically, the number of published articles found in MedLine (1971) and PsychoInfo (2000) about trichotillomania in comparison to the number about schizophrenia and bipolar
disorder illustrates a stark contrast.\textsuperscript{1} Across the two databases there are 679 articles about trichotillomania, 70,675 about schizophrenia, and 14,961 about bipolar disorder.

A study that attempted to determine the prevalence of trichotillomania was conducted in 1991 by Christenson, Pyle, and Mitchell. They surveyed 2,579 college students and found that 0.6% of the students met the diagnostic criteria for trichotillomania. A very different picture emerged when the criteria were less restrictive and the students did not need to report the tension-gratification criteria to obtain a diagnosis (American Psychiatric Association, 1987). In this case, it was found that 3.4% of females and 1.5% of males engaged in hair pulling. Other investigators, including Graber and Arndt (1993) and Christenson, Mackenzie, and Mitchell (1991), have consistently demonstrated that a considerable number of individuals engage in hair pulling who do not fully meet the criteria outlined in the DSM. It is also important to note that a vast majority of individuals with trichotillomania do not seek treatment for their disorder (Cohen et al., 1995) suggesting that its prevalence may be higher than estimated. It has also been suggested by some researchers that the frequency of hair pulling exceeds that of, “the more commonly known conditions such as schizophrenia, manic depression, and even panic disorders. Indeed, only the most common of conditions, like depression and substance abuse disorders, seem to occur with greater frequency than hair pulling” (Keuthen et al., 2001, p. 4).

Trichotillomania generally affects more women than men, though the clinical literature does suggest that men also display clinically significant hair-pulling symptoms (Christenson, Mackenzie, & Mitchell, 1994). Some investigators have suggested a more even

\textsuperscript{1} Medline (1971) and PsychInfo (2000) were the databases used by Woods and Miltenberger (2001) to establish this comparison.
gender distribution, particularly when it comes to the lifetime prevalence rates for women and men (Christenson, Pyle, & Mitchell, 1991). And yet, women continue to outnumber men as sufferers of trichotillomania. The research that is currently available to us has not adequately addressed gender differences in trichotillomania. Of the studies that have examined its prevalence, the consistent conclusion is that the majority of individuals who engage in this type of behavior are females; figures range from 73.4% (Muller, 1987) to 97% (Wetterneck, Woods, Norberg, & Begotka, 2006).

One study suggests that overall there are few differences between men and women with trichotillomania (Christenson et al., 1994). They are similar with respect to chronological age, age of onset, pulling sites, characteristics of hair pulling and psychiatric comorbidity (Christenson et al., 1994). As well, there has been some discussion in the literature suggesting that trichotillomania among males is underreported. For example, Christenson, Mackenzie, and Mitchell (1991) note that males may be able to disguise the condition more easily than females. One could also postulate that it is more socially acceptable for males to be bald. As well, the differences in the numbers of identified female to male sufferers may be due to differences in help-seeking behaviors (Anders & Jefferson, 1994; Christenson, Mackenzie, & Mitchell, 1991; Penzel, 2003). In general, males may be less likely than females to seek help (Christenson, Mackenzie, & Mitchell, 1991; Keuthen et al., 2001), and males who do seek medical or psychiatric attention for their concerns do not seek help specifically for hair pulling (Christenson et al., 1994). As well, men who do seek help may be presenting to clinics other than psychiatric ones and this may account for their underrepresentation in the psychiatric literature (Christenson et al., 1994). To date, the
information that we have on trichotillomania has been drawn largely from studies of women with the condition.

Trichotillomania has also been shown to have a significant economic impact. Though anecdotal evidence suggests that hair pulling has economic consequences, it is only recently that this issue has been systemically examined. According to Wetterneck et al. (2006), trichotillomania is associated with increased absenteeism and costs arising from the concealment of the effects of pulling. In this study, Wetterneck and colleagues present findings based on two sample groups of individuals with trichotillomania. Both groups completed the Massachusetts General Hospital Hair Pulling Scale (Keuthen et al., 1995) and a survey created by the authors that examined the social and economic impact of chronic hair pulling on the lives of the participants. The first group consisted of attendees of a TLC conference and the second group was recruited a year later through the TLC web site. Participants from both groups indicated that their hair pulling caused difficulties with relationships and leisure activities as well as work and career aspirations. Participants also indicated that they had spent money concealing effects of their hair pulling and that the hair pulling had greatly impacted their ability to attend social events and participate in various activities. The authors of this study provide suggestions for improving treatment of trichotillomania, namely, the education of mental health professionals with respect to presentation and treatment options, funding, and public education.

An earlier study by Seedat and Stein (1998) also examined the economic impact of trichotillomania and its psychosocial complications. A sample of 27 participants completed a questionnaire that focused on demographic information, symptoms of trichotillomania, medical information, family history, interference with day-to-day functioning and treatment
history. Results from this study indicate that trichotillomania significantly impacts an individual’s everyday functioning and interferes with relationships. For example, of those who responded to questions about its effect on their ability to participate in everyday life, 10 respondents stated that they experienced a moderate degree of distress as a result of their symptoms. Five respondents were unable to continue with their academic careers and four respondents had a disruption in their work. The authors further noted that chronic hair pulling can result in costs associated with treatment seeking and misdiagnoses. The authors conclude that there is a need for increased awareness on the part of health care professionals and the public with regards to diagnosis and treatment options.

Social functioning is also negatively affected by chronic hair pulling. In other words, interference in interpersonal relationships, a reluctance to attend social gatherings, and a preoccupation that others will discover their secret are typical of individuals with trichotillomania. Casati, Toner, and Yu (2000) interviewed seven women with compulsive hair pulling and found that isolation and other negative effects co-exist with this condition. The authors of this study also note that these negative effects (humiliation, fear, guilt, embarrassment, anger, and frustration) significantly impact the way the women engage in everyday activities. For example, avoidance of social activities was reported by the majority of the women. Townsley-Stemberger, Thomas, Mansueto, and Carter (2000) also note significant social impairment as a consequence of chronic hair pulling. These researchers completed a chart review of 63 patients and noted difficulties including avoiding going outside on a windy day, engaging in organized sporting events, participating in public events, attending brightly lit areas, and going to get a haircut. In other words, normal everyday activities taken for granted by most of us are considerably difficult for these patients (Penzel,
Wetterneck et al. (2006) and Seedat and Stein (1998) provide further evidence of the predicament faced by individuals with trichotillomania and emphasize the need to understand the complications and struggles faced by these individuals on a daily basis.

Problems related to self-esteem, more specifically, low self-esteem and a negative sense of self, have also been reported as a consequence of chronic hair pulling. Soriano et al. (1996) conducted a survey examining self-esteem in 62 individuals with trichotillomania. Participants were provided with a survey package that included the 1965 Rosenberg Self-Esteem Scale, the 1961 Beck Depression Scale, and the 1988 Beck Anxiety Inventory, as well as a questionnaire intended to assess body image concerns, and collect demographic information and medical histories. “This study suggests that several factors – frequency of hair pulling, body dissatisfaction unrelated to hair pulling, and levels of anxiety and depression – are related to self-esteem in patients with trichotillomania” (Soriano et al., 1996, p. 81). Interestingly, the authors of this study note that a number of factors (e.g., age of onset, number of years of pulling) were unrelated to self-esteem and “surprisingly, severity of hair loss was not related to levels of self-esteem, suggesting that trichotillomania may have an equally negative impact on one’s self-esteem regardless of the amount of actual hair loss incurred” (Soriano et al., 1996, p. 80). Other studies also highlight a relationship between hair pulling and low self-esteem. For example, Townsley-Stemberger and colleagues (2000) note that 77% of their sample reported low self-esteem. Similarly, Diefenbach, Tolin, Hannon, Crocetto, and Worhunsky (2005) report that patients with trichotillomania have lower self-esteem than the control group. Associated with this negative sense of self, individuals with trichotillomania may be aware of the negative perceptions of others, further reinforcing the negativity that they feel as a result of their hair pulling. A recent study by
Boudjouk, Woods, Miltenberger, and Long (2000) examined the social acceptability of hair loss and note that individuals with trichotillomania are viewed negatively because of hair pulling.

Taken together, these studies provide further evidence of what individuals with this condition have always known: trichotillomania has devastating effects on one’s life, particularly on interpersonal and social functioning. In addition, trichotillomania is unique in how it compromises one’s quality of life (Diefenbach et al., 2005; du Toit, Kradenburg, Niehaus, & Stein, 2001). A recent study by Keuthen et al. (2004) examined functional impairment and quality of life of individuals with chronic hair pulling. These researchers failed to demonstrate significant impairment of quality of life. One explanation they suggest is that the psychosocial experiences faced by many individuals with trichotillomania are unique to them and cannot be fully explored by generic quality of life measures (Keuthen et al., 2004). Despite this finding, it is interesting to note that the individuals in the study all reported impairment in the areas of social, occupational, and leisure functioning. This study provides further evidence that understanding the effects of trichotillomania, particularly on quality of life, requires further research using specific trichotillomania-related measures. Nevertheless, Keuthen et al. provide important clinical direction in that they suggest that the phenomenon of hair pulling and its associated features are not as straightforward as once believed.

**Childhood Experiences and Trichotillomania**

Trichotillomania appears to begin in adolescence as evidenced by the numerous clinical studies that suggest mean age of onset of between 11 and 13 years of age
Christenson, Mackenzie, & Mitchell, 1991). To date, there have been no studies that have specifically identified and examined the life events surrounding the onset of trichotillomania. Clinical experience and preliminary research suggest that several factors may be associated with the onset of this condition. However, some investigators argue that trichotillomania is not associated with any particular life event. For example, Christenson and Mansueto (1999) and Penzel (2003) have found that some individuals with trichotillomania report relatively mundane circumstances, such as modeling or pulling a hair out in response to a science teacher’s request, as precipitants to hair pulling while others can recall no specific event that precipitated their hair pulling. Clinically and anecdotally, the literature seems to suggest that there is no specific kind of event associated with chronic hair pulling, however, it does imply that there is an array of factors involved in the development and maintenance of trichotillomania (Keuthen et al., 2001; Penzel, 2003). Recent research has demonstrated that childhood trauma is associated with the development of trichotillomania (Boughn & Jaarsma Holdom, 2003; Lochner et al., 2002). This suggests that at least for some individuals, trauma is a significant factor that precedes hair pulling, however, the development of trichotillomania appears to be multifaceted. This is clearly an area that deserves further study.

Indeed, little is known about the development of trichotillomania, including whether there is an association between childhood experiences and chronic hair pulling. In their review of the literature, Christenson and Mansueto (1999) provide a list of studies that have reported on particular events and/or situations that have been identified as contributing to the start of hair pulling for some individuals. Some of these studies are described in detail below. What becomes evident is that although different factors may play an important role in how
trichotillomania gets started for individuals, knowledge about what these factors might be is limited. A few studies have noted that family stress due, in particular, to separation of parents and child, other problems in the home, and school difficulties have typically been associated with the development of hair pulling. For example, Oranje, Peereboom-Wynia, and Raeymaecker (1986) reviewed the clinical records of 21 children with trichotillomania, all under the age of 15, and note that a significant percentage of the sample reported stress as the trigger for pulling. Stress-related factors include separation of child and mother due to hospitalization, sibling rivalry, difficulties at home and school, and a disturbance in the mother-child relationship.

Horne (1977) describes the cases of two patients, one a male in his early 40s and the other a female in her early 20s. In the first case, the man reported that he began his hair pulling at the age of 7, and although he did not report any events that may have precipitated it, he did note that as a child he stuttered. In the second case, the woman had an 8-year history of trichotillomania that began at the age of 17. She reported that her pulling had developed in response to the stress of studying for examinations. In addition, both pulling and nail biting in her immediate family were reported. Horne writes that, “there seems to be little doubt, from the cases reviewed, that whatever initially produced compulsive hair pulling behavior, there is a strong habitual component by the time a person presents for treatment” (p. 195). The author further notes that an examination of the relationships between anxiety and hair pulling, in addition to fostering an increased awareness of the behavior, are important aspects in treating hair pulling.

Oguchi and Miura (1977) focused on the mother-child relationship and note that for six of their participants, trichotillomania was associated with difficulties the participants had
in the mother-child relationship. These authors conclude that the development of compulsive hair pulling is related to maltreatment by the mother. In the cases discussed, the mothers were reported to be timid, obedient, inattentive, neglectful, dominating or irritable. In contrast, the fathers were distant or aggressive. In the case of H. A., a 6-year-old girl, there was no indication that the mother-daughter relationship was problematic. Traits of the participants are also described as being important contributing factors in the development of trichotillomania. For example, participants are described as being self-punishers, of having detached relationships with their mothers, and of having suppressed impulses. The authors conclude that a combination of these factors may contribute to the onset of trichotillomania.

Glaski (1983) discusses the cases of two sisters who were diagnosed with trichotillomania and sought treatment for it. In both cases, problems in the parent-child relationship were implicated in the etiology of the condition. The author, discussing trichotillomania from a psychoanalytic perspective, notes that:

> The quality of the parent-child relationships impairs the ego development and causes failure of the trichotillomaniac patient to establish object constancy. Without the establishment of object constancy an individual requires visible evidence that the object/person capable of gratifying basic security needs is present or available. (p. 345)

Schnurr (1988) presents the results of psychological assessments completed on three adolescent girls. The author’s findings suggest that personal loss, in particular, separation from friends and family, may be factors in the onset of chronic hair pulling. The author also notes that although separation issues were noted in all three cases, personality traits are also associated with the onset of this illness. For example, in one case, the girl is described as being, “a very strong and determined person who could use manipulation to obtain her wishes” (p. 465). In contrast, another girl is described as, “passive, indecisive, and
conscientious” (p. 464). This study attempts to discover indicators that may make individuals more susceptible to the development of trichotillomania, however, the author does note that the small sample used makes conclusive results impossible, pointing to the need for a more exhaustive study.

Schnurr and Davidson (1989) report on the case of a 10-year-old boy who developed trichotillomania in the context of disruptions in the mother-child relationship and gender identity issues. The family history revealed substance abuse and an affective disorder. Problems in the immediate family included communication problems, an intense mother-son relationship, and a distant father-son relationship. Individual factors on the part of the child included lack of coping skills and an inability to provide insight and motivation to this problem. The authors conclude that the interplay of all of these factors resulted in gender role confusion, which in turn caused this young boy to develop gender identity issues, culminating in chronic hair pulling. The authors also note that treatment for this boy’s trichotillomania involved integrating individual and family therapy, which resulted in a successful resolution of the chronic hair pulling.

Parental divorce has also been discussed as a factor associated with the development of trichotillomania in children. For example, Bornstein and Rychtarik (1978) report on the case of a 21-year-old female who started pulling out her hair at the age of 8. The authors note that the hair-pulling behavior first began when her parents divorced. This finding is consistent with Weller, Weller, and Carr (1989) who examined trichotillomania and depression in a 7-year-old girl. The authors identify two events in this girl’s life that coincided with her hair pulling: the divorce of her parents and her entrance into school. The childhood environment of this girl is characterized as unstable due to the separation of her
parents, homelessness, and abuse and neglect. This study identifies family instability as one of the factors that can precipitate hair pulling.

Muller and Winkelmann (1972) report on the cases of 24 patients with a diagnosis of trichotillomania and note that only 6 were able to identify a potential stressor for the onset of the hair pulling. Stressors for the six included enuresis, moving to an unfamiliar large city, and surgery. One patient recalled several stressors, the onset of menstruation, a ruptured ovarian cyst, and being a victim of a robbery, all occurring within a few weeks. The authors of the study conclude that underlying emotional factors should be considered when treating trichotillomania.

Cordle and Long (1980) describe two clients, 25 and 19 years of age, who had a 10-year and 5-year history of trichotillomania, respectively. The 25-year-old, Ms. A, was a married woman who began pulling as a result of being the victim of bullying in school. The 19-year-old, Ms. B, began pulling her hair shortly after her mother’s death. Interestingly, in Ms. B’s case there was also a family history of hair pulling: her father pulled hair from his nose.

Though not specifically addressing childhood experiences, Casati and colleagues (2000) found that chronic illnesses, sexual harassment, and family disruption (divorce or death) were reported as possible factors associated with the development of trichotillomania. However, not everyone who reported these factors connected them to their hair pulling, indeed, in one case, the subject had experienced harassment while in elementary school, but she stated that this event did not precipitate her hair pulling. She identified watching her mother pull her hair as the precipitating factor for her own hair pulling. This study highlights
the individualistic and multifaceted nature of trichotillomania and the difficulty of identifying precipitating events.

Finally, it has also been suggested that a history of trauma may be associated with chronic hair pulling. Several investigators have reported a relationship between a history of abuse and trichotillomania (Keuthen et al., 2001). For example, a study by Singh and Maguire (1989) explores trichotillomania in a girl who had experienced incest as a child. In this particular case, the girl reportedly began to pull her hair in response to the psychological difficulties she experienced as a result of the incest. Yet, Christenson, Mackenzie & Mitchell (1992) report that a history of sexual abuse is not common among individuals with trichotillomania. Evidence for this is based on their study of 60 chronic hair pullers of which only 10 females and 1 male reported a history of sexual abuse. Indeed the authors of this US study note that the figures are much lower than those found in the general population (Christenson, Mackenzie et al., 1992; Christenson & Mansueto, 1999). Based on these findings, one could hypothesize that the situation in Canada is similar. According to the Committee on Sexual Offences Against Children and Youths, more than half of all Canadian women (53%) report that they were victims of childhood sexual abuse (Health and Welfare Canada, 1998). As noted by Christenson & Mansueto (1999) the link between childhood sexual abuse and trichotillomania has not been well established and the available evidence would seem to suggest that sexual abuse is not a requirement for trichotillomania.

Boughn and Jaarsma Holdom (2003) conducted semi-structured interviews with 44 women with trichotillomania to examine the role of violence in the development of hair pulling. They found that violence is associated with the onset of chronic hair pulling. Results from this study indicate that violence plays a significant role in the lives of these women.
Ninety-one per cent of the sample reported violence or trauma at some point in their lives and 86% reported a violent incident prior to the development of trichotillomania. Specific types of violence included sexual assault, rape, and gang rape. These authors conclude that a history of violence and/or traumatic incidents experienced predominantly in childhood is disproportionately represented among women with trichotillomania. The authors strongly recommend that the issue of violence be addressed in both the assessment and treatment of the disorder.

A more recent study by Gershuny et al. (2006) examined the role that trauma and post-traumatic stress (PTSD) might play in the development of trichotillomania. Forty-two patients with trichotillomania completed a series of measures that assess trauma and post-traumatic stress disorder and hair-pulling sequelae. Results from this study indicate that there is an association between trauma and PTSD and trichotillomania. A significant percentage of the participants indicated that they had experienced one or more traumatic incidents in their life (76.3%) and 19% had PTSD. The authors also note that the number of traumatic events and type of trauma is associated with the duration and site of hair pulling. For example, individuals who have suffered from trichotillomania for longer periods and who report pulling hair from their scalp are likely to report a significantly higher number of traumatic incidents. This study provides support for the hypothesis that there is an association between trauma and the onset of trichotillomania. Although a definitive conclusion cannot be drawn, one can conclude that trauma plays an important role in the development of chronic hair pulling in some individuals.
Methodological Considerations for This Research

The literature pertaining to factors that may be associated with, or contribute to, onset of trichotillomania, specifically, early adverse experiences, is limited. The preceding studies consistently suggest that childhood experiences have an impact on the onset of hair pulling, however, the exact relationship between these experiences and trichotillomania is not well understood. For example, from a review of the literature, Graber and Arndt (1993) report that only 6.8% of those studied identified an event that coincided with the onset of hair pulling. Events identified in their review include parental divorce, death of a relative, parental conflict, and school-related problems. However, these authors also note that the research reviewed quite often did not explore precipitating events and that is likely that, “figures in support of this contention would have been higher if more authors would have provided this information in their case studies” (Graber & Arndt, 1993, p. 344). In contrast, Greenberg and Sarner (1965) report that in half of their 19 cases an identifiable event precipitating the onset of hair pulling was reported and the theme of a perceived or actual loss was prevalent. As well, a study by Santhanam, Fairley, and Rogers (2008) suggests that pulling in childhood is associated with a number of different contexts and the course of the behavior is dependent on a variety of stressors. Interestingly, these authors note, “we found no clear evidence of a cyclical nature to hair pulling, for example related to school term or, as in adults, to the menstrual cycle” (Santhanam et al., 2008, p. 411).

To date, no studies have specifically investigated childhood events in the lives of women with trichotillomania. The studies cited above have a number of methodological limitations that make it difficult to ascertain the specific role that the identified factors play in
the development of trichotillomania. First, several of these are case studies that focus exclusively on childhood trichotillomania. The work that has been done in this area suggests that its clinical presentation and psychosocial complications differ significantly from those of adult trichotillomania (Reeve, 1999). Second, these studies did not systematically investigate the childhood events surrounding the onset of trichotillomania. Several of these studies address other issues and the ensuing discussions and conclusions do not specifically address the issue of childhood environment. Third, we do not know the influence of co-morbidities, e.g., depression, anxiety, or eating disorders, on trichotillomania. Systematic studies looking at the question of the influence of comorbidities on trichotillomania have not been done. Finally, most of these studies, with the exception of Boughn and Jaarsma Holdom (2002, 2003) and Casati et al. (2000) did not provide an opportunity for participants to share their experiences of trichotillomania in a qualitative manner. Understanding trichotillomania from the perspectives of individuals with the condition is an important, if not, crucial, aspect of identifying the possible factors that may contribute to its development.

Given these limitations, it is important that we begin to focus our research attention on the possible relationship between childhood events and the discovery of chronic hair pulling. Trichotillomania may be viewed as a multidimensional condition and as such a multidimensional approach, one that examines the interplay between genetics, life events, and family dynamics, is needed. While the etiology of trichotillomania remains unclear, and it is quite likely that finding a single cause for hair pulling is not possible, an investigation of childhood events may provide important preliminary information that will help to untangle the complexities of chronic hair pulling.
The Current Thinking on What Factors Are Associated With the Development and Maintenance of Trichotillomania

In addition to discussing the childhood environment and its impact on the development of trichotillomania, it is also important to review the current thinking on the best approach to understanding the onset and maintenance of compulsive hair pulling. This is best addressed by examining the literature in two areas: biological explanations and psychological explanations. While each of these kinds of explanations highlights different aspects of the origin of trichotillomania, they both offer important insight into the development and clinical expression of the condition. Though many explanations and models have been put forth, only those that have received widespread research attention will be discussed. What becomes evident in reviewing this literature is that the question of what causes trichotillomania is a complex one that to a large extent remains unresolved.

Summary of the Biological Explanations Literature

Are there specific genes that predispose an individual to trichotillomania? Are there abnormalities in specific brain structures or irregularities in brain chemicals that make it more likely for an individual to develop hair pulling? Attempts to provide responses to these questions are offered by the biological models of trichotillomania. In recent years, there has been a shift in how researchers and clinicians understand trichotillomania. Biological explanations or theories of chronic hair pulling focus on abnormalities in the brain, in particular the role that serotonin, a neurotransmitter, plays in the development of this disorder. This explanation, often referred to as the “serotonin hypothesis,” suggests that individuals with trichotillomania have a dysregulation of serotonin (Keuthen et al., 2001). This particular theory of trichotillomania is supported in two ways: first, the similarities
between obsessive compulsive disorder and chronic hair pulling and second, response to treatment with selective serotonin reuptake inhibitors (SSRIs) (Stanley & Mouton, 1996). Both trichotillomania and OCD include a compulsive aspect (Swedo & Leonard, 1992), and individuals with trichotillomania have relatives who have been diagnosed with OCD at a higher rate than the rest of the population (Franklin & Tolin, 2007; King et al., 1995), suggesting a relationship between the two disorders. In addition, there has been evidence to suggest that clomipramine is an effective drug for the treatment of chronic hair pulling. For example, utilizing a double-blind cross over study, Swedo et al. (1989) examined the efficacy of two drugs on trichotillomania: clomipramine and desipramine. Results of this study demonstrate that clomipramine is much more effective in the treatment of trichotillomania. In their review of the literature, Diefenbach, Reitman and Williamson (2000) suggest that trichotillomania shares more similarities with Tourette’s syndrome (e.g. O’Sullivan et al., 1997). This has prompted some investigators to consider hairpulling, tic disorders, and other repetitive disorders together given their commonalities (Woods & Miltenberger, 2001). In other words, the repetitive nature of these groups of disorders, the psychosocial sequelae, and treatment approach suggest similarities (Woods & Miltenberger, 2001). Other investigators have noted that trichotillomania may be associated with body dysmorphic disorder (BDD) and that this association may be stronger than previously thought (Christenson & Mackenzie, 1995). Indeed, Soriano et al. (1996) report that 22.6 % of their participants self-reported having body dysmorphic disorder, though the authors of the study also note that they were not able to validate these self-reports.

Complicating the question as to whether the neurobiological explanations adequately account for trichotillomania, subsequent studies have provided mixed results about the
efficacy of selective serotonin reuptake inhibitors in its treatment (Christenson, Mackenzie, Mitchell, & Callies, 1991; Diefenbach et al., 2000; Winchel, Jones, Stanley, B., Molcho, & Stanley, M. A., 1992). Also, it is generally accepted that trichotillomania can be distinguished from obsessive compulsive disorder in that many of the diagnostic criteria associated with obsessive compulsive disorder are not characteristic of trichotillomania (e.g., intrusive and repetitive thoughts) (Diefenbach et al., 2000; Franklin & Tolin, 2007; Stanley, Swann, Bowers, Davis, & Taylor, 1992). Furthermore, a review of the literature by Keuthen, O’Sullivan, and Sprich-Buckminster (1998), which highlights these similarities and differences, notes that challenges of classification, conceptualization, and treatment will continue unless longitudinal and large-scale studies are undertaken to address the documented contradictions. Overall, the nature of the relationship between trichotillomania and obsessive compulsive disorder remains unclear, though it is generally accepted that there are more differences than there are similarities between the two conditions (Chamberlain, Menzies, Sahakian, & Fineberg, 2007; Diefenbach et al., 2000).

Other neurotransmitters that have been implicated in the development of trichotillomania include the dopamine (DeSimoni, Dal-Taso, Fodritto, Sokola, & Algeri, 1987), opioid (Christenson, Crow, & Mackenzie, as cited in Stein, O’Sullivan, & Hollander, 1999), and hormonal systems (Keuthen et al., 1997). It is hypothesized that trichotillomania may involve imbalances in these three systems. For example, Keuthen and colleagues (2001) discuss the involvement of the hormonal system in trichotillomania, suggesting that hormonal changes in the body might account for it. According to these authors:

The fact that Trichotillomania is more common in women may point to the involvement of the female hormonal system in hair pulling. In addition, hair pulling sometimes begins or is worsened during adolescence or during the
premenstrual period, times when there are important hormonal changes. (Keuthen et al., 2001, p. 64)

Data supporting the role of these neurotransmitters is still preliminary; the specific role of these neurotransmitters in trichotillomania is still unclear, although the findings thus far provide a fascinating possibility for the etiology of this complex and misunderstood condition.

The genetics of trichotillomania have also been investigated. In their review of the literature in this area, Woods and Miltenberger (2001) have noted that a number of studies have found that a significant number of individuals with the condition have family members who are also hair pullers (e.g., Cohen et al., 1995; King et al., 1995; Lenane et al., 1992; Schlosser, Black, Blum, & Goldstein, 1994). Because it is generally speculated that most psychiatric disorders, such as depression, anxiety, and obsessive compulsive disorder, involve, at least in part, genetic components, it stands to reason that trichotillomania might also have a genetic basis. Though the studies cited above do seem to indicate that genetic factors play a role in the development of trichotillomania, the exact nature of this role is still to be determined.

Another possible explanation of trichotillomania, put forth by Grant, Odlaug, and Potenza (2007) and Christenson et al., 1994 (as cited in Penzel, 2003), is the addiction model. A central assumption of this model is that trichotillomania and other addictive disorders have features in common, in particular,

1. repetitive or compulsive engagement in the behavior despite adverse consequences;

2. diminished control over the problematic behavior;
(3) an appetitive urge or craving state prior to engagement in the problematic behavior; and

(4) a hedonic quality during the performance of the problematic behavior. (Grant & Potenza, as cited in Grant et al., 2007, p. 81)

In addition, the authors note that the lack of effective treatment for trichotillomania argues for moving beyond the OCD and trichotillomania framework and towards an alternative explanation of compulsive hair pulling. Taking a broader view, Brewer and Potenza (2008) examined the neurobiology and genetics of impulse control disorders and conclude that these disorders may be conceptualized as addictions based on their biological underpinnings. “Endophenotypes inform the understanding of genetic factors underlying the disease processes by focusing on specific biological features rather than diagnostic categories which in psychiatry are typically heterogeneous in nature” (Gottesmann & Gould, as cited in Brewer & Potenza, 2008, p. 70). Though the addiction model provides an alternate and interesting perspective on trichotillomania, additional studies are needed to test it.

Other biological lines of investigations have included: brain imaging studies (Stein, Coetzer, Lee, Davids, & Buwer, 1997; Swedo et al., 1991), neuropsychological studies (Keuthen et al., 1996; Rettew, Cheslow, Rapoport, Leonard, & Lenane, 1991), and animal studies (Bordnick, Thyer, & Branson, 1994; Goldberger & Rapoport, 1991; Rapoport, Ryland, & Kriete, 1992). Brain imaging studies have been done on individuals with trichotillomania to look for the underlying brain mechanisms that may be involved in hair pulling. Neuropsychological studies have provided further evidence of possible biological underpinnings of trichotillomania through the discovery of abnormalities in specific structures of the brain. The animal model of trichotillomania proposes that a, “neuroethological perspective of Trichotillomania and OCD is suggested based on
observable similarities of human hair pulling to displacement activities in animals” (Moon-Fanelli, Dodman, & O’Sullivan, 1999, p. 68).

Other less well known explanations for trichotillomania, including the stimulus regulation model and the yeast model, have been reviewed by Penzel (2003). The stimulus regulation model, which is based on Penzel’s clinical experience, suggests that:

It has always been my observation that people pull when they are either over stimulated (due to stress or either positive or negative excitement) or under stimulated (due to being bored or physically inactive). It would appear that pulling might therefore be an external attempt on the part of the genetically prone individual to regulate an internal state of sensory imbalance. (p. 69)

With respect to the allergy model, Penzel acknowledges his skepticism and describes the premise of this model: “TTM is somehow the result of an allergic reaction to a variety of yeast called *Malassezia furfur*” (p. 73). Further research is needed to address the possible benefits, if any, of these models as explanations for trichotillomania.

Overall, findings from these studies highlight the role of the biological components in the development of trichotillomania; and they provide further questions about the role that these components have, the degree of their involvement, and which parts of the brain are ultimately affected by them. Though these explanations of trichotillomania provide compelling evidence that biological factors may be associated with the onset and maintenance of compulsive hair pulling, they account for only one aspect of this condition.

**Summary of the Psychological Explanations Literature**

While the above explanations target the biological underpinnings of trichotillomania, the psychological explanations of trichotillomania focus on the psychological factors that might play a role in the development of this condition. Do psychological difficulties cause
trichotillomania? Is hair pulling a result of early trauma? Are some individual’s more vulnerable to developing trichotillomania because of life experiences? In an attempt to answer these questions, investigators have proposed several models under the umbrella of psychological theories.

The earliest explanation of trichotillomania comes from the psychoanalytic perspective, which is viewed by many investigators (Greenberg & Sarner, 1965; Krishnan, Davidson, & Guajardo, 1985; Tattersall, 1992) as an effective tool for understanding hair pulling. A general premise of the psychoanalytic explanation is as follows:

The stage is set for the development of Trichotillomania by the ambivalent relationship that evolves between the child and the parents, most particularly the mother, or the primary caretaker during the first 2 years of life. The hair may be used to comfort or to express the pain of loss or may serve as the recipient of anger for that loss. Eating the hair may symbolize oral impregnation, incorporation of the mother, or an aggressive destruction of the mother. Or it may represent a displacement of anger from the punishing and rigid mother to the self and, at the same time punishment for that anger, while the pleasure and pain generated may sow the seeds of masochism, with the fusion of pain and pleasure later possibly leading a person to seek out self-punishing or self-destructive experiences.

Finally, at yet another level, hair pulling may express loss of physical and sexual power as punishment for loving wishes toward one parent and competitive anger toward the other, or a masturbatory equivalent and punishment for a forbidden wish for self-gratification. (Koblenzer, 1999, p. 137)

Though the psychoanalytic literature offers its own argument for the factors that it sees as involved in the development and maintenance of hair pulling (Buxbaum, 1960; Koblenzer, 1999; Sperling, 1954; Winneck & Gabbay, 1965), questions still remain that cannot be answered solely from a psychoanalytic perspective. For example, not everyone with these early difficulties develops trichotillomania nor do all individuals with trichotillomania report these psychological difficulties. In addition, that pharmacological and behavioral treatments
have been successful at reducing and/or eliminating hair pulling highlights the importance of examining other factors that may play a larger role in its development.

Another psychological explanation of trichotillomania emphasizes the behavioral aspects of hair pulling, in other words how the hair pulling is learned, what factors reinforce the behavior, and how hair pulling can be unlearned. More specifically, the behavioral model of trichotillomania likens hair pulling to a nervous habit. The first proponents of this model, Azrin and Nunn (1973), indicate that generally:

A nervous habit originally starts as a normal reaction. The reaction may be to an extreme event such as a physical injury or psychological trauma (see also Yates, 1970), or the symptom may have started as an infrequent, but normal, behavior that has increased in frequency and been altered in its form. The behavior becomes classified as a nervous habit when it persists after the original injury or trauma has passed and when it assumes an unusual form and unusually high frequency. (p. 620)

Following in the steps of Azrin and Nunn, several authors have developed simplified versions of the original habit-reversal protocol. For example, Miltenberger (2001) detailed that the treatment protocol for:

Habit reversal is comprised of three treatment components: awareness training, in which the client learns to become aware of each instance of pulling; competing response training, in which the client learns to engage in a compatible behavior contingent on hair pulling or antecedents to hair pulling; and social support, in which a significant other helps the client successfully use the competing response to control the hair pulling. (p. 171)

Other investigators have developed similar protocols (Rapp, Miltenberger, Long, Elliot, & Lumley, 1998; Rosenbaum, 1982; Tarnowski, Rosen, McGarth, & Drabman, 1987). The efficacy of utilizing habit reversal for trichotillomania has been well documented (e.g., Mouton & Stanley, 1996; Rapp et al., 1998; Tarnowski et al., 1987). In addition, the low cost associated with behavior therapy, the long lasting effects of this treatment, and the relative
ease of administering it makes behavior therapy, specifically, habit reversal an ideal treatment choice for some individuals with chronic hair pulling (Keuthen et al., 2001).

Other behavioral models of trichotillomania have included the cognitive model of hair pulling, which involves identifying the thoughts, feelings, and perceptions associated with this behavior, and then addressing the cognitive distortions via the introduction of different thoughts and clearer perceptions (Gluhoski, 1995). A more comprehensive approach proposed by Mansueto, Stemberger, Thomas, and Golomb (1997) extends the behavioral model of hair pulling to include a functional analysis of hair pulling focusing on five modalities: cognitive, affective, motoric, sensory, and external. The model highlights the importance of addressing the internal and external cues that maintain hair pulling.

Recently, Woods and Twohig (2008) extended and modified the comprehensive model of Mansueto and colleagues (1997) to develop an ACT-enhanced behavior therapy approach to trichotillomania. This approach, “is a combination of habit reversal training (HRT) and stimulus control (SC) procedures as well as acceptance and commitment therapy (ACT)” (Woods & Twohig, 2008, p. 12). According to these authors:

The purpose of this treatment is to educate the client about TTM and teach her to (a) be aware of her pulling and its antecedents, (b) use self-management strategies to prevent or stop the pulling, (c) stop fighting against private experiences that lead to pulling, through learning skills such as defusion and acceptance, and (d) work consistently toward increasing her quality of life. (Woods & Twohig, 2008, p. 12)

This model of hair pulling suggests that thoughts, feelings, and urges all play an important role in reinforcing the hair-pulling behavior and that an acceptance of these factors versus an attempt to control them will be helpful in the treatment of trichotillomania (Woods & Twohig, 2008). Studies examining the efficacy of this model are still relatively new;
However, they do suggest that it provides an important addition to our understanding of trichotillomania.

Another model that deserves some mention is the view that trichotillomania is a form of self-injuring behavior. Trichotillomania is defined as a self-harm behavior because of its compulsive and repetitive nature (Favaro, Ferrara, & Santonsataso, 2007). However, trichotillomania cannot be clearly defined as an impulse control disorder given that for some with the disorder, hair pulling is not described solely as resulting from an irresistible impulse. Evidence for this is provided by first, the 17% of individuals who do not experience the tension-reduction cycle (Christenson, Mackenzie, & Mitchell, 1991; Stanley & Mouton, 1996), and second, those who do not reach the level of clinical significance for impulsivity on clinician- and self-rated measures (Stanley & Mouton, 1996). As well, a number of individuals with trichotillomania do not find pleasure in pulling (Stanley & Mouton, 1996). Though some investigators have noted that individuals with trichotillomania also exhibit other self-injurious behaviors, such as nail biting, skin picking, and lip biting, to name just a few (Christenson, Mackenzie, & Mitchell, 1991; Christenson & Mansueto, 1999), the majority do not engage in the more extreme forms of these behaviors such as self-cutting and self-inflicted burns (Christenson, Mackenzie, & Mitchell, 1991). Indeed, based on research done in 1995, (unpublished data, as cited in Keuthen et al., 2001) Keuthen et al. note the following:

Only 6.9 percent of patients have ever purposefully cut themselves and only 3.2 percent have attempted to burn themselves. Suicide attempts were reported for 15.1 percent of the sample, though this should be interpreted keeping in mind the high rate of co-occurring depression in hair pullers. Thus, this behavior may not be associated with the hair pulling per se, but rather with the depression that can often co-occur in those individuals who suffer from hair pulling. (p. 19)
A Biopsychosocial Explanation

A more recent explanation of the causes of trichotillomania is the model put forth by Franklin and Tolin (2007) and Franklin, Tolin, and Diefenbach (2006). The biopsychosocial model of trichotillomania incorporates a body-focused repetitive behavior (BFRB) approach in its conceptualization of trichotillomania and other habit disorders such as nail biting, skin picking and lip biting (Franklin et al., 2006; Franklin & Tolin, 2007). Similarities have been noted among these disorders (du Toit et al., 2001) and yet, despite these similarities there is still some question as to whether this categorization is conceptually appropriate. Franklin and Tolin (2007) suggest that, “there is insufficient taxometric data to inform us as to whether TTM and these other BFRBs indeed constitute a theoretically coherent constellation of disorders, and it is therefore unlikely that a new category of BFRBs will emerge as yet” (p. 13). Nevertheless, the authors note that they view BFRBs and trichotillomania as theoretically similar (Franklin & Tolin, 2007).

According to Franklin and Tolin (2007), the biopsychosocial model of trichotillomania is still a work in progress; however, it helps clarify how trichotillomania develops by incorporating biological, psychological, and social factors in the model. A more detailed explanation of this model is as follows:

Our model of TTM starts, as do other models, with a biological vulnerability of some kind; the implication here is that without this vulnerability, body focused habits are less likely to blossom into full-blown impulse control disorders. This biological vulnerability may be manifest in the form of altered pain sensitivity, increased perception of negative internal states, or increased drive to engage in repetitive behavior. Negative internal states, as well as discriminate internal and external cues that have been associated with the behavior, trigger the onset of the problem behavior, perhaps through powerful urges to perform the behavior. The behavior itself is then rewarded in one of two ways: by decreasing negative internal emotions or thoughts, or by eliciting positive feelings. The positive sensations elicited by the behavior may be linked in part to the altered pain sensitivity, and the repeated hair
pulling or other BFRB [body-focused repetitive behaviors] may also alter pain sensitivity further. These rewards increase the probability that the behavior will occur again. Pulling, picking and other BFRBs are often associated with long-term social and emotional consequences, but these are not sufficient to override the immediate gratification obtained via the problem behavior, so the behavior persists. (p. 18)

The biopsychosocial model presented above does present a plausible explanation of what causes and maintains trichotillomania. The template developed by these investigators highlights the important contribution of these factors in understanding trichotillomania and it also allows for a more comprehensive examination of its causes. An area of future study would be to examine the effectiveness of this model in clinical practice.

Summary of the Factors Associated With the Development and Maintenance of Trichotillomania

To date, the etiology of trichotillomania remains very much unknown; however, this has not stopped investigators from speculating about the factors that may be involved in its development and maintenance. Indeed the etiology of trichotillomania is an area of study that has gained much attention in the last few years. Thus far, the etiologic explanations of trichotillomania may be divided into two different categories: psychological and biological. In addition, comprehensive models have been recently proposed: the biopsychosocial and the acceptance enhanced behavior therapy approach. What is apparent is that trichotillomania is likely the result of a number of different factors interacting together. Diefenbach et al. (2000) comment that the different mechanisms that have been proposed to explain the occurrence of trichotillomania should be viewed as complementary models in that they interact and influence one another to provide a template that makes the development of hair pulling
possible. Franklin and Tolin (2007) note that the heterogeneous nature of hair pulling further suggests that:

Although the common features identified in the DSM-IV TR definition of TTM give the clinician some expectation of what TTM is, there appears to be so much variety in terms of descriptive psychopathology that it raises the question as to whether TTM could possibly have a single etiological factor. Our view is that it is multi-determined, serving different functions for different people; and that discovery of the function of TTM for each individual patient is critical to the development of a successful CBT strategy. (p. 4)

The biological theories of trichotillomania focus on the dysregulation of serotonin, specific brain structures, other neurotransmitters, and genetics as factors. The evidence for these biological explanations stems from the similarities between trichotillomania and OCD and more recently similarities with Tourette’s syndrome. The consideration of neurological factors offers an important step to understanding trichotillomania because it helps to explain why some individuals are more susceptible to developing it than others.

The psychological theories of trichotillomania, including the psychoanalytic and behavioral approaches, offer another explanation for trichotillomania. These theories suggest that psychological factors play an important role in the onset and maintenance of the disorder. While these theories offer another important contribution to the literature on the etiology of chronic hair pulling, the psychoanalytic theory, in particular, while suggestive does not provide a satisfactory explanation. In addition, psychology does not provide an explanation of why some individuals are more vulnerable to developing trichotillomania than others. Perhaps a combination of biological and psychological factors is required to explain trichotillomania. Recently, several models, including the comprehensive model by Mansueto and colleagues (1997), the biopsychosocial, and acceptance and commitment approach, have
provided a multifaceted approach to understanding trichotillomania. These models highlight the roles that both psychology and biology play in the onset of compulsive hair pulling.

The literature on the etiology of trichotillomania continues to provide fascinating information about this condition and offers important groundwork for future studies. Recent research in the area of genetics (e.g., family and twin studies) has highlighted the important contribution of the field of genetics to understanding trichotillomania. In addition, psychological and pharmacotherapy studies continue to advance our knowledge of the possible factors associated with its onset. However, further research is needed to examine the complex question of how trichotillomania develops and what makes some individuals more vulnerable to developing this chronic and devastating condition than others.

As suggested above, there are glimmers of possible answers but the etiology of compulsive hair pulling continues to elude the scientific community. While the current literature has focused on biological and psychological factors, additional research that examines the life events and circumstances that coincide with the discovery of trichotillomania is needed. This study seeks to contribute to the literature by performing such an examination. In addition, that the problem of hair pulling is complex is further reinforced by the experiences described by the participants in the present study. As one of the participants stated:

I don’t know why, some days I don’t need to pull, and some days I just have to pull. I pull when I am happy or I pull when I am sad. I pull when I am bored; when I am lonely . . . there are different reasons.
These experiences as well as many others unique to individuals with trichotillomania reinforce the importance and need for further research into this condition.
Objective of This Study

To try to better understand the childhood and social experiences of women with trichotillomania and the various pathways to the discovery of trichotillomania, this study utilizes a qualitative approach. It is hypothesized that women with trichotillomania will report a number of life circumstances consistent with the discovery of trichotillomania. The overall purpose of this study is to provide preliminary, exploratory data that can be used to improve upon current research, and extend our understanding of the various pathways to the discovery of trichotillomania. In doing so, we can provide individuals with trichotillomania a more optimistic outlook on the course and treatment of this condition.
Chapter 3: Research Design and Methodology

In this chapter, I provide an outline of the design and methodology utilized for this study. I also include a description of the ethical considerations involved in the study and how they were addressed. In later sections of this chapter, the recruitment process, data collection, and data analysis are discussed.

Research Design

This study utilizes an exploratory, qualitative approach in examining the childhood environments and experiences of women with trichotillomania. To date, the influence of childhood life events on the onset of trichotillomania have not been investigated. In utilizing a qualitative research method, more specifically, semi-structured interviews, participants are provided with an opportunity to share their stories and experiences in their own words. According to Seidman (1991):

The purpose of in-depth interviewing is not to get answers to questions, nor to test hypotheses, and not to “evaluate” as the term is normally used (See Patten, 1989, for an exception). At the root of in-depth interviewing is an interest in understanding the experience of other people and the meaning they make of their experience. (p. 3)

This is echoed by Jones, Torres, and Arminio (2006) who affirm that, “the intent of qualitative research is to illuminate and better understand in depth the rich lives of human beings and the world in which we live” (p. 2).

The qualitative paradigm provides researchers with the opportunity to examine and facilitate the participant’s exploration of his or her experiences within the context of the
As Jones et al. (2006) note, “qualitative inquiry requires the researcher to become embedded in context and responsive to what is happening in that context. There often is, and should be, a relationship between the researcher and the researched” (p. 2). Creswell (1998) further notes:

Qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social and human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting. (p. 15)

And according to Seidman (1991):

Interviewing provides access to people’s behavior and thereby provides a way for researchers to understand the meaning of that behavior. A basic assumption in in-depth interviewing research is that the meaning that people make of their experience affects the way that they carry out that experience. (p. 4)

In other words, it is through this method of inquiry that we, as researchers, have the opportunity to understand, through observation and storytelling, the meaning of the experience to the participant (Seidman, 1991).

**Method of Inquiry:**

**The Grounded Theory Approach**

An important first step in conducting qualitative research is to choose an approach, in other words, a tradition of inquiry that is applicable to the topic being studied. In this particular study, a grounded theory approach is utilized because the main objective of this study is to develop an understanding of the childhood environment and experiences of women with trichotillomania. According to Creswell (1998), the researcher’s task in grounded theory is to, “generate or discover a theory, an abstract analytical schema of a
phenomenon that relates to a particular situation. This situation is one in which individuals interact, take actions, or engage in a process in response to a phenomenon” (p. 56). This type of research approach is suited for this particular study because it helps to identify the factors that are involved in onset of trichotillomania.

When using a grounded theory approach, several challenges must be met. First, “the investigator needs to set aside, as much as possible, theoretical ideas or notions so that the analytic, substantive theory can emerge” (Creswell, 1998, p. 58). Second, “the researcher must recognize that this is a systemic approach to research with specific steps in data analysis” (p. 56). Third, “the researcher faces the difficulty of determining when categories are saturated or when the theory is sufficiently detailed” (p. 58). Finally, “the researcher needs to recognize that the primary outcome of this study is a theory with specific components: a central phenomenon, causal conditions, strategies, conditions and context, and consequences” (p. 58).

To address each of the above challenges, I took the following steps. First, my review of the literature was undertaken in a manner that allowed me to set aside any preconceived hypotheses with respect to the study topic. As Creswell (1998) notes:

This literature review shows gaps or bias in existing knowledge, thus providing a rationale for grounded theory study. A researcher does not provide a theoretical framework in this review inasmuch as the intent of grounded theory is to generate or develop a theory. (p. 179)

The literature review reveals that this study, a systematic exploration of the childhood environments of women with trichotillomania, fills a gap. The research method utilized provides an opportunity to identify and explore the relationship between childhood factors
and onset of trichotillomania. The purpose is to begin to develop a model of the relationship between these variables.

Second, analysis of the transcripts of the interviews with the participants consisted of the following steps: “grounded theory provides a procedure for developing categories of information (open coding), interconnecting the categories (axial coding), building a ‘story’ that connects the categories (selective coding), and ending with a discursive set of theoretical propositions” (Strauss & Corbin, as cited in Creswell, 1998, p. 150). Details about coding and the development of the categories are described in the data analysis section of this chapter.

Third, to achieve saturation, the transcripts were extensively reviewed until it was determined that no new information could be gleaned. As noted by Seidman (1991):

“Enough” is an interactive reflection of every step of the interview process and different for each study and each researcher. The criteria of sufficiency and saturation are useful, but practical exigencies of time, money, and other resources also play a role, especially in doctoral research. (p. 45)

Taking these practical issues into consideration, it was decided that a sample size of 10 participants would be adequate.

Finally, the results of the study are presented in a way that highlights themes that emerged from the data.
Rationale for Utilizing This Method of Inquiry

As previously mentioned, qualitative methodology is utilized in this study for two specific reasons. First, the topic, specifically, the childhood environments and experiences of women with trichotillomania, is an area that has not been explored. Qualitative research provides an excellent means of eliciting participants’ perspectives to gain a better understanding of a specific phenomenon. Creswell (1998) highlights the importance of utilizing a qualitative method of inquiry in a previously unexplored area:

In a qualitative study, the research question often starts with a how or a what so that the initial forays into the topic describe what is going on. . . . second, choose a qualitative study because the topic needs to be explored. By this, I mean that variables cannot be easily identified, theories are not available to explain behavior of participants or their population of study, and theories need to be developed. Third, use a qualitative study because of the need to present a detailed view of the topic. The wide-angle lens or the distant panoramic shot will not suffice to present answers to the problem, or the close-up view does not exist. (p. 17)

This type of research allows for a more flexible approach to studying a specific phenomenon. Flexibility is important for this particular study because of its exploratory nature. Exploring the childhood environment and experiences of women with trichotillomania is still a relatively new area of research. Indeed, this is the first study that has asked women with trichotillomania to recall experiences and events from their childhood that coincided with the onset of trichotillomania. As such, given the limited information that is available in this area, it is important to explore events and context in a manner that allows participants to articulate their experiences in an open-ended and non-restrictive framework (Creswell, 1998). For example, according to Mack, Woodsong, MacQueen, Guest, and Namey (2005):
Qualitative methods . . . allow greater adaptive and adaptation of the interaction between the researcher and the study participant. For example, qualitative methods ask mostly “open-ended” questions that are not necessarily worded in exactly the same way with each participant. With open-ended questions, participants are free to respond in their own words, and these responses tend to be more complex than simply “yes” or “no.” Participants have the opportunity to respond more elaborately and in greater detail than is typically the case with quantitative methods. (p. 4)

**My Role as the Researcher**

One of the important, if not necessary aspects of qualitative research is reflexivity (Corbin & Strauss, 2008). Qualitative researchers are asked to locate themselves in their study and reflect on the extent to which they identify with the topic under consideration and the context in which the information is derived (Corbin & Strauss, 2008). This is done to ensure that the integrity and quality of the study is maintained (Lincoln & Guba, 1985). As noted by Seidman (1991):

Although the interviewer can strive to have the meaning being made in the interview as much a function of the participant’s reconstruction and reflection as possible, the interviewer must nevertheless recognize that the meaning is, to some degree, a function of the participant’s interaction with the interviewer. (p. 16)

For these reasons, and to facilitate an exploration of potential biases that might influence the data collection and analysis, I decided to use a journal to log my experiences. The journal was also one important element of the audit trail I established. Lincoln and Guba (1985) discuss the importance of this by noting that:

The reflexive journal, a kind of diary in which the investigator on a daily basis, or as needed, records a variety of information about *self* (hence the term “reflexive”) and *method*. With respect to the self, the reflexive journal might be thought of as providing the same kind of data about the *human* instrument that is often provided about the paper-and-pencil or brass instruments used in conventional studies. With respect to method, the journal provides information about the methodological decisions made and the reasons for
making them—information also of great import to the auditor [italics in original]. (p. 327)

In the next section, I review the steps undertaken to ensure that this study was completed in an ethical and consistent manner. This is an extremely crucial aspect of any research, however, its importance is even more pronounced in qualitative research given the role of these factors in the production of credible results.

*Special Considerations in Conducting This Study*

In conducting this study, I was immediately cognizant of the sensitive nature of the subject and the importance of resolving the issues and challenges one faces in the research process. According to Lee and Renzetti (1993), the problems faced by researchers conducting a study on topics that are deemed to be sensitive range from methodological considerations (e.g., study design, recruitment of study participants) to considerations regarding the findings and implications of the study. The sensitive nature of trichotillomania cannot be overstated. The emotional impact of hair pulling on individuals with this condition, the lack of visibility, and understanding from others (e.g., family and society in general), and the potential ramifications of this behavior (e.g., noticeable loss of hair), all contribute to the sensitivity of trichotillomania as a research subject. Because trichotillomania is a sensitive issue, I took steps to ensure that this study was completed in an ethical and considerate manner. This is an extremely crucial aspect of any research, however, it becomes even more critical in qualitative research relying as it does on the relationship between the researcher and the participants, and the participants’ willingness to respond to open-ended questions.
An important first step was to outline my research project in a detailed manner and to address potential ethical and methodological issues that could arise. These issues included, but were not limited to, consent, confidentiality, sampling, and the research process. A research proposal outlining the study was submitted to the University of Toronto Ethics Review Committee. It was granted approval in February 2007.

Second, the participants in this study were self-selected, which raises the question of how applicable the results are to other individuals with trichotillomania. The women who participated in this study were willing to talk about this issue and to some extent had accepted the hair pulling as an aspect of themselves. It is likely that a sample with different characteristics would produce different findings. Nevertheless, given the sensitive manner in which this study was conducted, the inclusion of excerpts from the interviews, and the richness of the grounded theory approach, people reading this study will very likely resonate with the findings.

Third, all but one of the participants initiated contact with me about their possible participation in response to a call for volunteers. This allowed each of them to maintain a degree of control over their participation and to maintain anonymity until such time as their study participation was finalized.

Fourth, given the sensitivity of trichotillomania, issues of confidentiality were particularly important for the women who I interviewed. Participants who were interested in this study were provided with two copies of the consent form; one that they were required to sign for the research file and one that they kept for their personal files (see Appendix A). Each participant was provided with an identification number to ensure confidentiality. The
interviews were transcribed by a professional transcriber who was required to sign a confidentiality agreement (see Appendix B). I made the decision to use a professional transcriber to ensure objectivity. Each participant was then invited to create a pseudonym. This provided an opportunity to utilize participants’ excerpts while ensuring confidentiality. All research material obtained as a result of this study was placed in a locked filing cabinet accessible only to the researcher.

As previously mentioned, trichotillomania has been described as a condition that is both embarrassing and shameful, and thus, a sensitive issue. For many of the participants, this study was the first opportunity to share their experiences and day-to-day struggles with someone who was not familiar to them. At the same time, however, I had to be mindful of the fact that my role was as a researcher and not as a clinician. As Seidman (1991) says, “the researcher is there to learn, not to treat the participant. The participant did not seek out the researcher and is not the patient” (p. 82). Having said this, it is the responsibility of the researcher to address personal difficulties of participants that develop as a result of their participation in the research. A resource information sheet was provided to participants, if it was requested, which served as a means of assisting with personal problems without changing my role as researcher or influencing data collection (see Appendix C).

Legitimizing and validating the participants’ experiences was also an important aspect of the study. One of the ways that I accomplished this was by being honest with each participant, particularly when I was asked about my reasons for conducting this research. As Zeller (1993) and Seidman (1991) note, appropriate self-disclosure is an important aspect of qualitative research. Seidman (1991) remarks:
There are times when an interviewer’s experience may connect to that of the participant. Sharing that experience in a frank and personal way may encourage the participant to continue reconstructing his or her own in a more inner voice than before. Overused, however, such sharing can distort an interview and distract participants from their own experience to the interviewer’s. (p. 66)

The participants’ experiences were also validated through the opportunity provided to review the transcript of their interview, make corrections if necessary, and provide comments, if desired. In addition, the follow-up interview provided further opportunity for participants to comment on their participation and facilitated this researcher’s greater understanding of the material discussed in the interview. This ensured that the experiences described by each participant were understood in the manner intended. It also allowed me to assess any impact that the research process may have had on participants and to address any emotional issues that may have arisen as a result of the women’s participation.

Finally, it is important that the findings of the study accurately depict the participants’ experiences of the phenomenon (Creswell, 2003). To address this, trustworthiness of the data must be established. Lincoln and Guba (1985) outline four criteria of trustworthiness: credibility, transferability, dependability, and confirmability.

Credibility arises from the internal validity of the study (Lincoln & Guba, 1985). To address the issue of credibility, a semi-structured interview guide was utilized. As previously mentioned, this type of interview guide allows flexibility in data collection so that both interviewer and interviewee can take an active role in guiding the interview process, and both inform subsequent interpretations of the data. A second step taken to promote credibility was to ensure that the interview transcript was an accurate representation of the participant’s experience of the phenomenon. Member checks were utilized to further ensure credibility.
This was accomplished by providing each participant with the transcript of her interview and asking her to review it for accuracy and to make any revisions or clarifications needed. The follow-up interview that most of the participants completed further ensures the credibility of the study.

Transferability establishes the external validity of a study (Lincoln & Guba, 1985). To ensure that this study meets the criteria of transferability, the purpose of the study, eligibility for participation, and the methodology are described in detail. Also, demographic information was obtained from each participant and a brief biographical sketch is provided for each of the women.

Dependability and confirmability establish the reliability and objectivity of the study (Lincoln & Guba, 1985). Strategies that were utilized to address these two criteria include: keeping a journal to document research decisions made in the study and reflect on my personal feelings about what the material that came up in the interviews, utilizing a professional transcriber to transcribe the tapes verbatim, and including excerpts throughout the report to ensure each participant’s experience is captured accurately and to illustrate and justify findings. In addition, an independent reviewer examined and coded the transcripts. The independent reviewer holds a graduate degree and has had extensive clinical training in the mental health field. She is someone who has experience in the area of trichotillomania, and in qualitative research. The independent reviewer and I met to discuss, compare, and negotiate the categories to ensure consistency and relevance. This helped to facilitate an objective approach to the data. An audit trail was also established. A doctoral student familiar with the project reviewed the documentation (e.g., transcriptions, memos, journal, codes, categories, and themes) to verify the process of data collection and analysis. Finally, the
members of my thesis committee were involved in reading the various drafts of this study, providing comments and critiques, and ensuring that the results are ethically and scientifically presented.

All of the above mentioned steps are important when conducting research with participants who are vulnerable and who are discussing an issue that is sensitive in nature.

**Recruitment Process**

Participants for this study were recruited via a flyer posted at the Health Centre at the University of Toronto, in the Department of Psychiatry newsletter, and on the web site of the Ontario Obsessive Compulsive Disorder Network (see Appendix D). The recruitment flyer provided a summary of the proposed research, eligibility criteria, and contact information. Interested participants contacted the researcher via a toll free telephone number or e-mail address. Participants were eligible for this study if they met the following criteria:

1. have trichotillomania,
2. is age 18 or older,
3. is willing to participate in a 1- to 2-hour telephone interview, and
4. is willing and able to provide consent.

All but one of the participants contacted this researcher via e-mail to inquire about the study. Prior to participation in the study, participants completed a pre-screening interview which helped to further determine eligibility for the study. This interview was designed based on examples of eligibility screens in the book, *How to Conduct Interviews by Telephone and in Person* (Frey & Oishi, 1995). The pre-screening interview used a telephone script that outlined the purpose and procedure of the study, asked how the participant found out about
the study, determined eligibility criteria, including age, diagnosis of trichotillomania, age of onset, problems that might make it difficult for the participant to take part in the study, and the participant’s willingness to provide consent and to read the ensuing transcripts and make corrections, if necessary (see Appendix E).

An important purpose of the pre-screening interview was to establish an informal diagnosis of trichotillomania. Participants responded to a series of questions based on DSM-IV TR diagnostic criteria for trichotillomania. This procedure was successfully utilized in a previous study (Casati et al., 2000). Eight participants reported that they had a formal diagnosis from their physician. Given that many do not disclose this condition to physicians and other health care providers, many individuals with this condition do not have a formal diagnosis (Cohen et al., 1995). All participants completed the pre-screening interview. Results of this interview determined study eligibility (see Appendix F). Consent and information forms were sent via mail to each of the participants. Participants were informed that if they had any questions about the study, they could contact this researcher for clarification. Once the consent forms were returned, a telephone interview was scheduled.

**Data Collection**

Each participant completed a semi-structured interview of 1 to 2 hours in length (see Appendix G). Given that this is a relatively new area of inquiry, a semi-structured interview format was deemed to be an appropriate method of inquiry. As previously mentioned, the semi-structured interview provides an open-ended framework that allows participants to explore issues. The questions asked in the interview were open-ended probes intended to obtain clarification of the issues raised and to elicit additional information. The interview
guide was developed after an extensive review of the literature on trichotillomania. As well, the pre-screening interview helped to inform this one and thus further exploration of issues touched on then took place. During the interviews, the participants were encouraged to ask questions if they didn’t understand the topics under discussion. They were also given an opportunity to provide feedback about the interview. This helped to ensure that the participants’ experiences were captured accurately during the interview. Additional questions were asked during the interview to probe for additional issues. The interview guide addressed demographics, trichotillomania-related questions, general family questions, and childhood experiences. Demographic information sought consisted of age, marital status, education, ethnic group, occupation, and income. The trichotillomania-related questions addressed the sites; method of pulling; co-morbid conditions; cues that trigger and maintain the behavior; the impact of pulling on emotional, social, and occupational functioning; and treatment. General family background questions asked about family of origin, the relationship between the participant’s parents, and her relationships with siblings and parents. The childhood experiences questions began with the same two questions: “Describe for me when was the last time you had a normal relationship with your hair?” and “Tell me as best as you can, what was going on in your life at the time of pulling?” In responding to these two general questions, participants were able to determine the direction and content of the interview. The general questions asked and the probes and follow-ups used when warranted helped to ensure that the interview proceeded in a conversational manner.

Each participant was also asked to complete the MGH-HS (Keuthen et al., 1995) (see Appendix H). This is a measure that identifies the severity of hair pulling. The MGH-HS provided participants with an opportunity to describe hair-pulling severity in the following
aspects: frequency of urges, intensity of urges, ability to control urges, frequency of hair pulling, attempts to resist hair pulling, control over hair pulling, and distress about hair pulling. A review of the literature indicates that it has been extensively utilized in other studies because to date it is the only instrument that has been shown to have valid psychometric properties (Diefenbach et al., 2005; Twohig & Woods, 2004). Respondents were read the questions by this investigator and each participant rated her response on a 5-point Likert scale. The MGH-HS has an internal consistency of (coefficient alpha) .89 (Keuthen et al., 1995) and a test-retest reliability of .97 (O’Sullivan et al., 1995). At the end of the interview, each participant was asked if there was anything else she would like to say or ask. All but one of the participants asked the investigator about her interest in this area. The investigator’s personal connection to trichotillomania was disclosed to these participants.

Due to both geographical considerations and the sensitivity of the issue, the interviews were conducted via telephone and recorded. The anonymity of the telephone allowed participants to disclose information that they might have felt uncomfortable discussing in a face-to-face meeting. The interviews were transcribed verbatim by a professional transcriber. Once the transcripts and tapes were returned to this investigator, they were reviewed to ensure that there were no discrepancies between the transcripts and audio tapes. The transcripts were then sent to each participant via e-mail. The purpose of having participants review the transcripts was to ensure the accuracy and integrity of the interview and to provide them with an opportunity to make corrections. Once the transcripts were returned to the investigator, a follow-up interview was scheduled with each participant. The purpose of the follow-up interview was to address any concerns and/or questions that the participant might have as a result of her participation as well as giving her an opportunity to
clarify her responses and provide additional information (see Appendix I). Participants were also asked about their feelings and thoughts about participating in this study. The follow-up interview took approximately 15 to 30 minutes. During this interview, many of the participants requested information about trichotillomania and its treatment. A resource and referral information sheet was e-mailed to participants and a package of articles was made available to them upon request.

**Data Analysis**

Data analysis in qualitative research involves following a series of steps that help to establish the credibility and reliability of the data. An important first step in data analysis, particularly when utilizing the grounded theory approach, is to review the data, identify the themes that emerge, and develop a theory that explains the phenomenon. Once all of the data collection was completed, I began by reviewing a printout of the transcripts. This was done multiple times to thoroughly familiarize myself with the data and to obtain a general understanding of the interview material. I utilized a line-by-line approach in reviewing my transcripts. Although the transcripts would eventually be analyzed with NVivo 7 (QSR International, 2007), a qualitative data analysis program, it is important to begin the process of coding on the hard copy. As Seidman (2006) notes:

> For those who choose to work with either a dedicated analytical program or even a word processing program, I suggest caution in doing significant coding or editing on screen. I recommend working first on a paper copy and then transferring the work to the computer. My experience is that there is significant difference between what one sees in a text presented on paper and the same text shown on screen, and that one’s response is different, too. (p. 125)
Underlining meaningful passages, words, and phrases was the second step in the data analysis. As Jones et al. (2006) note, “in this microscopic phase, these words and phrases are then listed as possible codes in what is referred to as open coding” (p. 91). The codes chosen for the analysis are tentative, not pre-determined, they emerge as a result of reading the transcripts, and are continuously modified as analysis goes on. To facilitate this process, I utilized the following questions: “What is the subject of the marked passage? Are there words or a phrase that seems to describe them, at least tentatively? Is there a word within the passage itself that suggests a category into which the passage fits?” (Seidman, 2006, p. 125).

To further facilitate analysis of the data, NVivo 7 was used. One of the benefits of using this program is that it organizes data and allows for easy retrieval of information. In addition, codes and categories can be identified, modified, or deleted and text can be easily manipulated as required. To familiarize myself with this program, I took a workshop, offered at the Ontario Institute for Studies in Education of the University of Toronto, entitled Conducting Qualitative Analysis: Introduction to NVivo. I also purchased the NVivo Workbook (QSR International, 2006). This workbook describes the steps involved in conducting qualitative research, in particular, the process of managing and analyzing data. Difficulties with data management and data analysis were addressed with the Statistical Consultation Department at the Ontario Institute for Studies in Education of the University of Toronto. All of these resources provided me with the skills necessary to ensure that data analysis and interpretations of the data were sound and accurate.

Each of the 10 transcripts was exported from Microsoft Word into NVivo 7. Codes originally developed as a result of reviewing the printouts of the transcripts were entered into NVivo. When I initially began the coding process in NVivo, I simplified my data analysis by
using free nodes. This enabled me to go through the transcripts and code them without predefined sets of codes. During this process, I reviewed my transcripts line by line, selected single words and phrases to code as free nodes. For example, “frustration,” “distress,” “control,” and “acceptance” were all initially coded as free nodes. Once the coding had progressed to the point where I had a sufficient number of nodes, excerpts from the remaining transcripts were placed in existing free nodes or new nodes were created. I then organized and reduced the free nodes into tree nodes; essentially, the codes were clustered together under common issues with relevant text under the appropriate heading. For example, “relationship between parents” was one of the codes that emerged as a result of reviewing the free nodes. Summaries were printed and re-read. NVivo also has a memo writing feature, which allowed me to document, in a stepwise fashion, my impressions of the data. This process facilitated the development of patterns and relationships among the categories. The final stage consisted of reading and re-reading the memos and summaries to develop a core category on which to base the development of a model to explain the phenomenon (Strauss & Corbin, 1998).

Although already discussed in “Special Considerations When Conducting this Study,” a final aspect of data analysis is worth revisiting. That is the issue of triangulation: strategies utilized to ensure that the rigor of the research is maintained and that the findings of the study can be validated (Patten, 2002). One example of triangulation is the use of an independent reviewer (i.e., a second coder) to read, examine, and code the transcripts. This was done to further establish validity of the coding system. As is to be expected when utilizing this type of methodology, data gathering and data analysis are subjective. Differences of opinion between the researcher and the reviewer were resolved through negotiation to consensus.
This helped to ensure that the coding system was relevant and accurate. It is important to highlight that qualitative research is not dependent on replicable coding. Indeed, if another researcher were to examine the raw data, there is no guarantee that he or she would come up with the same codes. The use of a second coder in this study helps to justify the emerging codes, categories, themes, and subsequent model in this study, and to reduce the potential for researcher bias (Patton, 2002).

A second example of triangulation is the establishment of the audit trail (Lincoln & Guba, 1985). As discussed previously, the audit trail ensures that the findings are consistent and “make sense” given how the data was collected and analyzed. In other words, it is a visual representation of the documentation produced in the study (i.e., the audio recordings, transcripts, reflexive journal, codes, categories, themes, and memos). This documentation of the study provides evidence to the reader that the findings of the study are credible and warrant consideration.
Chapter 4:  
The Women:  
Brief Biographies

In this chapter, I introduce each of the women who participated in this study in order to establish the context from which each of their stories emerges. The reasons for their participation are also discussed.

Demographics

A total of 10 women participated in this study. These women responded to ads that were placed at the University of Toronto Health Centre, on the Ontario Obsessive Compulsive Disorder web site, in the newspaper, and in the University of Toronto, Department of Psychiatry newsletter. After viewing the postings, seven of the women contacted me via email to inquire about the study and to express interest in participating. Two women telephoned me. One of the women was invited to participate because of a prior communication we’d had in which she expressed interest in trichotillomania. The women ranged in age from 21 to 40. Three of the women were living with their partners and 7 were single. All self-identified as Caucasian. The women came from middle- to upper-middle-class backgrounds. Two of the women had completed college, four had university degrees, one had a master’s degree, one had some university and college education, one was half a credit away from completing her university degree, and one was currently attending university. Nine of the women were employed. The tenth had recently left a job in the health care field. Of the nine who were employed, employment included: health, business, law, writing, and sales and service. More specifically, one worked in the mental health field, one worked as a program assistant, two were in law, one worked part-time delivering newspapers
and flyers, one worked at the student publication of her university, one was self-employed as a free lance writer, one worked part-time as a dietician, and one worked in marketing and copy writing. The household income for the women varied: one declared an income between $10,001 and $20,000, one between $20,001 and $30,000, one between $40,001 and $50,000, and seven had incomes of $50,001 or greater.

Information About Trichotillomania

All of the women completed the Massachusetts General Hospital Hairpulling Scale (MGH-HS) (Keuthen et al., 1995) (see Appendix H). The overall score for the women was mean: 15.3 and standard deviation: 5.64. This suggests that in general, hair pulling severity for the women was clinically significant and in the mild to moderate range. Details of the group’s scores on the MGH-HS are presented in Table 1.

Table 1

Participants’ Scores on the Massachusetts General Hospital Hairpulling Scale (MGH-HS)

<table>
<thead>
<tr>
<th>Frequency of urges</th>
<th>Participants’ scores on the MGH-HS</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>--</td>
</tr>
<tr>
<td>Occasional urge</td>
<td>1</td>
</tr>
<tr>
<td>Often</td>
<td>6</td>
</tr>
<tr>
<td>Very often</td>
<td>1</td>
</tr>
<tr>
<td>Near constant</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intensity of urges</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>--</td>
</tr>
<tr>
<td>Mild</td>
<td>2</td>
</tr>
<tr>
<td>Moderate</td>
<td>5</td>
</tr>
<tr>
<td>Severe</td>
<td>2</td>
</tr>
<tr>
<td>Extreme</td>
<td>1</td>
</tr>
</tbody>
</table>
Participants’ scores on the MGH-HS

<table>
<thead>
<tr>
<th>Ability to control urges</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>1</td>
</tr>
<tr>
<td>Most of the time</td>
<td>--</td>
</tr>
<tr>
<td>Some of the time</td>
<td>4</td>
</tr>
<tr>
<td>Rarely</td>
<td>3</td>
</tr>
<tr>
<td>Never able</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frequency of hair pulling (actual hair pulling)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>1</td>
</tr>
<tr>
<td>Occasionally</td>
<td>2</td>
</tr>
<tr>
<td>Often</td>
<td>2</td>
</tr>
<tr>
<td>Very often</td>
<td>4</td>
</tr>
<tr>
<td>Always</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attempts to resist pulling hair</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No urges</td>
<td>--</td>
</tr>
<tr>
<td>Almost all of the time</td>
<td>4</td>
</tr>
<tr>
<td>Some of the time</td>
<td>2</td>
</tr>
<tr>
<td>Rarely</td>
<td>2</td>
</tr>
<tr>
<td>Never</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Control over hair pulling</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not pull</td>
<td>1</td>
</tr>
<tr>
<td>Almost all of the time</td>
<td>1</td>
</tr>
<tr>
<td>Most of the time</td>
<td>1</td>
</tr>
<tr>
<td>Some of the time</td>
<td>1</td>
</tr>
<tr>
<td>Rarely</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Associated distress</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not feel uncomfortable</td>
<td>3</td>
</tr>
<tr>
<td>Vaguely uncomfortable</td>
<td>5</td>
</tr>
<tr>
<td>Noticeably uncomfortable</td>
<td>1</td>
</tr>
<tr>
<td>Significantly uncomfortable</td>
<td>1</td>
</tr>
<tr>
<td>Intensely uncomfortable</td>
<td>--</td>
</tr>
</tbody>
</table>

*Note.* Based on the MGH-HS (as cited in Keuthen et al., 1995; see Appendix H).

In addition, during the interview, all of the participants described their hair pulling, specifically, the sites, severity, and consequences of pulling. Treatment and current feelings about pulling were also elaborated on, as were the reasons for participating in this study. This information is summarized below for each of the women.
Given the sensitivity of this topic and the need to maintain confidentiality, a pseudonym was created by seven of the women and utilized throughout this study. In addition, inviting the women to create their own pseudonyms allowed them to feel more connected to the data. Two women did not respond to my request to create a pseudonym and one woman expressed discomfort at creating one. In these three instances, I created the pseudonyms. Excerpts from the transcripts are used to illustrate the women’s experiences of trichotillomania. Furthermore, to ensure that the excerpts are reader friendly, nonsensical words such as “ah” and “um” have been removed. An effort was made to utilize a wide range of excerpts to provide a more comprehensive picture of the women’s experiences.

**Natalie**

Natalie was the first person to contact me about the study. She had heard about it through her doctor at one of the local hospitals. She has a formal diagnosis of trichotillomania.

In discussing her hair-pulling behaviors, Natalie stated that she pulls the hair on her scalp, from the crown. In the past, she has pulled her eyelashes, but she doesn’t pull them as much since they’ve started to grow back. Natalie noted that she uses her fingers now to pull, but in the past she has used tweezers. She started pulling her hair in Grade 2 and this continued until she was in Grade 5. In Grades 6, 7, and 8 she did not pull. She started pulling again when she was in Grade 10 and has been pulling ever since. Natalie also engages in skin picking, specifically on her face, especially, “when I am bored in conversations with people.” She used to avoid hair salons and intimate relationships. But as she grew older, she accepted her pulling and now the only things she avoids are swimming and the wind. According to
Natalie, her hair pulling is not very noticeable because of the thickness and style of her hair. Natalie acknowledged having psychological difficulties because of her pulling, namely, embarrassment, low self-esteem, and, on occasion, anxiety and low mood. She indicated that when she first came to Toronto, she did go to her family doctor about her pulling and was prescribed Effexor; however, she did not find it helpful. She also indicated that she sees a therapist for other issues, and though she found the cognitive behavior therapy to be helpful, it, “really didn’t help with the trichotillomania at all.”

When she was asked about her reasons for participating in this study, Natalie explained that she felt good about sharing her story and it was nice to know that other people deal with this condition. She was also pleased that investigators are taking an interest in the condition and she hoped that there would be an increase in support, especially here in the city.

Claire

Claire heard about this study from her doctor at one of the teaching hospitals in the city. She could not recall if she had been given a formal diagnosis of trichotillomania, however, she did note that the diagnosis was discussed during her treatment for another medical condition, Tourette’s disorder.

Claire stated that she pulls her eyebrows and eyelashes and has always pulled from these two sites. She uses tweezers and, if necessary, when she is out and feeling compelled, she will use her fingers to pull, but this is rare. Claire indicated that her hair loss is noticeable in that she has no eyebrows and only the eyelashes of her upper lids are left. She also engages in other repetitive behaviors such as nail biting and picking scabs and imperfections
on her skin. Claire started to pull when she was 8 or 9 years of age. Claire stated that there were periods in her life when she stopped pulling. She recalled stopping in Grade 8 or 9 and again at the end of high school. Both times she stopped for a period of 6 months. When asked about avoidance of activities, Claire stated that she avoids getting facials and she feels uncomfortable at cosmetic counters. In addition, if she is buying tweezers, she will do it very quickly so as to avoid drawing attention to herself. She further stated that she does not avoid social situations or formal events; however, she did acknowledge she is self-conscious, particularly when meeting and getting to know new people. In the past, Claire has used an eyeliner pencil to cover up her lack of eyebrows and eyelashes but she noted that she doesn’t do that anymore. She is more self-conscious when her picture is taken than she is passing someone on the street because pictures are permanent. Claire is in treatment for her Tourette’s disorder and takes medication to manage her repetitive twitches. She is not currently in treatment for trichotillomania, however, she did recall attending a therapy group in the past, but did not find it to be helpful. When asked why, she stated that it was a group for individuals with general compulsions and it was not specific to trichotillomania.

In discussing her reasons for participating in this study, Claire stated that she was hesitant at first because she was not sure with whom she would be sharing her story, but knowing that she would be anonymous made her more comfortable. In addition, knowing that the researcher has a personal connection to trichotillomania made it easier for her to share her story because she was not as worried about disclosing things that others might perceive as strange.
Kathleen

Kathleen had emailed me when I was working in the Women’s Mental Health and Addictions Program (now known as Society, Equity, and Health) of the Centre for Addiction and Mental Health. She had read about my previous research on trichotillomania and was interested in obtaining additional resources and referral information. I contacted Kathleen to ask if she would be interested in this study. After I described the specifics of the study to her, she consented.

Kathleen stated that her primary hair-pulling site is her scalp. She has always pulled from this site. She uses tweezers and fingers to pull out her hair and also engages in eating of the hair (trichophagia). In addition to her hair pulling, Kathleen also engages in face-picking behavior. Kathleen stated that throughout the years there, “have been good and bad periods, but I don’t think that there has been, you know, a year when I’ve gone without doing it.”

When she was asked about the complications of trichotillomania, Kathleen indicated that she has not avoided social contacts such as gatherings, intimate relationships, hair salons, or visits to her family doctor. She also said that she has thick hair, but that her hair is finer on the left side and near the front. This is where she pulls most often. She does not cover her hair, but on occasion, particularly if there is a bald patch, she will wear it in a ponytail.

Kathleen stated that she has had psychological difficulties such as low mood, anxiety, loss of self-esteem, and embarrassment and shame because of her pulling. She further stated that lately she has noticed that these difficulties are more pronounced due to the stress of her current situation. She provided this example:
I think that I had my first panic attack when I was in an exam during the December exam period. Lately, I found that when I first started school, I found myself crying for no reason. I actually book cry time, thinking to myself, okay I’ve got a half hour before my spouse comes home so I can come up and cry.

Kathleen is not currently in treatment for this condition but has requested a referral to a clinic for treatment. She also is not taking any medications for this condition. Kathleen expressed distress about her hair pulling, particularly when speaking about her trichophagia. Kathleen reported that she felt good about participating because knowing that there were other participants in this study made her, “feel less like a freak.”

Marion contacted me after seeing an advertisement in the health clinic at the university. She self-diagnosed her trichotillomania. She reported that in the past she has been diagnosed with bipolar disorder and major depressive disorder; however, she felt that her diagnosis of bipolar disorder didn’t fit with her issues.

She reported pulling from, “the back of the head and the crown. . . also sometimes from around behind the ears.” She said that these have always been her sites. She also engages in nail biting. She pulls her hair with her fingers. She reported that there have been periods in her life when she stopped pulling her hair for a short time; however, these periods have been few and she resumed due to stress or emotional turmoil. She further stated that:

When I’m in a period of stress or when I’m working very hard, especially if I’m working in front of the computer, I can catch myself not noticing that I’ve been doing it for awhile.
Her hair pulling has not caused her to avoid activities or situations where her hair loss might be noticed. Marion also indicated that she does not cover her hair loss; she has thick hair and, “it’s not something that I have to work at to hide.” Marion stated that on occasion she has experienced feelings of low mood and she doesn’t, “always have 100% great self-esteem.” She has never sought treatment for her hair pulling; she has spoken to a psychiatrist and psychologist about her depression but has never been medicated. Marion did not participate in the follow-up interview, so I was not able to ask her about her reasons for participating in this study.

_Shanna_

Shanna found out about this study from her physician. She has a formal diagnosis of trichotillomania and obsessive compulsive disorder (OCD).

Shanna noted that her pulling sites include eyebrows and eyelashes and, on occasion, she also pulls the hair on her scalp. She uses her fingers to pull the hair. She indicated that there was a period of time when she didn’t engage in pulling. For a couple of years her OCD symptoms overwhelmed her hair pulling. Over the years, she has tried to stop pulling and at times has been successful. Shanna stated that to minimize her lack of eyebrows and eyelashes, she will style her hair so that it falls over face. She also indicated that she does not currently avoid social situations because of her hair pulling. She described herself as being:

A shy person, so I don’t go out anyway. And if I do, I like to keep long hair or I like to keep it over my face. It’s less noticeable and I do wear glasses, so that covers it up.

Shanna acknowledged having low mood, low self-esteem, low confidence, shame, and embarrassment because of her trichotillomania. In terms of treatment, Shanna indicated that
she is in treatment for her OCD and depression. She had in the past tried behavior therapy for the trichotillomania, however, she only attended two sessions and therefore could not comment on its effectiveness. She is currently taking Effexor for her OCD and depression.

Shanna stated that she “felt good about participating in this study. It was easier than expected”. Shanna’s reasons for participating in this study were to, “hopefully provide some information that would be used to help others with trichotillomania, and for future studies, research, and eventually more ways to help afflicted people.”

**Rachel**

Rachel saw the advertisement that I placed on the Ontario Obsessive Compulsive Disorder web site. She indicated that she had formally been diagnosed in 2007 by her psychiatrist but that in 1997 she self-diagnosed as a result of an Internet search on this issue. Rachel had also been recently diagnosed with OCD and depression.

Rachel stated that she pulls hair from her left and, on occasion, her right eyebrow. She uses her fingers and tweezers to pull. She also indicated that there have been periods of times when she’s stopped pulling, usually for 2 to 3 weeks. When she was asked if she avoids certain activities, Rachel stated that she avoids getting facials or getting her makeup done. In particular, she avoids, “really any sort of social activity that places emphasis on my face.” Her trichotillomania also impacts the relationships that she has, particularly with her mother and her boyfriend, because they are aware that she does it and comment on it. According to Rachel, her boyfriend seems to be more supportive than her mother. To cover up, she wears her hair in a way that covers the eyebrows.
She recently sought treatment for her trichotillomania and was prescribed a combination of anti-depressants and cognitive behavior therapy. When she was asked if she found treatment helpful, she said that she hadn’t really noticed if the medication was working but it had only been recently prescribed and, “didn’t feel like it had kicked in.” At the time of the interview, Rachel had been free of pulling for 3 weeks and attributed this to being aware “of what my triggers are.”

In the follow-up interview, Rachel reported that she had not pulled for 3 months. She also stated, “sharing my story felt cathartic, and I’m happy that it will help to advance understanding of trich.” She volunteered because, “more trich-related research is needed.”

**Trichster in Toronto**

This participant contacted me after she saw my call for volunteers while searching the Internet for information on compulsive hair pulling. She indicated in the pre-screening interview that she has a formal diagnosis of trichotillomania.

Trichster in Toronto stated that her pulling sites include scalp, eyelashes, chin, legs, and pubic region. She indicated that her main pulling site is her scalp. In the past, her pulling sites have also included her arms and eyebrows. Trichster in Toronto indicated that when she was about 21 years of age, she pulled out all of her eyebrows and they never grew back, so she decided to have a hair transplant. After that the pulling from there stopped, but then she began to pull from other areas. She uses her fingers and tweezers to pull. In the past, she has stopped but not for an, “extended period of time.” She avoids going to the hair salon and if the pulling has been particularly bad, in other words, if she has bald spots on her scalp, she
will usually wear a ponytail. Trichster in Toronto noted that her trichotillomania has had a significant impact on her relationship with her parents:

> They watch me closely to see if I’m missing more hair than normal. . . . I think that sometimes creates tension in the relationship and certainly romantically, I haven’t had a long-term boyfriend in years.

When asked about psychological effects, Trichster in Toronto stated that she has experienced low mood, low self-esteem, loss of self-confidence, and embarrassment and shame because of her hair pulling. She further indicated that she has been formally diagnosed with depression, anxiety, and an eating disorder. Trichster in Toronto has been in treatment for depression and this has included medication and electroconvulsive shock therapy. When she was 16, she saw a professional for her trichotillomania, but admits that she was not ready then to pursue the help. She described her first meeting with this professional:

> She suggested to me the most offensive thing that you could possibly say to me . . . she said that I should take all the hair that I pulled and keep it in a bag. To me that was just repulsive at the time so I never went back.

In the follow-up interview, Trichster in Toronto was asked if there was anything else that she wanted to share about her experiences with trichotillomania. She reported the following:

> You had asked if there were any other behaviors that I partake in and I didn’t mention that at times I pick my skin. I guess I said no because it’s a regular pattern and occurs only under extreme stress. However, during those times I pick my scalp until it bleeds and then I sometimes pick the scabs.
When she was asked to describe her feelings about participating in the study, Trichster in Toronto stated the following:

I found it cathartic to participate in this study and share my story. Hair pulling is something that I rarely speak about because of the stigma associated with the disorder. Speaking about the issue and the challenges/problems it’s caused in my life was a positive experience for me. Primarily, I participated in the study because I think it’s important to help advance research and find a cure/treatment for trichotillomania. As well, I felt it was a study that would not only benefit me but the next generation of hair pullers—who may not have to suffer in silence or without hope as I did for so many years.

_Penny_

This participant also read about this study while searching for resources on trichotillomania on the Internet. She indicated that she has a formal diagnosis of trichotillomania.

Penny reported that she currently pulls her eyelashes and hair from her scalp. In the past, she stated, she pulled hair from her legs. She uses tweezers and her fingers to pull the hair. She also recalled a few periods in her life when she stopped pulling. Penny stated that she stopped pulling her eyelashes from 17 to 19 years of age, due to sheer determination, because, “I wanted to have eyelashes at school,” however, “that’s when I started playing with my hair.” She indicated that she does not avoid activities; however, Penny acknowledges that certain situations cause her anxiety. For example:

Going to the hairdresser is particularly awkward because the back of my head... it’s not even that there are bald spots but that there are really, really short... there are sections that I’ve lost that have really, really short hair.
She also explained that situations, “where I know I’m going to be close to somebody, and they are going to be looking down, in particular, that’s when I feel it’s most obvious.”

Penny stated that her hair pulling has interfered with her life. For example, “in my family, it’s a source of contention; they know not to bring it up.” In addition:

When my family was trying to deal with it and trying to understand it. . . . they don’t really understand it. . . . you can’t really expect them to. I have a lot more information than they do. . . . but I am not really telling them because then I am going to have to engage in that conversation. . . . I don’t really want to do that.

Penny stated that her hair pulling has caused her to experience a loss of self-confidence and embarrassment and shame. She also has diagnoses of depression and generalized anxiety disorder. She has never been in treatment for her trichotillomania, partly because her research has revealed that there is a lack of experts in this field and, “it’s such a time investment that I find it prohibitive.” She is also not interested in pursuing pharmacological treatment for her hair pulling because:

Medication helps with the symptoms and doesn’t help with problems. . . . and I believe that giving up the level of control is not something I am interested in.

She further stated that for her, hair pulling causes frustration because, “it’s embarrassing, time wasted, and sometimes feels unproductive.”

In the follow-up interview, Penny stated:

It did feel strange participating in the phone interview, largely because it involved revealing personal information about myself and my history. I participated in the study as an attempt to talk about my trichotillomania and see if I can learn more about it. I appreciate the opportunity to speak with
someone who is a researcher in the field. By listening to the questions that were asked, I was able to take the time to think about factors I never considered as potentially playing a role in my hair pulling. For example, given my comments about being a relatively private person and not going to family members of (sic) friends for help with dealing with my problems, the hypothesis regarding hair pulling as a coping mechanism seems stronger. It would be interesting to know this sort of information across a larger population to see if there is indeed a strong correlation.

Interestingly, Penny told me that since the interview she had enrolled in the annual conference of the TLC.

_Cindy_

Cindy contacted me by telephone to inquire about obtaining resources for trichotillomania. In my conversation with her, I agreed to send her some articles on the topic and asked if she would be interested in participating in the study. She agreed.

Cindy indicated that she currently pulls out her eyebrows and eyelashes. In the past, she pulled the hair on her legs and on the bikini line. She uses her fingers to pull but does report that she will use tweezers for hair that she can’t get at with her fingers. There have been periods of time when she has stopped pulling and she attributes these to major events in her life.

For example, . . . when I was getting married, I had huge motivational factors for not pulling because I didn’t want to look weird. Another example would be like when I’m expecting visitors from out of town that have known me for a long time like my parents. . . . it’s a huge motivational factor to stop pulling.
When Cindy was asked if pulling caused her to avoid certain situations or activities, she indicated that she prefers to avoid the dentist because the hair loss is easily noticeable given the close proximity of the dentist. Cindy uses eyeliner to cover up her hair loss. She reported that she has a slightly lower self-esteem because of, “feelings of not looking as beautiful and not being as normal as a normal person.” She has not been clinically diagnosed with any other psychiatric difficulties. Cindy stated that she has had some treatment for her trichotillomania. She saw a social worker for a month from whom she learned some behavioral strategies that she found to be quite useful.

Cindy did not participate in the follow-up interview. Several attempts were made to contact her, however, she did not respond. As a result, I was not able to obtain any information about why she participated in this study.

Samantha

Samantha contacted me via telephone after reading about the study in a local newspaper. She indicated that she has a formal diagnosis of depression but not of trichotillomania. She said that she did on one occasion mention her fidgetiness and her habit of playing with her hair to her therapists, however, “maybe they never heard of trich or maybe they didn’t pick up on it and I guess I wasn’t ready at the time to talk about it.” Samantha is currently receiving treatment for her depression.

Samantha indicated that she plucks her eyebrows and other facial hairs, and repetitively runs her fingers through the left side of her hair, causing pulling and breaking of the hair. Bald spots are not noticeable because she has recently cut her hair and her hair pulling is, “much more controlled than in the past.” Samantha remembers pulling her
eyelashes when she was younger, and in the past, when she was pulling from her scalp, she
did have a noticeable bald spot. She also recalled a period in her life when she stopped
pulling for a couple of years. She attributed this to a “lack of personal stressors.” Samantha
indicated that she does not avoid social gatherings or formal events, but her trichotillomania
does prevent her from going to the hair salon and she has resorted to cutting her own hair. In
recalling attempts to cover her hair loss, Samantha said that, for example, “I wore my hair up
in a barrette for 8 months.”

When Samantha was asked to describe psychological difficulties in relation to her
hair pulling, she said:

There is definitely a time period where thinking about and actually pulling my
hair, running my fingers through this one specific area, was rather stressful for
me, partly because . . . I knew what I was doing was actually causing . . . not a
huge physical damage . . . but that I was physically damaging my hair and yet
unable to restrain myself.

She further stated that, “the push and pull between wanting something and, you know, not
actually being able to control yourself caused me psychological strain.”

Samantha indicated that she has not been in treatment for her trichotillomania. When
she was asked if she would consider going for treatment, she replied:

I’m not exactly sure if there is a specific medication for hair pulling. . . . I’ve
done a bit of reading. I don’t know how the OCD medications would work in
relation to that but I don’t tend to have a lot of other OCD type behaviors so I
wouldn’t want to be medicated unless it was absolutely necessary.
Samantha did not participate in the follow-up interview although several attempts were made to contact her. Samantha’s reasons for participating in this study remain unknown.

The 10 women who participated in this study represent a community sample of women with compulsive hair pulling. These women initiated contact with me for a variety of reasons, however, overwhelmingly, they demonstrated a desire to share their individual stories, and each highlighted the need for more understanding and support from family members and society in general.

In discussing their experiences of trichotillomania, the women provided a considerable amount of information about the characteristics of their hair pulling. Main areas of pulling included the scalp, eyelashes, and eyebrows and they typically reported using their fingers or tweezers to pull. Repetitive habits including nail biting, skin picking, cuticle picking, and lip biting and pulling were also described. Natalie, Claire, Rachel, Trichster in Toronto, Cindy, and Samantha noted situations that they avoided due to their hair pulling including swimming, going to a hair salon, going to the cosmetic counter, or going to the dentist. Penny acknowledged that though she does not avoid specific situations, she does describe feeling more anxious in some situations because of her hair pulling. Shanna described herself as being a shy person who doesn’t really go out very much. All of the women described psychological difficulties including low self-esteem, anxiety, embarrassment, and shame that they associated with their hair pulling. Surprisingly, though many of them acknowledged hating the fact that they engage in hair pulling, they had all, to some degree, accepted their trichotillomania. The majority of the women described having treatment for other conditions such as OCD, depression, and anxiety, however, only Shanna,
Rachel, Claire, and Trichster in Toronto described seeking treatment specifically for hair pulling. Trichster in Toronto was so disgusted about what she was asked to do as part of her treatment (i.e., saving the pulled hair and bringing it to sessions) that she never went back. Claire indicated that she went to a therapy group for individuals with compulsions, but found it difficult to relate to the others because, “I didn’t feel it was my environment, the environment for me. . . . it wasn’t anything for people with trichotillomania.” Kathleen was in the process of requesting a referral from her family physician at the time of her interview. Interestingly, among the women not currently in treatment for hair pulling there was a reluctance to seek out treatment, particularly the use of medication, citing the lack of effective treatment options for this condition.

For Natalie, Shanna, Rachel, and Trichster in Toronto, sharing their stories of shame, isolation, and embarrassment in relation to compulsive hair pulling provided them with an opportunity to make a very important contribution to the literature. In addition, the women indicated that it was their hope that it would help to improve understanding of this complicated and still very much misunderstood condition. Penny and Claire alluded to the strangeness and discomfort associated with not knowing with whom they were sharing their stories, however, for Claire the anonymity of the study made it a more comfortable experience. For Penny, participation provided her with the opportunity to talk about the issues with someone who was interested and experienced in this research area, which she welcomed as a learning opportunity. Kathleen indicated that as a result of her participation, she felt less alone: knowing that there were others who had this condition and shared her experiences, made her feel “less like a freak.” I did not have the opportunity to discover
Samantha’s, Cindy’s, and Marion’s reasons for participating in this study because they were unavailable to participate in the follow-up interview.
Chapter 5: Findings

Analysis

In this chapter, I present the themes that emerged as a result of my analysis of the transcripts. The specific steps involved in the analysis are outlined elsewhere (see Chapter 3). Utilizing a grounded theory analysis, five major themes were identified:

1. Looking Back: How it All Began,
2. Childhood Environment,
3. Relationship Between Specific Experiences and the Discovery of Hair Pulling,
4. Role of Hair Pulling, and
5. Journey of Hair Pulling.

The core category that was derived from the women’s experiences is The Road to Discovering Trichotillomania: The Issue of Control. This core category encompasses a process that begins with the first major theme: Looking Back: How it All Began. This theme describes the context of the pulling behavior, while Themes 2 through 5 each contain various categories (see Table 2).
Table 2

*Research Study Themes, Categories, and Subcategories*

<table>
<thead>
<tr>
<th>Major themes</th>
<th>Categories or aspects</th>
<th>Subcategories</th>
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<tbody>
<tr>
<td>1. Looking back: How it all began</td>
<td>1. Context of hair pulling</td>
<td>1. Who I grew up with</td>
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<td>2. Family dynamics</td>
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<td>3. Styles of communication</td>
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<td>5. Traumatic stress</td>
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<td>2. Childhood environment</td>
<td>1. Family experiences</td>
<td>1. Silencing the emotional self</td>
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<td>2. Perceptions of self</td>
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<td>3. Relationship between specific experiences and the discovery of hair pulling</td>
<td>1. Stress</td>
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<td>4. Role of hair pulling</td>
<td>1. A means of coping</td>
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<td>2. Catch-22</td>
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<td>3. Out of control</td>
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<td>4. An avenue for gaining control</td>
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<td>5. Journey of hair pulling</td>
<td>1. How I feel about myself</td>
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<td>2. Self-esteem and other psychological difficulties</td>
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<td>3. Self-disclosure</td>
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<td>4. Stigma</td>
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<td>5. Acceptance of self</td>
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Overall, the five major themes and subsequent categories that emerged from this study represent an attempt to examine the childhood environment and experiences of women with trichotillomania. This examination culminates in the development of a model for understanding the experiences of the women in this study.

Each of the themes is discussed in more detail below under the headings Theme 1, Theme 2, and so forth. Excerpts from the interviews are included to illustrate each of the themes and categories.

**Theme 1:**

*Looking Back: How It All Began*

The first major theme, Looking Back: How it All Began, includes a recollection and exploration of each of the women’s initial hair-pulling episode. This recollection consisted of exploring the context of the pulling behavior. Taken together, the experiences described by the women illustrate the process of discovering trichotillomania.

Given the general difficulties inherent in memory, to facilitate a recollection of experiences that provides contextual details of past events, Seidman (2006) suggests:

> Avoid asking participants to rely on their memories. . . . Ask participants, in effect, not to remember their experience but rather construct it. . . . Reconstruction is based partially on memory and partially on what the participant now senses are important about the past event. (p. 88)

Taking this into consideration, each of the women was asked: “When was the last time that you had normal relationship with your hair?” This question elicited the age at which they first began to pull out their hair. The follow-up question: “What was happening at the time
that you first began to pull out your hair?” helped each of the women to reconstruct as best as
she could the circumstances of her hair pulling.

The women reported an age of onset in the range of 5 to 12. Periods of stopping (for
several months to several years), and then resuming hair pulling were also reported. In all
cases, the age at the initial episode of hair pulling recalled was used as the age of onset.
Though all of the women were able to identify a particular context for the onset of hair
pulling, what was notable was the variation among the circumstances. It is evident though
when listening to the recollections of the women that each was led, in one way or another, to
become more involved with her hair.

Shanna described her first experience of pulling at the age of 5. She does not recall
any stress in her life and attributes the hair pulling to curiosity.

When I first started I was 5 years old. I think I had a happy childhood. I think
it was just curiosity. I don’t remember being under any stress or anything
when I was 5 years old. I don’t know why I started it at that time except for
curiosity.

Later, Shanna explained that her pulling, which initially began in childhood and
targeted her eyelashes, transferred to other parts of her body. Her descriptions also allude to
the cyclical nature of the pulling and her futile attempts to stop:

I was probably looking for something else. I probably pulled out a lot of my
eyelashes so I was probably looking for more. I started with my eyebrows and
they did hurt because I remember when I had my eyebrows plucked one time
I said “ow, ow, no more, that’s it.” Then I started doing it and it was, I guess,
it worked. I did start pulling them out and eventually it felt good. . . . the
eyebrows, the eyelashes. I continued and they would grow back a little and I
would pull them out more. . . . I thought that if I could try another area, if I could try my eyebrows maybe my eyelashes would grow back and then I could stop my eyebrows; it would be easy to stop, but you know that obviously wasn’t the case.

Penny also began pulling her eyelashes during childhood and then, as in Shanna’s case, her pulling transferred to another part of her body, in her case, the scalp. Penny is quick to point out that she does not actively pull out her scalp hair, but that her hair comes out as a result of her playing with it.

I’ve picked from my eyes, the earliest I can remember was about 6 and then coming out of high school, I was picking out my hair, not quite picking, it’s more like playing and sometimes it comes out. I feel the urge that gets me to play with my hair is the same sort of urge as the one for my eyelashes, so I kind of gravitate to the same place.

Later in the interview, Penny indicated that in her earliest recollection pulling occurred while at school. And school was the place where she learned that her behavior was not looked upon favorably. Eventually, her behavior was accepted at home because her parents believed that it was her means of coping with stress.

I remember sitting in the class in Grade 1 and my teacher asked me what I was doing. . . . that was an incident of me picking my hair and I got caught and I think that was probably when I internalized, “you don’t do this in public.” [Penny acknowledged that she was unsure if this was a direct memory or something that was told to her by her parents]. . . . There were a couple of times that we went to a doctor to try and figure out what was going on, but because my dad is a psychiatrist as well as a psychoanalyst, I think that they sort of made a decision in their heads that it was how I was dealing with stress. They sort of just accepted it; obviously it was harder at the beginning.
In reconstructing her experiences, Natalie recalled pulling when she was very young, around the age of 7. Prior to this, at around 5 years of age, she pulled the fur out of her stuffed animals when her mother made her go for a nap. Natalie went on to say that her brother demonstrated hair pulling to her, and that from then on she was unable to control it.

It started with my eyelashes. Then I remember my brother in school had learned something about hair and I guess at that point the teacher probably made them pull out a piece of their hair and you could see the little white thing at the end of the hair and he showed it to me and that day I became obsessed with trying to find it on my own head. And so I would find them and I started not chewing on them, but I would hold them up against my lip because it was kind of a cool feeling. And then after that it went downhill from there. I guess I became addicted, I don’t know what happened.

Natalie’s experience also highlights the difficulty of trying to understand this behavior. Though she describes her initial episode of pulling as a common everyday experience, Natalie’s story also demonstrates how this behavior can become out of control.

For Rachel, her hair pulling started when she was 8 years old, however, she does recall stroking her eyebrow repetitively as young as 4 or 5 years of age. Academic stress preceded Rachel’s initial episode of hair pulling. Rachel stated that receiving what she perceived to be a bad mark on a test and the subsequent reaction of others contributed to her first incident of hair pulling. Rachel’s description emphasizes the emotional aspect of her experience.

I basically had the equivalent of a nervous breakdown for an 8-year-old. I got a mediocre mark on a test on the first day of school and it sent me into a tail-spin because I was normally a straight “A” student. I was convinced that I was going to fail fourth grade and I basically just started to cry and didn’t stop for
2 months. My parents, I think, did what they could to some extent to help me but after awhile they really got sick of my behavior. So, one night, my mom was a nurse and worked nights at the hospital and my dad was an elementary school teacher, he actually taught at my school, he got sick of it. My teacher called him saying, “you’ve got to settle down your kid,” so one night he pulled me aside and told me a story where if I didn’t stop crying, I was going to get a bleeding ulcer in my stomach. . . It wasn’t too long after that that I started pulling. There are pictures from back then where you can actually see a hole and a red spot where I started pulling.

For Claire, the onset of her eyelash pulling coincided with the onset of the symptoms of Tourette’s disorder, at the age of 9. She remarked, “at that age I don’t really know why I did it. I don’t remember the feelings I had when I first started. I have no idea what that feeling was like.” However, during her interview, Claire alluded to the possibility that the Tourette’s may have caused her to pull. The possibility of a connection between trichotillomania and Tourette’s disorder has been noted in the research literature.

I remember being at the doctor’s, my mom or my dad saying, “Claire’s pulling her eyebrows out now.” And the doctor didn’t say anything of course at the time; they didn’t diagnose me until much later. They were kind of leaving us in the dark. They didn’t give us answers so I’m sure that it was something. I know that my mom and dad wondered and then I started to wonder, well maybe that’s why; you know is it because of the onset of the twitching; is that why I’m pulling my eyebrows and eyelashes.

The rest of the women described a start on the road to discovering trichotillomania that occurred later. For Samantha, Trichster in Toronto, Marion, Kathleen, and Cindy, onset of hair pulling occurred at age 10 or beyond. For these women, social stress, culture shock, and puberty were all offered as possible explanations for it.
Samantha recalled pulling in Grade 7. She attributed it to adolescent concerns, namely, her liking of particular boy, social stress, and puberty. Samantha went on to say that a combination of these three may have precipitated her hair-pulling behavior. She described her first hair-pulling incident as follows:

I had this English class and at the end of the class there would literally be a pile of my hair on the floor... Maybe it was happening in the other classes too. In this specific class, I did sit next to a boy I liked and maybe, I don’t know, maybe that was enough to trigger it. I’m not entirely sure... Also that was the year that I had the bald spot and that was because I had a gray or silver hair growing and it was very short basically and I kept trying to pull it out to the point that I was getting all the hairs around it and caused damage... I was quite happy in Grade 7, but maybe it was the social stress and puberty hitting, I’m not exactly sure.

Kathleen also started pulling in Grade 7. She started pulling in school without being aware that she was doing so, and the other children discovered her secret. Her description of this experience suggests that she was subjected to the ridicule of her peers because of the pulling. It also suggests that for Kathleen, hair pulling was a means of coping with stress.

I remember being in the classroom, I remember someone making fun of me, I didn’t realize that I had been doing it, but apparently I had been for a long time and they were mimicking me... I remember scratching a patch of dry skin on the top of my head... I was scratching that until it bled, until I felt that I didn’t have to anymore, but I also started pulling out the hair around the area because it was good... to relieve some tension.

Later in the interview, Kathleen recalled that the first clear memory she has of pulling was when she was watching a hockey game with her father.
For some odd reason I remember watching a hockey game with my dad and I remember having a patch of missing hair the next day. It was a playoff game or something like that, something emotionally charged. . . . That’s the first time I remember doing it very clearly and very systematically. Just decimating an entire area. Everything, every single hair in that area was gone.

Kathleen’s account suggests that for her hair pulling is connected to being emotionally engaged. Though she didn’t clearly articulate the reasons for being tense, her responses clearly indicate that for her, hair pulling is a means of reducing the tension of an emotional situation.

Marion started to pull at age 10 and can remember exactly how it happened.

We were at a friend’s, my parents’ friend’s place in Sri Lanka and I was feeling stressed or upset about something in my life but I don’t remember what it was. . . . but I remember I had my hand in my hair and I was touching my hair and I was looking at the computer, which is weird to me but I was looking at the computer and touching my hair and one or two of the hairs felt funky and I pulled them out and I looked at them and they were different colors and I thought that was weird and I found myself not being able to stop and I kept doing it and doing it. Then I was thinking, “Oh, I shouldn’t be doing this, this is something I might get in trouble with,” but nobody noticed and nobody said anything.

When she was asked to describe what was going on in her life at the time of the pulling incident, she described the culture shock she experienced when she and her family moved to another country. The move was extremely stressful for her.

Maybe the first 18 months that we were there I remember that it was quite a stressful transition for me and probably for the rest of the family because you know we had never moved before. And suddenly we move and I was
unprepared as a kid for what Sri Lanka was going to be like because it is a very poor country and there was a lot of visible poverty everywhere and that was what really struck me as a kid. We were living in a little town with 6000 people in Ontario and I wasn’t aware that people lived like that . . . It was a shock and also when we got there, we thought we were going at a good time. My parents thought we were going at a good time but almost as soon as we got there, there was a lot of conflict that escalated right away. So there were bombings going on in the city and people being killed and you could hear gunshots a lot at night. There was racial tension there that was fairly visible.

Cindy, like Marion, began to pull when she was 10 years old. Cindy’s experience suggests that the beginning of adolescence, in particular the discovery of makeup, led to unhealthy and lifelong consequences. For Cindy, the innocent act of wearing mascara resulted in the development of a vicious cycle of pulling that she has been unable to conquer.

I strongly remember at that time starting to wear makeup . . . And then I started experimenting with mascara and I was probably using my mom’s mascara. . . . I was putting it on only on a few occasions to go to school, this would have been in Grade 7, and I would touch my eyelashes. After wearing the mascara and I would feel whether they were clumpy . . . at the end of the day or whether they were still like in straight perfect rows. I’m a perfectionist, the more you touch, the more they clump. It’s a vicious cycle, I would want to touch them and look in the mirror at recess break and see if it still looked good. I was fascinated with this makeup thing, a new adventure, something new in my life. I remember somehow pulling an eyelash out from touching the mascara too much. It was very weird, it was more gradual; it took many months for me to have pulled out a few because it wasn’t actually something that I was actually thinking about and then there was also at the time, shaving my eyebrows. I was doing that all by myself and I think that I may have over shaped them and I kept shaping them too much and taking too much hair out. Then I would touch them, look in the mirror, they were nice and thick, the
edges were much thinner and then I just kept touching them with my hand going up. After so much repetitive motion of touching the eyelashes, I started touching my eyebrows and somehow it turned into a big problem.

Trichster in Toronto started when she was 12 and for her, the onset of pulling was unusual.

I remember being 12 and I just remember one day putting masking tape and pulling the hair on my legs and it felt good. . . . You know I could have shaved if I wanted to shave, but it wasn’t about removing the hair, it was more about the feeling and then from there it went to my eyebrows and my eyelashes and I remember the first time I ever pulled out my eyelashes: I just started pulling and it felt good. It was like this sense of release, and then it went from my eyelashes to my eyebrows to my hair. And I would spend hours in the bathroom with tweezers until I was bloody pulling out the hair on my legs. It drove my parents crazy. It was just that simple, one day I didn’t and the next day I did.

Trichster in Toronto’s description is similar to some of the previously described experiences of the other women in that she reports a sense of release felt when pulling, and changing of hair-pulling sites. She also talks about the suddenness of the onset of the behavior. In other words, one day she wasn’t a hair puller and the next day she was.

**Theme 2:**

*Childhood Environment*

The second major theme that emerged from my analysis of the transcripts is Childhood Environment. The issues described in this overall theme are represented by two categories: family experiences and the women’s responses to these experiences.
Family Experiences

In describing family-related issues, the women were asked about the following: who they grew up with, family dynamics, styles of communication, early life experiences, and traumatic stress. All of these issues highlight the role that familial factors play in the experiences of the women.

Who I grew up with.

The first family-related factor, Who I grew up with, reflects the constellation of the women’s families. The majority of the women came from intact, two-parent families with siblings. This was the experience of Claire, Marion, Trichster in Toronto, Penny, Shanna, Cindy, and Kathleen. Kathleen was adopted at 8 months of age and has had no contact with her biological parents. She grew up in an intact family with one sister. Some of the women indicated that their parents divorced later in life. Take the example of Natalie. She grew up in an intact family for a significant portion of her life. Her parents separated when she was in Grade 9. Similarly, Rachel also lived with two parents up to the age of 12, when her father left and her stepfather entered her and her mother’s lives. Samantha also grew up with a stepfather and stepsiblings.

Family dynamics.

A second family-related factor that emerged was Family dynamics, i.e., the various relationships in the immediate family. Several of these relationships are highlighted. One is the relationship that the parents had with one another. This relationship was characterized as supportive, loving, and connected, for some, and dysfunctional and chaotic for others. A second aspect of family dynamics is the women’s relationships with their parents. Several women described having a caring and supportive relationship with their parents whereas
others described a difficult relationship. The women’s relationships with their siblings was
the third aspect of family dynamics. Overall, the experiences presented below illustrate the
various aspects of family dynamics and demonstrate the effect of family dynamics on the
overall childhood environment.

Seven of the women spoke about the supportive, healthy, loving, and connected
relationship that they observed between their parents. Though some of the descriptions also
revealed occasional conflict, generally, the supportive aspect of the relationship dominated.

Marion characterized her parents’ relationship as a good partnership that had a
positive effect on the family environment.

I think they had a good relationship. You know they had their share of
disagreements, it wasn’t always paradise, but I think they had a good
partnership that was positive.

Shanna, likewise, described a good relationship with some disagreements, but nothing
that would warrant a negative judgment of the relationship.

I think good, happy. I don’t remember any problems, of course there was
yelling and fighting and normal problems, but they are still together. I guess
normal; I don’t remember anything different growing up.

Trichster in Toronto also speaks about her parents’ loving and caring relationship.

They’re very connected to each other and this question is so much harder
when you’ve gone to school, I’m trying to think and if you had asked me that
question 10 years ago it would have been a different answer. I mean they’re
close, I mean it is a loving relationship. They care about each other, they are
dependent on one another.
Kathleen described the supportive and loving nature of her parents’ relationship by highlighting how they complement each other. She described her parents’ relationship as follows:

They are still married. My mother is a very dominant personality; she’s a teacher and treats everyone like they’re 5. My dad is a minister and he is very laid back. Definitely very dominant mother very laid back, no disciplinarian father who likes to spoil his daughters. He is the kind of father that doesn’t mean to, but he tries to buy your love, type of thing. Same thing with my mother, so lots of fights over money, but they’re very loving parents and they love each other very much obviously. . . . They do balance each other. It is sort of a yin and yang thing. The disciplinary mother and the father that loves to spoil his girls. But definitely some cause for conflict. Not a lot of yelling or screaming and that kind of thing because of their very different temperaments.

Cindy also described her parents’ relationship with one another as supportive and loving. Although that they’d had conflicts in the past they had worked on their marriage resulting in a stronger and more positive relationship.

They have a great relationship; they’re as strong as ever, they went through their ups and downs. I think it’s better for them now that they have less stresses in their lives with raising children. Probably when my brother and I were still in the house, we would hear them fight and argue and that was uncomfortable, but we didn’t think that it was abnormal. We never really thought any of their fighting would lead to a major problem like divorce. We never had to worry about that because their relationship was very stable and my mom, she talks a little bit more loud, a little bit more argumentative than usual, so it’s almost become normal. Some people might hear her and say she’s yelling and sometimes she’s not.
Claire on the other hand describes the relationship between her parents as good, but undemonstrative.

They were loving, they were sort of conservative, so they didn’t show their affection. . . They never fought in front of us, I didn’t see anything like that so I would say their relationship was good, they lasted 50 years. My mom passed away before they had their 50th.

Samantha described the relationship between her mother and stepdad as loving and comfortable.

It was okay, they seem happy. They didn’t really fight in front of us or anything, not that I don’t think that that happened, but that was something between them.

In contrast, three of the women spoke about dysfunctional and often times conflictual relationships between their parents. Natalie’s account, for example, highlights the dysfunctional aspect of her parents’ relationship. She described verbal abuse and then, towards the end of their relationship, physical abuse. Natalie, describing her parents’ relationship, stated:

Completely dysfunctional . . . I guess for my entire life, I mean my dad is a heavy drinker and he at one point he was able to maintain his own businesses for a few years. But he was never abusive towards me, ever! But towards my brother, I witnessed physical abuse on four or five occasions throughout my childhood. And then with my mother, I heard him yell at her. I never witnessed any physical abuse. I don’t think he was physically abusive until towards the end of the relationship. If you talk to him, it’s because she started hitting him and he was trying to push her off of him or something like that. So, I don’t know what the whole story is.
Rachel, likewise, characterizes her parents’ relationship as negative. She describes her mother and father’s relationship as pretty tense, with constant conflict. I would say that within about 2 to 3 years before he actually left there was this increasing tension in their relationship and constant fighting. I was pretty sure that he cheated on her. He was always the playful one and impulsive and she was the one that kept order, so there always seemed to be a level of chaos between them and their styles of parenting.

This is in contrast to her mother and step-father’s relationship, which she describes as healthy and attributes this to the fact that they have similar values and interests. They seemed to be much more loving toward each other and just comfortable with being who they are and who they were in that relationship and they seemed to share the same values so they just seemed to be on the same plane.

Similar to Natalie’s and Rachel’s experiences, Penny also describes her parents’ relationship with one another as conflictual. However for her, though she wishes that the communication had been better, she has come to appreciate the loudness, laughter, and openness and views it as a positive. Not particularly stable. They are still together but they are by no means the model marriage. They fight a lot, yell a lot (not so much in the last couple of years but when I was growing up). We’re a loud family, we’re Israelis, and we fit the stereotype of the loud Israeli family for better and for worse. Better because the picture of the sort of quiet, polite home kind of nauseates me. I’ve never had that and I’m glad that I never did, you know loud, and in terms of laughter, in terms of openness but overall in terms of always yelling, a lot of communication could be done differently . . . very supportive, they are not conservative people, very liberal very sort of “do what makes you happy” type of people. A very positive influence to have in my life.
The second aspect of family dynamics is the women’s relationships with their parents. Six of the women described a supportive, open, and balanced relationship with parents. This type of relationship was characterized by good communication, closeness among parents and participant, and little conflict and rebellion. In contrast, the remaining four women described conflictual and unhealthy relationships with parents. These relationships suffered from problems with communication and a lack of support.

Penny, for example, highlights the positive and supportive nature of her relationship with her parents. Though she acknowledges being irritable at times, even so her parents’ support is unconditional.

Very supportive in terms of my extracurricular activities, I have been really involved ever since I was a young person. I was always in the student council; I was in the band, choirs. I did it all and got the good grades. I was one of those kids. I would describe myself as an irritable person, especially around my family. So that gets in the way, but it doesn’t really get more supportive than they are. Everything that I want to do, they just get excited about. I’ve changed my major three times and they’ve just sort of responded with “oh, cool.”

Marion also spoke about the support that her parents offered her. However, although she feels supported, she does not always share her problems with them in order to spare them from unpleasantness.

There are certain things that I don’t talk about with my parents, you know for their sake, for their feelings. I don’t always tell them every detail of my relationship breakups and stuff like that, but by and large I think we have a pretty open relationship that is strong. I feel my parents are pretty supportive and I don’t see them as much as I would like because they live in another city,
but generally speaking I think we’ve got a pretty good relationship. As I got older we talked about different things, I had different interests and needs that they needed to fulfill but by and large they are pretty great actually. They’re pretty non-judgmental and supportive, and, you know, have always been like that. It sounds like a boy scout but fortunately it’s true.

Shanna described a similar experience to that of Marion. For both of these women, the overall relationship was positive and supportive. However, both Marion and Shanna indicated that ultimately they were responsible for managing the relationship. While Shanna, asserted that her relationship with her parents was good, she attributed this to her being a good child who did not challenge the house rules, but rather adhered to the standards set by her parents. In this way, she was able to maintain a supportive and loving relationship with them.

We would take trips together and go to different places. I remember every winter we would go snowmobiling. That was always fun. I guess it was a normal, happy childhood. Nothing out of the ordinary that I can remember. I think it was good, I was the baby so I was always babied. So I was always a good child. I’m not bragging or anything, but I was always, you know, quiet, and always would listen and, you know, never had a problem with peer groups or anything like that, smoking, drugs. So I think that me and my parents had a good relationship because I was an obedient kid. I was a good kid, I wasn’t running round and screaming and carrying on like that.

Claire’s relationship with her parents was also described as being an overall good experience. She described growing up in a happy and loving home environment and attributes it to her sister.
Happy, and loving. I had an older sister that was 13 years older that really took me under her wing when I developed my Tourette’s. Even before that, she was like a second mom. It’s not that my mom wasn’t a good mom or anything. She was a great mom but you know older sisters enjoy doing things with their younger sisters and so my sister was the one that understood me, the most about my Tourette’s and my hair pulling. That was a good relationship, so it was all around a good experience.

Claire’s Tourette’s disorder definitely contributed to the tension in her relationship with her parents, particularly her relationship with her father.

My mom was more empathetic to my hair pulling and my Tourette’s than what my dad was. My dad had a hard time coping, more so with my Tourette’s. So there was tension definitely between myself and my dad. But now there’s not, it’s taken a lot of years. But there was definitely tension and my mom would often say, “Claire, why are you in the bathroom for so long?” knowing very well what I was doing.

Two of the women, Kathleen and Trichster in Toronto, reported being much closer to one parent than the other. Kathleen, for example, described a close and supportive relationship with her mother. She attributed this closeness to her mother’s willingness to listen to her.

My mom and I, I mean we saw each other today, we see each other a lot. We talk on the phone a lot. With my dad it’s good, but we don’t sit and talk for long periods of time, but family is important to him, so I try and go over there at least once or twice a month for dinner.
This was also evident in Trichster in Toronto’s experience. Though earlier, there was the suggestion that there was a lot of conflict in her relationship with her parents, overall, she reported she had a closer relationship with her father.

I was very close with my dad growing up. I was closer with my father than with my mother.

In contrast, four of the women (Natalie, Rachel, Cindy, and Samantha) offered experiences illustrating conflictual and unhealthy relationships with parents. Natalie’s description, for example, highlights the chaotic and unhealthy aspect of her interactions with her parents.

I do talk to her [mother] on a regular basis but she actually drives me insane. She is very, very aggravating to me and she is a little bit, not clinically delusional, but she kind of lives in her own world. I guess because of the way her world was in the past. She chooses not to recognize it. And she only looks at certain aspects; she thinks she is the perfect mother and she wasn’t.

I still talk to my father on a regular basis. I guess the relationship did improve maybe in my early to mid-20s and then up to 2 to 3 years ago. Two-and-a-half years ago our relationship improved where we did talk about his not being a good father in my childhood, and we really have a good relationship now. But you know he is a dysfunctional person, he is an alcoholic, and he has a lot of his own problems. He ended up with a woman and got himself into some legal trouble with her and ended up in jail and I had to go bail him out over Christmas holidays. So that was a huge problem. After that our relationship has never been the same. We see each other a lot less; we talk less now because he did end up in jail again for the same charges last summer. I just said, “you know what, you’re on your own, seriously, you’re an adult.”
On a similar note, Rachel offers this description of her relationship with her biological father. Her description highlights the distant relationship they have.

I’ve seen him here and there over the years. I would say that the last time that I saw him was in 2001, but I’ve seen him over the years; it’s never been for anymore than say a half hour to an hour at a time.

When Rachel was asked to describe her relationship with her father prior to his leaving, she stated the following:

I would say it wasn’t good. I was the oldest child and I was really Daddy’s little girl and then my dad became a workaholic and was always focusing on his job and other people associated with his job to the exclusion of our family. Now that I can look back and say, “okay, I really felt like I was second or third or fourth priority,” but yeah, just before he left it was really tense and I was trying to cling to him but he was sort of pushing me aside.

Rachel’s description of her relationship with her mother suggests that as a child it was distant, however, after her father left, Rachel made an attempt to get to know her mother. She does, however, acknowledge that this was a difficult process occasionally marred with conflict.

It’s an interesting relationship. When I was growing up, I was Daddy’s little girl so I found that I didn’t really like my mom and it always seemed that she was the one who wasn’t any fun and I didn’t really know her. Then after my dad left, I really felt sort of lost at sea because he had abandoned the family and then my mom was the only one we had left and yet I felt like I really didn’t know her. So I think that after my dad left, I got to know her a little better, but she’s very strong willed and critical so I sort of bounced back and forth between, I wouldn’t say a love-hate relationship, but it’s definitely had its rocky parts.
Cindy likewise described her relationship with her parents as conflictual, particularly her relationship with her mother; however, Cindy’s account also reflects a need for independence.

There was only me and my brother to fall back on each other and I think I had a little bit more, wanting more out of my youth. . . . So I would fight more with my parents than my brother ever did, so there was more fighting with my mom because my mom was home and my dad was at work.

In Samantha’s case, because her parents divorced when she was young and she was unable to recall the specifics of their relationship, she was asked to describe her relationship with her mother and stepfather. The relationship was strained and conflictual due in large part to the divorce and the resulting economic complications. She described her relationship with her mother and stepfather as follows:

Varied. Sometimes strained. We moved to North York and in the past living in Toronto and I went to school in North York for a few years, and it was decided that I would go back to my old school because it was more challenging. So I spent a lot of time commuting between North York and Toronto. The divorce and the move, it was cause for a big economic change. A lot of my friends had a lot more money than we did and that was sometimes a source of conflict. I would feel like I really, really needed a jean jacket to fit in and they would say, “Well, we just can’t afford to get you the jean jacket,” and that would be horrible.

Later on in the interview, Samantha described her relationship with her stepfather as initially almost nonexistent but gradually over time becoming quite amicable.
It was quite strained for a while and part of that straining was that my sister that was 3 years older than me also had a very strained relationship with him, very oppositional: a self-created oppositional relationship with him and that affected me. So when I was younger I didn’t really have much of a relationship with him, he was just there. And then when my sister moved out, I mean at this point, it was just my mother, my stepfather, me, and my dog. Things were just calmer, much more comfortable, and we began to develop a much more friendly relationship. We would watch TV together, he would watch bad teen stuff with me and we would share the TV, which wasn’t really happening before.

The third aspect of family dynamics is the relationship that the women had with siblings. The majority of the women characterized the sibling relationship as fluid, supportive, and close. They also described being closer to one sibling than the other(s). For some of the women the relationship changed from one of sibling rivalry and competitiveness to one of mutual respect. But this was not true in every case. One woman’s experience was the opposite. Her relationship with her brother changed from one of closeness and comfort to one of distance. She attributes this to her emotional difficulties and the impact that they had on the home environment. Some of the women indicated that they did not have a very good or close relationship with their siblings. Overall, the relationships that the women had with their siblings varied, however, they all influenced the home environment.

Some of the women asserted that they were closer to one sibling than the other(s). Take the example of Claire. A previous excerpt highlights the close relationship she had with an older sister and the support this sister gave her. However, in this excerpt Claire characterizes her relationship with another of her sisters as one of sibling rivalry and describes her relationship with her brother as distant.
I always had tension with one of my sisters [who was] 3 years older than me but I think that was just natural sibling rivalry and my brother, I mean he is 9 years older, so there was too much of an age difference for him and I to fight. You know we do things together but as well as being different gender we didn’t do a lot together.

A positive relationship with a sibling is evident in Penny’s experience. She provides this description of her relationship with her sister.

With my sister, definitely a positive relationship, she was always the quiet one in the family. She was the peacemaker, she didn’t want to get involved in the fights, she would try and calm everything down. We always got along. I don’t really have many memories of fighting with her, I have memories of getting annoyed with her and wanting to do something to make her upset and then thinking, “Oh, no, I can’t possibly do that, she’s too good; she hasn’t done anything bad.”

For Shanna and Cindy, there was an affectionate aspect to the sibling relationship. For example, Shanna described the playful teasing and light-heartedness that characterized her relationship with her brother.

My brother, we used to call him the devil. He would tease me to no end so I would always be scratching him and I remember you know I had the claws out because he would tease me and chase me around the house; you know it was a fun relationship. We got on well together but we were brother and sister, he would tease me to no end and I would just be scratching the heck out of him because he was a little devil.
The affectionate aspect is also evident in Cindy’s experience. She acknowledged being close to her brother and relying on him to support her when she had problems with their parents.

We were really close. I would always do everything with him and it was good to have him. I can’t imagine being an only child because it was always good to have him. When I was in the mood of hating my parents at least I could talk to him as we were driving to school in the car. When we were teenagers, we would be talking about our parents, no one else could understand the same things if they were not living in the household, so you really feel like you have someone to talk to. We were also interested in the same things, we liked sports, science and different things we have good conversations and when we were older, we were very respectful of each other. I wouldn’t say that we were like best friends, but at least a shoulder to talk to and understanding between each other.

Three women described the relationship that they had with a sibling as fluid in that it changed over time. Rachel described a relationship changing for the better. Kathleen and Trichster in Toronto indicated the opposite.

For Rachel, her relationship with her brother seems to be developing now that they are adults.

My brother. I think it’s growing right now. There is a 5-year age difference and I was really resentful with him when I was a child and basically we grew up in different life stages than each other. I mean I was going to university and he was just starting high school, so basically it was separate upbringings. I would say that now we are trying to forge a relationship as adults.
On the other hand, Kathleen’s relationship with her sister was once close, but became stressful and abusive. Currently, Kathleen describes it as more manageable given that she no longer lives at home.

It’s still stressful, she is at home for the summer and she can be verbally abusive when she is upset. You know everyone has got to be upset. But I think our relationship is better now that I am no longer living there. . . . But we were pretty close when we were young. My best friend and I would go somewhere and she was usually the third party. So it was always the three of us. It was pretty good when we were younger.

For Trichster in Toronto, the change in her relationship with her brother as she grew older was more problematic. She described having a close relationship with him when she was younger, however, at age 12, puberty and the impact of her emotional difficulties placed a strain on their relationship. To date, the damage to the relationship is still evident and though she has tried to make amends, she acknowledges that it may never be repaired.

I remember being younger and being close with him as siblings, and then everything changed when I hit puberty because we were 2 years apart. When I hit 12, I think when I turned 12 everything in the house changed. He resented me because he felt like I got all the attention from my parents and they were always giving me the attention. The attention I got was negative attention because I was getting yelled at a lot and I was very jealous of him because he was good looking and into sports and always had girlfriends. I was stuck dealing with an eating disorder and pulling my hair out and never dated. We just really started to hate each other and I think the worst of it was around when I left for university and I was around 18, 19. Then he left 2 years after that and he hasn’t been home since. We’ve tried to repair our relationship, he lives in the States and is married and expecting a baby, but it’s hard. I mean I’ve been in therapy for a long time but he’s never, he’s always refused
therapy and has never wanted to go there, so he has a lot of resentment towards me, so it’s very hard, I don’t know if he’ll ever forgive me.

In contrast, Marion indicated that she and her brother did not relate very well to one another when they were young. Differences in personality contributed to the strain in their relationship.

We didn’t really get along very well, lots of personality, power clashes and teenage, typical stuff, like whose bag that is and whose turn it is to have the remote control and stuff like that. I left home when I was 18 and when I left home, he and I certainly started getting along much better. Now we have a much more congenial, mature relationship.

A similar experience was described by Penny. In her case, Penny’s brother would manipulate her by threatening to tell others about her eyelash pulling. According to her, threatening to disclose her eyelash pulling to others was a very powerful incentive for Penny to do what he wanted. In describing her relationship with her brother, Penny says the following:

My brother and I grew up sort of bothering each other. He would always like to tease me, just making fun, in a very sort of way that if I described it as an adult, it would really seem harmless because he would bother me in a way that was well mannered, like very well intentioned, trying to get attention. So things like laughing at me, pushing me, stuff like that. No hitting because I’m quite lucky because a lot of siblings they go to that route, we never did so I am grateful for that, but obviously when I was a kid I wasn’t like, “leave me alone.” That was my feeling towards him. When it got really heated, you know there would be times when he pulled out the eyelash card. . . . I would be mean too and I would say mean things and he would respond with things like, “you know, if I want to hurt you I can because if I wanted to do
something really mean I can,” and then he would pull out the eyelash card, he really didn’t have to say anything. But we got along as we got older because intellectually we’re on similar pages.

Samantha describes her relationship with her siblings, in particular, her stepsiblings as distant. She further highlights the emotional difficulties her sister had and the conflicts that arose because of them. Samantha provided the following account of her relationship with her siblings:

My two stepsisters were quite a bit older than me and really not interested in me. You know I wanted to play and you know one of them was 20, so that was a little awkward. The sister that I really associated with most was the one that was just 2 years older than me and she and I shared a room for a while. She had her own set of emotional challenges. So we had a very close and also very rocky relationship.

**Styles of communication.**

A third family-related factor that emerged from the participants’ experiences is Styles of Communication, i.e., how the women’s families dealt with conflict and stressful life events. The descriptions reveal three patterns of communication: first, some women described a lack of communication; second, some were described as verbally aggressive; and third, some were described as being in denial, i.e., as choosing not to deal with conflicts and stress. The women also spoke about who they could rely on during moments of conflict and other stressful events.

A lack of open communication between the parents and children, specifically when dealing with conflicts, was described by Claire, Shanna, Marion, and Trichster in Toronto. In these families there was an attempt to shield the children from the conflicts and life
difficulties that the family was undergoing. The parents were the primary decision-makers and the children were not privy to the decision-making process. This was apparently intended to protect the children from the stress of dealing with the difficulties of life.

In Claire’s situation, her parents were quite willing to shield her from the realities of life. She acknowledged leading a sheltered life and she was not a witness to the stresses that occurred. Although the complications of her Tourette’s (e.g., the twitching) did on occasion cause tension with her father, who seemed to be less supportive than her mother, his response tended to be non-confrontational. Claire described her experience as follows:

I was almost naive to things happening in my world. Not just my family, but beyond as well. I guess I was living an innocent life which is nice. I didn’t see any conflict or crisis, but one recollection I have is when my grandfather, my mother’s father passed away. And that was the only time I remember conflict, other than dealing with my twitching. . . . I’m sure my parents argued, but I never saw it. You know, my dad never understood it was me, it was tough. That is the only time I ever felt a little bit of conflict, because my mom, even though she didn’t understand, she would always say, “You know Claire you can stop it,” but she was there for me, my dad wasn’t as understanding. It’s not that there was tension, but there was some tension. With regards to your question about crisis and how they dealt with it, I think as any family would. I mean it was okay. There wasn’t any problem there.

Shanna’s experience is similar to Claire’s. Conflict resolution for Shanna also involved a pattern whereby the parents kept things to themselves so as to protect the children. Shanna, being the youngest, was shielded from many stresses and did not participate in discussions to problem-solve issues. The norm in Shanna’s family was for the parents to resolve issues without involving the children.
I guess like any normal family would do. Handling it as best as they could and getting over it and moving on. I know that my dad kept things pretty much to himself and my mom was always trying to keep peace in the family. I guess if there were any problems, they would work it out for themselves, me being the youngest probably wouldn’t hear much about it. I was probably sheltered from a lot of stuff so I didn’t hear anything going on.

A similar pattern occurred in Marion’s family. The following is a description of her experience.

My parents only tried to make things good for my brother and I. I think that they always tried to shield us a little from the difficulties that we were experiencing. My dad lost his job a few years ago and you know we had a family discussion about it and then my dad would handle it. You know, we would try asking him how he was doing, are things okay, we have no money and approach him, and he would say, “Don’t worry about it, we’ll take care of it, we will tell you if we need to,” and that was about it. I would say there was some cushioning going on with my brother and I.

However, in a later excerpt, Marion describes the evolving nature of this dynamic. Her description highlights how the pattern of conflict resolution shifted from a pattern in which her parents shielded her and her brother to a pattern of working collectively to problem-solve.

I think that we would have discussions like that, and it was pretty open and available for us to comment. Let me give you a better example. My brother for a period of time, maybe 15 and 19 or 20, he just had a really hard time attending school and I think he was pretty depressed. He basically just dropped out of school and he didn’t go to school, stayed at home. I wasn’t living home at the time, I mean I was worried about it but it wasn’t a huge stressor in my life except for maybe periods of time when I would come...
home because my parents were very, very upset about it and we would try to do the right thing for my brother. There were a lot of family discussions about it, my brother would get really, really, upset and angry. And my parents would too, but they sort of continued to do that, try to talk it out and come up with solutions and then suddenly my brother said, “You know what,” he sort of enrolled himself in university, got a job, and moved out and got on with his life. I’ve tried to ask him what happened but he doesn’t want us to know or doesn’t want to talk about it. It [the problem] sort of alleviated itself and was not longer a problem.

Related to this style of communication, is the idea that the parents are the decision-makers and the children follow the decisions made. This is the experience of Trichster in Toronto. However, like Marion, Trichster in Toronto also reported a shift in the dynamic. There seemed to be more negotiation later in life. Trichster in Toronto describes her experiences as follows:

I mean when we were younger, it was like, “Go to your room, wait for your father to get home.” When we were younger there was a lot of like, “this is how it is going to be because we are the parents and you’re the children.” Until probably that didn’t work anymore. The family did not handle conflict and stress well at all. I don’t think either of my parents necessarily handle stress all that well and I think if anything people saw my dad as being the rock of the family. I don’t think there was a lot of discussion about conflict. I think a lot of times it was just, “this is how it is, this is how it’s going to be and that’s how it’s going to be done because we are the parents and you are the kids.” As we got older there was more negotiation and because my parents started going to therapy on their own.

A second style of communication that emerged from the descriptions of the women was that of verbal aggression. The women described this pattern using terms such as “a lot of
lying,” “yelling,” and “avoidance.” The families who engaged in this type of communication pattern did not generally solve the problems; rather it seemed as if the issues became more complicated because of the verbal aggression. In other words, the verbal aggression pattern heightened peoples’ defenses and contributed little to problem-solving.

Take the example of Natalie. In describing her experience of conflict and crisis in her family, and her family’s reaction to these issues, Natalie indicated that there was a tendency to considerable verbal aggression coupled with avoidance and lying. She described her experience as follows:

There was a huge lack of communication and a lot of lying. For some reason, that is the other thing that I noticed, my mom lied a lot. I don’t know why, just about everything. I can’t even give you examples, just so many things. . . . I noticed that even my brother will change his story to suit his needs and my father is a pretty straight up guy, but he would lie to avoid bill collectors. There was a lot of avoidance, lack of communication, and I think if anything, verbal aggression, so everyone would act defensively.

Samantha, likewise, in summarizing her experience also highlighted the use of verbal aggression in response to conflicts, crises and stressful events in the home environment.

Yelling was one way we would handle it. At one point we tried family therapy, with me, my sister, my step-father and mom. That didn’t really go very well. I think that it’s because everyone was out of the house by then and it wasn’t very helpful. I think it just stopped because mostly it was getting people upset but it wasn’t resolving things. It was just people going and being upset and crying and then nothing. There was no kind of follow-up or understanding.
Cindy, also spoke about the verbal aggression that was exhibited in her home environment. However, in Cindy’s case, her father worked to resolve conflicts by putting things into perspective.

We would verbally fight and argue at the top of our lungs, we would yell and we had quite a lot of it from me. . . . My dad, he has a Master’s in psychology, so he is always the one to kind of put out the flames and be the mature family member that put things into perspective and helps my mom get through problems. You know, helps the family stay stable. If mom and I were fighting in the afternoon, when nobody was around, it was like how can you resolve it later in the evening.

Penny’s experience also highlights this pattern of verbal aggression, however, for her, there is the added step of apologizing. Penny acknowledged that she was not able to provide a specific example; she described her family’s pattern of communication by stating the following:

If I was to take an abstract case and say how I think my family would react to it, it would probably involve a lot of yelling and then maybe apologizing the next day and moving on.

Denial is another pattern of communication. The experiences of Rachel and Kathleen highlight this pattern. For these two participants, denial of the problematic issues was motivated by the need to present the family in a “good light” and to avoid drawing attention to difficulties. Rachel described her experience as follows:

Mostly it was steely resolve. Occasionally there would be a knockdown, drag out, yelling fight, but for the most part it was just put on a “good face” and pretend like everything is fine even though everything was falling apart behind the scenes.
Kathleen’s experience also highlights the denial response. There is a tendency in Kathleen’s family for her father to deny the issues at hand, whereas her mother tries to resolve issues. Kathleen provided the following description:

Well, my dad retreats, either into his office to read or listen to music or turns on the television or movie, that’s just his coping mechanism. My mom tends to get loud. She tries to settle things. This is what she does and she’ll take over and try to fix things in a way that she thinks is best. . . . the way that they deal with stress together is not very healthy. If everybody sat down and had a cool head, things might be dealt with a little better but dad goes into denial. He actually recently had to declare bankruptcy, my mom had been preparing for this for years because there was just no point in talking to him about it anymore. So she financially separated herself from him. Mom gets all logical and solves the problem, separates everything. Dad on the other hand is into this denial and keeps going as if nothing was wrong. And like I said, my sister doesn’t deal with stress very well. She gets upset and cries. She has tried to commit suicide a couple of times.

Related to the issue of styles of communication, is the question “who can you rely on in moments of crisis and stress?” Trichster in Toronto and Cindy indicated that there was no one specific person they would approach. These women felt equally comfortable approaching their mother or their father. Kathleen, Marion, and Shanna indicated that they could rely on their mothers during periods of stress. Claire and Samantha identified sisters as more approachable during times of conflict and stress. Rachel described being closer to her father, however, this quickly changed once he left the household. She then relied on her mother. However, this was not the experience for all of the women. Natalie indicated that friends were more approachable than family and Penny reported that she relied on herself. Overall,
with the exception of Penny, all the participants indicated that they had someone they could turn to during periods of conflict, crisis, and stress.

While Trichster in Toronto indicated that both parents were approachable, she also acknowledged being unable to talk to them about certain issues. Though her pulling and eating disorders were obvious, these were not issues that she discussed. Trichster in Toronto described her experience as follows:

I could speak to both of my parents. It’s very truthfully hard because I did speak to my parents about certain things and not about others. I spoke to them about a lot of things, maybe important things are things that I didn’t talk to them about. At different points of my life, it changed like early adolescence I did talk openly with my parents, about school and stuff like that but we never talked about my pulling. I mean, it was pretty obvious. And we never talked about my eating disorder. There were things that I talked to them about but I don’t think they were important things.

For Cindy, the decision to approach one member of the family over another depended on which family member was involved with the particular situation or issue. She, like Trichster in Toronto, stated that she did not talk to her parents about her trichotillomania. It was not something that she felt comfortable talking to them about. This continues to be an issue that is not discussed with them. In sharing her experience, Cindy offers the following:

It would probably be any of the three of them [mother, father, brother]. It could be the one that is most involved in the situation. If my dad was home that night, if I felt that I could get a better answer or solution from him versus my mom, if I had a problem and I just wanted to talk about it, it might be my brother. . . . if there were certain things I needed, more like physical things, then I would talk to my mom about it.
When was asked if she could talk to her parents about her trichotillomania, she responded:

We would never, ever talk about it. I mean the one time I actually remember the conversation being brought up, we might have been around the dinner table. I remember my brother making fun of my eyelashes and how I was missing a big gap of hair in the middle of my eyelashes. But other than that, I really never wanted or they never felt comfortable talking to me about it, so it’s not that I would go to anyone of them. I wanted to avoid it and they did too, and I think they still do because they visited my recently and they don’t ask about it. They just kind of assume that hopefully it’s gone away somehow. Miraculously, they don’t know what it is. I don’t think that I ever had a conversation about it as a mature adult.

Three of the women indicated that their mother was someone who they could approach when they were experiencing difficulties in their life. They described their mothers as more patient and willing to listen, and less judgmental than their fathers. This was the experience of Kathleen, Marion, and Shanna. Kathleen offered this description of her experience:

My mom definitely. I don’t think that my dad would deal well with it. I don’t see him offering advice. Maybe it might be the gender gap, and he’s not going to offer solutions to problems. My mother would be more likely to sit and listen, where Dad would not lose interest but not be sure what to do. I guess maybe sometimes I would talk to my little sister but definitely not as much.

Likewise, Marion indicated that her mother was someone she could rely on in times of crisis, conflict, and stress. While she didn’t articulate the reasons why this was the case, she clearly stated that her mother was approachable: “I would say my mom would be that person.”
Shanna described a similar experience to that of Kathleen and Marion in that her mother was the one person who she could approach. However, Shanna also acknowledged being selective in what she reveals. She indicated that she chose not to reveal her years of being bullied to her mother. It was only later on that she was able to talk to her sister. Shanna offers the following:

I could always tell my mom, you know, anything. Sometimes I didn’t, but a lot of times I did hold back. I would be bullied in school and, you know, I would keep that to myself, so, you know, except for that part I would normally talk to my mom. . . . I kept that to myself, I didn’t tell anyone. Later on, because I had a good relationship with my sister, we talk about everything. But I do keep stuff like that hidden, kept to myself, I didn’t tell anyone.

Sisters were also identified as someone that the participants could rely on. For example, Claire indicated that her older sister was someone that she could count on. Samantha also indicated that she could discuss problems that she was having with her sister; however, her stepmother was also identified as being helpful.

It would have to have been my sister, the one that was older than me, unless she was not in a position at that time to be talking. I guess, my stepmother, she was close enough but also removed enough.

Interestingly, for Rachel, her biological father was identified as the most approachable. However, this quickly changed once he left the home environment. Rachel indicated that once he was gone, she turned to her mother.

I would mostly approach my dad, my biological dad. I guess I kind of have to divide my childhood into two phases. When I was like before 12, I would go to my dad and then after that, after he left, I would go to my mom.
In contrast to the above, neither Natalie nor Penny felt that they could turn to family members in times of crisis. When Natalie was asked to comment on who she could turn to, she replied that she relied less on family members and more on friends to discuss issues of concern. She described her situation as follows:

Outside my family, I always went to friends. I had one friend, her parents were actually very supportive of me as well and so I became friends with her when I was 14 and I am still friends with her to this day.

But the rest of them, they were kids. I would complain and especially because I was always in a low mood because I was always stressed out because I was working; my mother kept stealing from me. She wasn’t being a mother, she wasn’t providing food, so I was always kind of bummed out, and it was difficult for the rest of my friends to understand. It was always difficult for them to understand why I couldn’t go swimming, why I couldn’t do certain activities.

Penny described a similar experience in that she did not rely on her family. However, unlike Natalie, Penny indicated that there was no one that she could talk to. She relied on herself to problem-solve.

I am relatively open with a lot of stuff that goes on in my life but not in sort of advice-seeking capacity.

**Early Life Experiences**

The women described a number of early life experiences that epitomized their childhood environment. The category Early Life Experiences can be broken down into supportive and healthy, dysfunctional and chaotic, and mental health issues. Phrases such as “supportive,” “normal,” “happy childhood,” and “always there for me” identify the
supportive and healthy aspects of the home environment. In contrast, the women utilized terms such as “neglected,” “critical,” and “disorganized” as descriptors of a dysfunctional and chaotic home environment. Mental health issues in self and the family include depression, anxiety, obsessive compulsive disorder, and alcoholism, to name just a few.

**Supportive and healthy.**

Claire, Cindy, Trichster in Toronto, Penny, Kathleen, Shanna, and Marion, spoke about a number of factors that contributed to a supportive and healthy environment. For Shanna and Marion, the home environment was not static but fluid and changed depending on the situation or issues being dealt with in the family. A typical example of this type of environment is represented in Claire’s experience. She came from a generally comfortable and healthy environment, where she doesn’t really remember too much conflict, except for when her grandfather died and difficulties the family had dealing with her Tourette’s disorder (as has been discussed).

Safe. Comfortable. I mean I wasn’t spanked, I wasn’t yelled at. Comfortable, happy and it was a healthy family environment.

Cindy also suggested a supportive environment; however, she highlighted the expectations placed on her by her parents.

I think it was okay. I don’t know, my parents always put us in different sports and dance. It was a very supportive environment where they really wanted us to excel in everything that we enjoyed. So if I wanted to play, if I wanted to do dance and gymnastics, they took me there. They did the same for my brother playing soccer. They always wanted us to do our very best, like in little clubs and getting really good grades in school and my mom didn’t work after I was 5 years old so that she could actually go to class and volunteer 1 or
2 days a week for a few hours. So kind of one of those families where my mom wanted to make sure that her two children grew up really smart and really involved. It’s not that we had a lot of money at that point where we were able to do anything and everything we desired, I think there were things that may have been limiting, but in what they could put us through, they wanted us to do great. They would come to every sports game; they would take tons of pictures. They were the parents that were always there; it was a very supportive environment.

Trichster in Toronto also spoke about the home environment as supportive and healthy. She attributes her well-being to the support of her parents. She asserted that without them she would have given up long ago.

For all that I talk about my parents, I love them dearly. I think it’s hard because as I’ve gotten older, I think that when you leave being a child, you experience your parents as an adult rather than as a child, it’s hard because there is a lot of anger that comes along with that. Looking back they were obviously very supportive of me because I wouldn’t be here had they not been. I would have given up a long time ago. In that sense they were very supportive of me.

Later on in the interview, Trichster in Toronto states:

I remember a lot of happy times, being younger as a child. I remember being extremely shy. My parents did a lot of great things with us. My mother said that she had to take me to school every day. I was always as a child clung to my mother. The first day of school and at parties, she could never leave me. I did do a lot of things that quote “normal kids” did, I went to activities and parties. I think that my childhood was certainly better than my adolescence.
Penny described her home environment as challenging:

Probably a positive challenging environment. I learned how to deal with the challenges, in dealing with friendships at school, with my family, with the eyelashes.

Kathleen recalled her home environment by stating the following, “definitely, a loving family, with periods of stress.” Both Shanna and Marion recalled a normal childhood, safe and comfortable. However, they both reported significant difficulties at school, which added a dysfunctional and chaotic aspect to their childhood environments. Shanna provided this description of the effects of this contrast:

I never liked school, from the time I was young to even today, I don’t like school. It brings back bad memories and I remember the bullying, of course. I was always a different person. I would always say like Jekyll and Hyde, I was two different people. Away from school and then when I was at home, I was more normal, more myself, more talkative.

Marion, likewise, described her home environment as safe and comfortable, however, she, like Shanna, had difficulties in school.

I’d say our home was pretty comfortable and safe. I always felt they weren’t total pushovers, you know soft style of parenting in terms of listening to problems and they wouldn’t really get angry about things too much. My brother and I fought a lot in terms of school, I think it was difficult for me right up until high school. I think I always found the social interaction at school pretty stressful. . . . but that’s something that I sort of perceived as being stressful or unpleasant about life. When I was in school, it was having to deal with the bigger kids, kids that were mean. I always felt that kind of stressful but then on the other hand, . . . I’d say that every year I’ve had at
least one friend who I felt was a good supportive friend that I could rely on. I never actually felt totally alone.

**Dysfunctional and chaotic.**

A second category under the subtheme of early life experiences, Dysfunctional and chaotic includes the problems that participants identified as being prominent in their home environment. Under this category, factors such as stealing, trying to keep up appearances, divorce, high standards, critical, and lack of support were all identified as being significant in the participants’ upbringing. Natalie’s experience clearly highlights the theme of dysfunctional and chaotic. Natalie described what it was like growing up in her family. Natalie’s description of her mother’s behavior towards her and her mother’s failure to take responsibility for these actions, all contributed to a dysfunctional and chaotic home environment.

She would steal money from me, I had a job, I worked since I was 12, I got it babysitting or having a part-time job. So I bought all my own clothes but she would take clothes out of my closet and if they still had tags on them, return them to the store to get money so that she could go out and do whatever it was she wanted to do. And if I confronted her on it, then it would blow into a huge fight and she would turn on me like I was the selfish one. I could as an adult talk to her about it, but I’ve kind of left it because I just think she is just so dysfunctional there is no point. I just make it a point now that whatever bothers me, I address it with her currently than in the past.

Natalie also spoke about her family’s need to keep up appearances and the financial chaos that she endured as a result of this.

I think my parents, well, my mother, always wanted to “keep up with the Joneses.” So it always had to be bigger, better, and nicer. And it was also
because my dad, at least I think it was, because we had to use the equity of the house to pay off outstanding debt.

Samantha also described her home environment as disorganized and chaotic. She specifically talked about her parents’ divorce and the subsequent absence of her mother.

I was the youngest and there were a lot of us and at least when I was very, very young my mom was sort of distracted, dealing with the divorce and trying to find another partner. I was maybe a little neglected, left a little bit to fend for myself. It was an environment where things were sort of out of control. I mean at least in those young formative years, I mean there were five kids, a dog running around, barking. My stepfather was also fairly disorganized. He was a programmer so he had 8 computers all over the place. There was definitely an element of disorganization, either in terms of how the house was organized, or in terms of people coming and going. And then you know going back and forth between my mom and dad’s on the week-end, then going back and forth from North York and Toronto. There was a lot of disorganization.

Rachel also described a dysfunctional environment, one in which she was constantly criticized and not supported.

In retrospect, I can see when I was living it, everyone pretended everything was great so I didn’t realize until I was an adult that I didn’t enjoy my childhood. It was a really critical environment. My parents had ridiculously high standards for me. One time in dance class, I had to do an exam and I got a 98 and my dad said, “Where is the other 2%?” And then because my dad actually taught at the elementary school that I went to, he was always keeping tabs on me, on how I was doing academically or socially in relating to other kids or physically how I compared to other kids. And he was constantly watching me at school and both my parents monitored me very closely at
home on how much I ate, how I looked, how I interacted with others. It was just a critical and not very compassionate environment. But my parents would put on the social mask that everything was fine outside of the house and even sometimes when we were in our home. So I learned that was what I had to do.

**Mental health issues.**

A third factor affecting early life experiences is Mental health issues, both in self and in family members. The women reported having other diagnoses such as eating disorders, depression, anxiety and Tourette’s disorder. Mental health issues in family members included mood disorders and anxiety. Alcohol problems were also identified as an issue affecting the family environment. Though for some women, mental health issues were identified in later life, these experiences were not categorized under this subtheme given the focus on early life events.

Trichster in Toronto, was diagnosed with depression and anxiety disorder as an adult but reported that she suffered from these as well as an eating disorder when she was still a child.

I do have major depression and also anxiety. I was diagnosed probably when I was, it’s a long history, I’m trying to think. I was probably diagnosed at 20, maybe around 23 or 24 but I know that I probably started suffering with depression or maybe anxiety and depression around puberty. The depression came first and then they worked on treating the depression, then the anxiety followed. I see a social worker and I take medications. I take Paxil and Ativan. I’ve been on about 20 different kinds of medication. When I’m not on it [medication], it’s not good. I did have electro convulsive shock therapy. It’s quite common for people who aren’t responding to traditional treatment and it is very commonly used in geriatrics. . . . I tried a number of different medications and then ended back on Paxil.
I think I was probably 12 [referring to the onset of her eating disorder]. I ate compulsively. I ate a lot but I was very active. I think as I got into my early adolescence, I stopped being so active and then I would just compulsively overeat huge amounts of food. I would try to make myself throw up and use laxatives and then starve myself for a week.

Claire, who, as mentioned, also suffers from Tourette’s, indicated no other family member had addictions or mental health issues.

In describing her early life experiences with mental health issues, Natalie reported that her father was an alcoholic and her mother had significant mental health issues.

He is a dysfunctional person, he is an alcoholic, he has a lot of his own problems. For sure my mother has mental health issues and I know that it exists in her side of the family. She actually, I think, has traits of a personality disorder. . . . when my parents split up she ended up having a mental breakdown. She totally lost it, so they did put her in the hospital, but she told me that she was going into the hospital for her back, but she really wasn’t. So, I went to stay with one friend, like I said I am still friends with her to this day, I stayed with her and her parents for a few weeks while my mother was in the hospital. But yeah, she was treated then, but I don’t know for what exactly. I would think that she has bipolar. But definitely she has personality disorder traits for sure. I think she was probably diagnosed with mood disorder, for sure.

Alcoholism and depression were also evident in Rachel’s description of her early life. He would never admit it, but I think my dad was battling alcoholism and I would say again neither of them would admit to it but I think they were both workaholics. My dad was treated for depression but I would only know this because I would pick it up here and there; no one really talked about it.
In addition to mental health difficulties with parents, Samantha and Kathleen reported that a sibling’s mental health had a significant impact on the family. Samantha’s sister’s emotional difficulties placed a strain on the family.

She had her emotional challenges, so we had a very close and also rocky relationship. She has mental health issues. . . . [she] my 2-year-older sister moved out, moved in with my dad and that caused to make our household much more calm and pleasant. . . . She lived in the basement until they, I mean essentially they [my father and stepmother] really kicked her out, but what they did was sort of set her up in an apartment, paid the first month’s rent or something.

Similarly, Kathleen’s sister’s mental health and physical difficulties had a considerable impact on the overall family environment.

My sister has a lot of physical and mental health issues. She was diagnosed with Type I diabetes when she was four and though a lot of the diabetes runs in that side of the family, so a lot of things around food and she actually has an eating disorder, a lot of focus in the family around food. There is definitely depression on my dad’s side and unfortunately it has been passed to my sister anxiety, panic disorder. My dad tends to shut down when he is upset and my sister tends to get very angry, been suicidal and she has spent time in and out of psych wards and things like that. . . . that’s my little sister, she sort of got worse, the older she got. So when she was younger, things were focused around medical issues, and the mental health stuff didn’t really come out until maybe until she was 12 or 13. . . . She is living on her own for the first time, which is a good thing, and working part-time, which is really difficult for her but she is doing it, she is pushing herself to finish off her degree.
Shanna also described mental health issues in her family, including anxiety and obsessive compulsive disorder (OCD).

My sister has panic attacks, but I don’t really have panic attacks, I have more like the anxious feelings and the worrying. I’m a worry wart. I think my dad, I mean me and my sister, even my doctor thinks he’s got OCD because he is very picky too and he’s got a little bit of germs, a little bit about everything being perfect. . . . Even though he wouldn’t admit it, Mr. Perfect, got to know everything. He wouldn’t admit to it but I think he’s definitely he’s got a little bit of OCD.

In describing mental health issues in her family, Marion talked about her father and his past struggles with depression.

I think my dad suffered from depression but he doesn’t talk about it very much. I think this was something that he experienced from the mid- to late 90s.

Penny also reported mental health issues in her family, however, it is important to note that this was not based on formal diagnoses, but rather on her perceptions of issues that she believes impacted her home environment.

I’m pretty sure that everyone in my family has ADD because from what I’ve researched, in other words, they display many of the behaviors that are common in people with ADD, in terms of attention spans, interrupting, multitasking, etc. It’s never good to make an amateur diagnosis but it’s pretty clear that my brother should be on Ritalin and my sister has attention problems. I think my mom has issues with depression but it’s not diagnosed. And I wouldn’t know enough that I would confidently make that amateur diagnosis.
**Traumatic stress.**

Traumatic stress is another factor in the category family-related issues. For the purposes of this study, I use the term “traumatic stress” in a broader sense to describe the consequences of traumatic events as defined by the participants whether or not they meet the strict definition of trauma. “Psychiatrically, “trauma” refers to an experience that is emotionally agonizing, traumatic, or shocking, which often results in lasting mental and physical effects” (Lamprecht, 2007). Sexual abuse, physical and emotional violence, and bullying were reported by seven of the women. Though the nature of the events varied among the women, the responses were similar. In each case, the traumatic events had a considerable impact on the lives of the participants.

The experiences of Trichster in Toronto illustrate the impact that trauma, in particular, sexual abuse can have on one’s life. The emotional and psychological impact of her sexual abuse cannot be overstated. The sexual abuse itself and the consequences of not being able to disclose it have greatly impacted her ability to cope. She described her experience as follows:

My first [suicide] attempt was when I was 25, then I went to Whitby and I stayed there for 6 months in their psychiatric, psychotherapy unit. And then my second attempt was on my 27th. There is a portion of my life that I don’t really remember but somewhere around there. I think that I just have been depressed since I was 12 and I think I had been sexually abused by a babysitter for 3 years when I was between ages 5 and 8, so I never told my parents and I think part of it is just because when I started pulling my hair out, I said there was something wrong and my father said, “It’s nothing, don’t worry about it.” When I said, “I think I have an eating disorder, I think there is something wrong,” my parents felt like it’s nothing, don’t worry about it. So as a child, I don’t think you feel comfortable. So when I was 18, I came out to
a therapist [about the sexual abuse] and I didn’t want to tell my parents. I asked the therapist to tell my parents and we walked out of the office and we never talked about it again.

Another source of traumatic stress described by participants is physical violence, which is defined as beatings, physical threats, and severe physical punishment. Rachel experienced physical violence at the hands of both her mother and father. She described her experience as follows:

There were a few [episodes] of physical abuse. My mom and dad would beat me. There is only three episodes that I can think of. The one that I can remember with my dad, he got upset with how long I was taking in the bath. I was 6 or 7 I think, and he put his hand on my face and then held me under water until I almost blacked out. And then afterwards, he said, “You deserved that, so don’t bother crying,” sort of thing. . . . There were two episodes with my mom. One she, I am not sure what I did, but she got really upset with me and she grabbed a wire hanger, she beat me with it across the back and then another one was, she just took her fists and just started hitting me. I might have been a bit older by that point. . . . my mom, it seemed she was pretty careful to hit me in spots that nothing would show up. So it was all in my back, I was completely bundled up at the time so no one would’ve seen the bruises anyway.

In Natalie’s case there was physical violence between her and her brother. She provided this description.

My relationship with my brother. . . . as a teenager, him and I developed a really good friendship and relationship between the two of us. My early teen and childhood, we got along for the most part but when we fought, we really fought, aggressively. He put my head through a wall. I threatened to stab him with a knife, I probably would never do it but it was really violent.
Witnessing an incident of physical violence is another source of traumatic stress. Penny described an incident of physical violence that occurred between her parents but she was quick to point out that physical violence was not the norm in her family. However, her description also alludes to the physical disciplining of her brother (and perhaps herself as well). Penny offered this experience:

There has been violent encounters but definitely violence is not the norm. It was more when we were younger and I think my parents had a learning curve around that. When we were younger, there were spankings but not a lot and I think they learned quickly that was not how to raise kids. My brother was the one who saw the worst of it because he was older and they learned by the time they got to me. It was so long ago that I cannot even picture a specific example, I just know it happened. I know at one point when I was in Grade 7 . . . there was a violent encounter between my parents, where my dad hit my mom because they had a big fight, it’s not excusable but totally isolated incidents and ones that I think they learned from but definitely lucky that violence was not the norm.

Rachel and Natalie provided examples of emotional violence. For Rachel, the constant criticism directed at her by her parents was just as damaging as the physical violence she experienced. Though her mother recently ascribed it to the child-rearing techniques prominent at that time, the impact of this emotional violence is profound.

I would say emotional abuse and I guess it falls into the category of them being so critical of me. I was always subject to remarks about my grades, or my personality or how I looked or how much I ate. It was just constant nit picking. . . . I talked to my mom about that and her answer was that child-rearing techniques had changed. I find that kind of ridiculous. I talked to my mother about that. Between when I was born and when my brother was born there’s 5 years between us and . . . I don’t really know why I was always
treated like a little adult they had to keep in line and he was allowed to be the playful kid.

Natalie, like Rachel, experienced emotional violence. For Natalie, the constant accusations directed at her by her mother, specifically, about the marriage breakdown, contributed to the negative self-image. Natalie offers this description:

Definitely emotional with my mother. She always tried to pin the fact that my father was a lousy father and a lousy husband on me, like it was my fault. So definitely, there was a lot of emotional abuse through my teens.

In Samantha’s case, emotional violence was experienced by the family as a whole. Her sister’s mental health difficulties created a stressful environment of emotional chaos.

There was no physical violence, as for emotional, I sort of hinted that my sister is not completely stable. Again she hasn’t been diagnosed and I’m not a mental health professional but she does show a fair amount of signs of a personality disorder so there was quite a bit of “I love you,” “I hate you.” A lot of mixed messages.

Bullying is another source of traumatic stress. In recent years, bullying and the consequences of being a victim of bullying have made headlines. Once considered insignificant, it is now appreciated that bullying can have a profound impact on the lives of victims. Marion’s experience, for example, highlights the consequences of bullying, in particular the stress. Marion was quick to point out that for her experience of bullying did not include physical violence and she downplayed its effects on her well-being.

Actually there was one year, my year in Grade 7, I think that was the year that we came back from Sri Lanka, I think I was pretty much completely isolated that year but every other year things had been much better [nervous laughter]
the year that we came back from Sri Lanka there were a few incidents where people would say, “I really hate you” or something like that, that I felt were kind of unprovoked. Acts of aggression that I would characterize as bullying, but my response tended to be to ignore them or cry. Like it never escalated to where I felt like I was being singled out and persecuted to the point where I couldn’t bear it. I think they were acts of bullying, whether or not I was a really great bullying target, I don’t think that ever got there.

Shanna was also bullied. Although she did not see bullying as a form of violence, the description that she offered clearly highlights the emotional distress that she endured as a result of it. Avoidance and keeping to herself were utilized by Shanna in response to the stress. Shanna’s source of traumatic stress was school. She described her experience as follows:

I’ve been kind of emotionally scarred not just bullying but just the whole aspect of school. I mean I would have nightmares about school and I still do, so in terms of that, that wasn’t the best part of my childhood. Going to school, getting lost in school, forgetting my timetable, forgetting homework, and it would really feel real and I would wake up and go, “Thank god, it was only a dream,” and then I remember on Sunday nights, Sunday nights were always the worst; I would feel really bad because I knew I would have to get up early the next morning. . . . I don’t remember telling anyone, no teachers, my parents, no siblings. I pretty much kept it to myself. I was called names, you know how kids are, and they can be cruel. I would definitely hide, try to avoid them, not be in the courtyard until the bell rang at 9 o’clock, then I would scurry into class and keep to myself.
Women's Responses to the Family Experiences

The category Women’s Responses to the Family Experiences describes the women’s internal responses to the family-related issues that occurred in their childhood environment. Their descriptions fall into two categories: silencing the emotional self and perceptions of self.

Silencing the emotional self.

“Silencing the emotional self” refers to the difficulties that the women had in voicing their needs and concerns in their family. Five women described experiences under this heading. The women used statements such as, “learned to keep my feelings in,” and, “had to take care of my own needs,” to describe their responses. For some of the women, silencing the emotional self was learned at home. The expression of emotions was viewed negatively in their homes and over time the women learned to suppress their emotions. In other words, silencing the emotional self was one response to potentially destructive situations. For Trichster in Toronto, as noted earlier, the learned inability to express emotions had devastating and painful consequences.

Rachel, for example, grew up in a family where expressing emotions was viewed negatively.

I pretty much pinpoint that night as when I stopped sort of expressing emotions out loud. . . . I just became aware that being vocal or expressing any sort of emotion, or anger, was not acceptable.

Natalie, likewise, grew up in an environment where expressing her emotional needs went against the norms of the family. For Natalie, the resulting inability to express her emotions caused her to insulate herself.
If I look back, I usually tried to ignore them [my family], avoid everyone. I would ride a lot as a kid or go out with my friends. When I was working, I really tried to remove myself from things.

Natalie described how her inability to express her emotional needs provides the impetus for her hair pulling. Considering the impact that expressing her needs may have on others, Natalie chooses instead to act out towards herself.

I know that when I pull it’s usually when I am on the phone with my mother or there are a couple of friends that I’ve, I don’t know if they stress me out but I know they are kind of more draining on me than other people. Or there are things that they do that bother me, and I just don’t bother to tell them and that causes me to pull.

In addition to causing emotional distress and leading to hair pulling, silencing the emotional self can also have devastating long-term effects. For Trichster in Toronto, her fear of revealing her sexual abuse to others resulted in her being unable to fully deal with the effects of the abuse. Her experience highlights the devastating effects that silencing the emotional self can have on a life.

I didn’t really have much of adolescence; I didn’t really have a childhood. I just think it’s too much, from the ages of 5 to 18, I hadn’t told anybody that I had been molested. I think I had a nervous breakdown around 20 and I was in university and just really unhealthy. It got worse and worse and I struggled through university and I finished school and I didn’t know what I was going to do with my life and I had broken up with my boyfriend, which was not a precipitating factor, but I just felt lost, and aimless and hopeless and there was just too much. It took me a really long time to get out of it, that terrible darkness.
Silencing the emotional self was also evident in women from families in which the focus was on another sibling or when the mother was perceived to be emotionally absent by the participant. Kathleen and Samantha described experiences of these kinds. For both of these women, their situation reinforced the idea that the needs of others must be put ahead of their own. Take the experience of Kathleen. Kathleen’s family’s focus was on supporting her sister and meeting her needs.

She [Kathleen’s sister] was definitely the main focus of the family. So there has been a little bit of family therapy, but it’s mostly been around her and her issues and supporting her and doing that kind of thing.

Samantha, likewise, described how the inability to express herself in her family impacted her home environment. For Samantha, there was no emotional support. The focus on her seemed to be generally negative. Samantha described her mother as focusing on getting her to eventually give in to her demands. In Samantha’s description of her experience, there is a sense of giving up on her own needs or on having those needs met. Samantha’s remarks illustrate this aspect of silencing the emotional self:

I mean she was there but she was largely absent. It is like that idea someone is there to support you for the things you don’t want support for, so she would nag me quite a lot about certain things but then in other areas be completely absent. She would decide that I needed a job and she would bother me about that, literally every day or twice a day or three times a day, bugging me, tearing away at your will until you break and did end up breaking. There’s so much a human can take. I don’t feel I was really emotionally supported or you know encouraged to follow through in things that I was interested in.
**Perceptions of self.**

A second factor highlighted in the responses to the family experiences is Perceptions of self, i.e., how the women see themselves. The women utilized a number of different self-descriptors. For example, terms such as “shy,” “introverted,” “perfectionist,” “irritable,” and “rigid” were used by the women to describe themselves. Generally, how the women perceive themselves reflects their overall sense of self, which impacts various aspects of their lives. The women also spoke about their perceptions of themselves and how this related to their roles in their families. As evidenced by the descriptions presented below, the women vary with respect to how they see themselves suggesting perhaps that it is unlikely that there is a single perception of self associated with trichotillomania.

Take the example of Shanna. She considers herself to be shy. Her shyness was particularly evident at school. She had a difficult time in school and the emotional consequences of that experience still affect her. Shanna described her experience as follows:

In school I was always shy. You know I did my work but I wouldn’t volunteer, even if I knew the answer, I wouldn’t put up my hand. I would cower at the back. . . . I’ve been emotionally scarred, not just bullying but just the whole aspect of school. I mean I would have nightmares about school and I still do.

Trichster in Toronto, likewise, related her experience of being shy and the impact that it had on her at school. She also described how for her the shyness and later, her perfectionism or the need to live up to high standards she set for herself, resulted in considerable stress and emotional difficulties. Trichster in Toronto explained her perceptions of self by relating the following:
I left a small public school to go into Grade 7, and I think it was just all the changes, the friendships and people started being more interested in boys and I was extremely shy and that was really hard for me. It was just really hard for me. I think also the stress of school. I became a perfectionist. . . I remember being a 12-year-old and I would stay up until 3:00 in the morning doing my homework and I was very obsessive. Everything had to be perfect. If something wasn’t right, I would start all over again. So I think that school has always been a huge stressor and that probably the change and the social expectations and then academics, it was just very stressful. I was a very shy child and very sheltered. I went to public school but it was a very small class. I just had a group of friends, we were in Grade 6 and we thought boys were gross and then we went into Grade 7 and we merged with other schools, and girls were a lot more mature and then it was co-ed. I was just not comfortable with that at all.

Samantha also considers herself a loner and introverted. She explained that initially, she tried to fit in at school, but eventually realized that this was not her goal.

I was a bit of a loner when I was younger, I didn’t have a lot of friends. I guess that started to change when I was in Grade 4 or 5, before I started to make more meaningful relationships. My high school, I went to a school where a large percent of the people that I went to, whatever you call it, Grade 7 or 8 with, went to my high school, so I went there with a large friend base. But it was a socially stratified school; there was a lot of cliquiness. There is the usual strains associated with that and then probably about the middle of high school, I sort of changed friend groups. I did smoke a lot of pot in high school but I saw it as a way of coping with high school and teenage restlessness than having to do with hairpulling. I guess I hit a point where I didn’t feel like, you know you spend so much or at least I spent so much time trying to fit in before I realized that I didn’t want to fit in. When
you’re younger, fitting in is the key, and then as you get older, being an individual reigns.

However, not all of the women perceived themselves as shy, introverted, or perfectionist. Indeed, Rachel’s experience was quite different. Rachel described herself as rigid or inflexible, particularly when it comes to discussing issues of emotional importance. She also highlighted the need to maintain a specific image to those around her. This is important so as to avoid the criticism that she believes would be directed towards her if she revealed her emotional issues. Rachel offered this description of herself:

I would sort of characterize myself as being somewhat rigid and I find it really hard to talk about the nitty gritty emotional stuff. And I guess the other thing is being aware that you should be doing all that you can not to rock the boat by being angry or sad or knowing that not being chipper is going to piss off some people. You know, just put on a happy face.

Penny and Kathleen described how their perceptions of self influenced the role that they played in their immediate family. Penny, for example, indicated that her irritability influences how she interacts with her parents. Describing herself, Penny stated the following:

I can be quite irritable. I would describe myself as an irritable person, especially around my family.

Later, she described how this way of being impacts her role in the family. She described herself as the instigator in the family.

I’m the instigator and still am. I think it’s just rooted in irritability. I find that I just have a feeling of annoyance when I’m with my parents. The things that they say. A lot of times, if it was coming from anybody else, it wouldn’t phase me, but coming from them, it just bothers me. It’s not rational.
In contrast, Kathleen considers herself to be the peacekeeper in her family. She loosely equates her role to that of parenting. Perceiving that one of her parents, her father, is unable to stand up to her mother, Kathleen takes it upon herself to intercede on his behalf, particularly in discussions with her mother. Kathleen provided the following example.

I’ve always been sort of the one to step outside and take the sort of objective viewpoint. My mother’s very logical and my father’s an easy target for her, I found myself stepping into the middle of that and saying, “You need to stop that, you can’t attack my father that way, show him some respect. You know, take a break; you’re attacking him for no reason.” Playing that sort of parenting role because my dad is not that aggressive with my mother, stepping in the middle and saying, “You both got good points.” Try to look at this from her point of view and you try to look at this from his point of view, and being the peacekeeper a lot of the time.

**Theme 3:**

*Relationship Between Specific Experiences and the Discovery of Hair Pulling*

The third major theme explores the relationship that might exist between the experiences described by the women and the discovery of hair pulling. Though the primary purpose of the interviews was to elicit the childhood experiences of women with trichotillomania, each of the women was asked to provide their perception of the possible relationship between their childhood experiences and the discovery of trichotillomania. The women’s stories indicate that there is a discernible connection between childhood experiences and their hair pulling. As the women discussed this connection, two kinds of experiences emerged: stress and a shift.
Stress

In discussing the relationship between their childhood experiences and the discovery of pulling, six of the women highlighted stress. In particular, these women experienced hair pulling as a response to the stress that they experienced in their environment, in relationships, or in general. For Natalie, Claire, Rachel, Shanna, Trichster in Toronto, and Kathleen, stress was a significant contributor to hair pulling. The excerpts presented below also highlight the struggles that the women have in understanding the relationship between their experiences and their hair pulling.

In looking for the connection, Natalie focuses on her family environment. In remarks quoted earlier, Natalie describes the stress that she endured from living in an unhealthy environment. Looking at the possible connection between her family environment and her hair pulling, she remarked:

I look at the environment that I grew up in and it was completely not a good environment for any child. So it’s hard for me to separate that and see the relationship between that and hair pulling. But talking about it, I mean I guess it’s possible.

Several of the other women also acknowledged a connection between experiences they related and the discovery of pulling. Claire speculates about the connection in the following:

I’ve often wondered over the years, that it must have been a comfort thing. I don’t know, maybe it was a self-infliction. Maybe it was that or I’m sure that there is many other ways that people would explain it, but I would definitely see it as a connection. Because I mean I never looked at my eyebrows before
that [the onset of Tourette’s symptoms], that’s something that needed to be dealt with.

Rachel also focused on the stress that she experienced in her childhood, in particular, the emotional breakdown for having received a bad mark on a test: “I absolutely do” [think that there is a connection]. In a separate note to me, Rachel clarified her response and stated that she:

was referring to the night that her father said that she would develop a bleeding ulcer, if she didn’t stop crying not the physical abuse. In retrospect, I think that the physical abuse kick started my ever escalating levels of anxiety but the actual pulling started after the ulcer lecture. One to two years separated the abuse and the lecture. I think just the timing is pretty close. I mean I was going through that breakdown and I can recall pictures taken about a month later, after that, where my eyebrows are gone.

Shanna also stated that for her there is a connection between stress and pulling. Shanna explained that though she experienced considerable stress in school, at the time she was unable to see the connection. However, looking back, Shanna sees a clear connection between increased stress, particularly in school, and pulling.

It’s hard to say, I mean they go hand in hand. I know now, definitely when I get more stressed, the first thing that I’ll do is start pulling my eyes. Back then, looking back, I would have to say probably yes, but at the time, I didn’t say, “Oh, this is why, I’m pulling my hair, because there is stress in the family or you know, someone was yelling at me.” I didn’t put two and two together and go “Ah, hah.” I guess probably because first of all I didn’t know what it was, why I was doing it. But even then, there was less information about it so I didn’t put two and two together and go “Oh, I’m pulling because there is
more stress in the family,” but looking back definitely, especially with school, I would probably pull more.

Trichster in Toronto also talks about this connection, but for her the pulling had more to do with her inability to express her emotions. As earlier excerpts from the interview indicate, there were many stressful incidents in her life. The eating disorder, sexual abuse, and hair pulling all contributed to her stress. Coupled with this was her difficulty in talking about her emotions with others, in particular, family members. Pulling helped her release these emotions.

Yeah, I think because I had to keep all of my feelings inside and I didn’t have an emotional outlet and in some way, hair pulling became a way to get my out all of my pent up emotions.

The connection between childhood experiences and pulling was also echoed by Kathleen. Kathleen, like Shanna, realizes, looking back, that a connection between the two is possible. Kathleen indicated that there were unidentified feelings that resulted from her early experiences that certainly help to explain the pulling. Reflecting on her experiences, described in earlier excerpts, of stress, losing friendships and the situation at home, Kathleen remarked on the possible connection.

I didn’t really think [there was a connection] at the time, but probably. I recently joined that horrible thing called Facebook a while back and they [people from school] all came out of the woodwork, suddenly very interested in me and what I’m doing with my life. That whole bit of anger; I don’t really want to deal with you. So I think I was probably a little bit more hurt than I admitted to myself at the time. There was probably upset but I wouldn’t have, with everything going on at home, I probably wouldn’t have dealt with it. It
probably would have seemed unimportant to me in regards to everything else that was going on.

In each of the above excerpts, the women identify a relationship between their experiences and pulling that involves stress. Natalie and Claire both spoke about the increased feelings of stress associated with a difficult childhood. For Rachel and Shanna, stress was attributed to difficulties at school. Trichster in Toronto also spoke about stress as a result of her inability to express her emotions to others, and how that was connected to her pulling. For Kathleen, difficulties at home and school were sources of stress. Though the sources of stress that each of the women described differed to some extent, the stories make clear that for them, the stress that resulted from their childhood environments contributed to the discovery of pulling.

_A Shift_

In contrast to the above, two of the women described a shift, not stress that was relevant to their perception of the relationship between their experiences and the discovery of hair pulling. For example, Marion describes how an infestation of lice caused her to become more aware and involved with her hair. She described this experience as follows:

No, I think that something else would have set in. I was quite young, so it could have been a month or it could have been 6 months, maybe within a year and a half, between 9 to 10 1/2 . . . I got lice, as most people do in Sri Lanka. And there, you can’t just use the shampoo, they really infest you because they’re Sri Lankan lice, it’s gross. And what you do, my nanny explained this, you use the shampoo that kills the bugs but then you have to actually manually take all the nits out of your hair, you have to sit there with a comb or with your fingers. There are actually people who are hired, called nits nanny
to do that. I had to sit there with my nanny for two hours at a time and pull them all out. It really took a long time. It was gross. And then I would still see them in my hair and pull them out and I sort of have this funny feeling that the mechanical action of touching the strand and pulling something off, might have gotten me going in that direction. . . . I’ve always thought there might be a little bit of a connection, but I don’t know whether I would have still pulled anyway.

Marion’s account clearly demonstrates that for her at least, having had lice and thus been engaged in the mechanical actions of pulling the nits off the hair helps to explain her pulling. Interestingly, though Marion stated that she feels there is a connection, she also expressed uncertainty about whether this fully explains her hair pulling. Her experience further serves to highlight the complexity involved in trying to define the exact relationship between experience and the discovery of hair pulling.

Cindy’s description offers another kind of shift. For her, modeling initiated the pattern of pulling by shifting to a focus on the face. Cindy’s pulling sites include her eyelashes and eyebrows. This focus on the face was eventually transferred to pulling her eyelashes and eyebrows. In this excerpt, she describes how this shift developed.

Growing up I would see my mom kind of touching her chin and my dad kept telling her, “Don’t pick that on your chin.” I don’t know maybe it was a pimple or something. She might get one or two pimples here and there as an adult and she would pick it really hard. My brother and I would always pop our pimples in the bathroom so I don’t know if that kind of started us, looking and touching our faces. And he and I both started biting our nails, I don’t know if it’s correlated or if we’re all different.
Penny, on the other hand, stated that her difficulty in remaining focused, as a result of her attention deficit disorder, is somewhat alleviated by her pulling. Penny described her experience as follows:

I was diagnosed with ADD and I’m relatively sure that it’s connected but I don’t have enough education to make a confident assessment. But I have attention deficit problems and you need stimulus, that’s why people take Ritalin. I think that’s why I pull, at least part of why I pull my hair when I read. I have a lot of attention problems when I try to read and I think that when I pull my hair or play with my hair, it really keeps me focused.

Samantha also did not see a connection between her childhood experiences and the onset of pulling. She alludes to this uncertainty in this excerpt:

I kind of feel that it’s just a mix of nature or nurture and circumstances. I don’t think that I would have developed something else or I hope not anyway, I would have just found a different, possibly more healthy coping tool.

The role of a shift is highlighted by Marion’s and Cindy’s descriptions in response to being asked about their views about whether there is a relationship between their childhood experiences and the discovery of pulling. For Marion, a lice infestation caused a shift to her hair, made her more focused on her hair and contributed to her pulling. Cindy also spoke about a shift, about becoming more focused on her face as a result of modeling. This contributed to the sequelae of her pulling. Given her pulling sites (i.e., eyelashes and eyebrows) there seems to have been a shift from her face to the hair on her face. In contrast, Penny offers a different perspective by describing the improved focus that she experiences as a consequence of pulling. Samantha was uncertain about whether there is a connection between her childhood experiences and the discovery of her trichotillomania.
Theme 4:  
The Role of Hair Pulling

The fourth major theme that emerged from the interviews is the role that hair pulling plays in the lives of the participants. As I reviewed the codes and the excerpts under this heading, it became apparent that an important core concept for each of the women was the out of control nature of the pulling and the process of regaining control. The women’s remarks in this area can be categorized under the following headings: A Means of Coping, Catch-22, Out of My Control, and An Avenue for Gaining Control. In reading the stories presented by each of the women, a commonality that emerges is that hair pulling developed as a way of coping with life stressors, an attempt by the women to regain control of what they perceive to be out-of-control aspects of their lives.

A Means of Coping

Coping is defined as, “constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman, 1984, p. 141, as cited in Macy, 2006, p. 179). According to Aneshensel (1992), “functions of coping include avoiding or eliminating the stressor, containing the proliferation of secondary stressors, altering the meaning of the situation, and managing states of arousal (Pearlin & Schooler, 1978, Pearlin & Aneshensel, 1986)” (p. 18). Some methods of coping, can, over time, themselves become a source of stress. This is evident in the experiences of the women.

Each of the women identified hair pulling as a means of coping with stress or an attempt to regain control of their situation. The women’s stories provide examples of coping
with various life stressors ranging from environmental stressors (e.g., critical home environment, school) to medical conditions (e.g., Tourette’s syndrome, ADD), and so on. Phrases such as “an escape,” “relieves stress,” “comfort strategy,” and “control” were utilized by the women when describing how hair pulling acts as a means of coping with what they perceive as stressful life events.

In describing her experience, Natalie focused on the escapist aspect of the hair pulling and the satisfaction she felt when she engaged in this behavior.

But as a kid, I remember I would go to my room just to do it, like I think it was probably an escape and there was some sort of satisfaction when once I found that one hair, which I never knew I was looking for to begin with. But there was some satisfaction due to it and then I would never say that I felt a relief of anything but I always felt satisfied.

Rachel’s remarks highlight the critical environment that she grew up in and her attempts to maintain her sense of control. For Rachel, it seems that there was a constant cycle of striving to achieve some normalcy in an otherwise unhealthy environment.

Back then, I guess it was a way for me to just calm myself from my nerves and my anxiety. It was an outlet. I found that I pull in one or two instances when I’m feeling really anxious, when I have a lot of self-doubt or at other times when I’m extremely bored. . . . It was a cycle of being criticized, then pulling to calm myself, then being criticized again. It was a stressful environment so I guess it was just my coping mechanism.

Marion, in describing her experiences, also cited stress relief as an explanation for pulling and the emotional effect that pulling had on her.
I think I remember thinking that it made me feel a sense of stress relief. I remember doing it and looking for a sense of stress relief and then finding it. But then again maybe because I think for me it’s strongly linked with stress relief, I might be remembering it that way.

When she was asked if she meant that hair pulling was a means of coping with life’s difficulties, she replied: “I think subconsciously, that’s what it was, I found it calming or soothing.”

It appears that Shanna likewise viewed her pulling as a means of dealing with life. In the following Shanna reports that her pulling helped with her anxiety.

Looking back, it just made me feel better. It sort of calmed me down or got rid of the stress. Overall, it just made me feel at least a little bit better not about myself but in terms of my anxiety.

The stories of Natalie, Rachel, Marion, and Shanna provide examples of using hair pulling to deal with environmental stressors. Earlier, Natalie described growing up in a dysfunctional family environment. Her father was an alcoholic and her mother struggled with mental illness. She further asserted that she grew in an abusive environment, both physical and verbal, though she was never a witness to the physical violence between her parents. This environment hindered her attempts to develop healthy coping skills. Natalie’s hair pulling was a way of distancing herself from the reality of the situation, a sort of “escapism.”

Rachel, likewise, grew up in an unhealthy environment. For her, there was a constant cycle of criticism. Rachel, quoted earlier, asserts that nothing she ever did was good enough for her parents. Her hair pulling was a means of dealing with the criticism and an outlet for the resulting emotions. Marion’s description of hair pulling as a means of coping is also
connected to an environmental stressor, but in her case the stressor is the culture shock she experienced when she and her family moved to a new country. Shanna, experienced damage to her sense of self as a result of the bullying she was subjected to in school. Her environmental stressor differs from those previously mentioned, however, her story is similar to the others in that hair pulling was used as a means of coping with a stressor.

For Claire, hair pulling was also a method of coping with the stress. In contrast to the above stories though, Claire’s source of stress was more specific. The hair pulling was a response to having Tourette’s and the continued stress that she experienced. Hair pulling was a means of alleviating the resulting anxiety of having to live with the complications of Tourette’s (e.g., the tics).

Even before I was diagnosed with my Tourette’s, I self-diagnosed myself with trichotillomania, I figured it was, the doctor figured it was, even though they didn’t say it, what my hair-pulling thing was, they said it was probably a comfort thing for dealing with my Tourette’s.

In addressing this issue, hair pulling as a means of coping, two of the women, Cindy and Penny, spoke directly to the issue of control. Cindy explained:

> It could have been a control thing; I wanted a lot of control in my life that I felt I had no control over because I was always wanting more from what I had. I was 14, I wanted to be driving at 14 not 16. I didn’t appreciate what I had.

For Penny, hair pulling is a means of gaining control, however, she also highlighted the lack of control it represents. For Penny the role of hair pulling is to keep her focused. Penny indicates that hair pulling is a response to her attention deficit disorder. She further adds that pulling helps keep her focused.
I think hair pulling serves a purpose and that is why people do it. I think that people use it to control things, they find it helpful. And I definitely do. It would be nice to find a way to channel it, to figure out exactly what it is that I’m trying to control and to find different ways to do it. . . . One way that I haven’t mentioned, aside from the ones that we’ve already talked about is that I was diagnosed with ADD and I’m relatively sure that it’s connected, but I don’t have enough education to make a confident assessment. I have attention deficit problem and you need a stimulus. I think that’s why I pull, part of why I pull my hair when I read. I have a lot of attention problems when I try to read and I think that when I pull my hair or play with my hair it helps me focus.

Like the previous women’s experiences, the stories of Claire, Penny, and Cindy also highlight the purpose that hair pulling played in their lives. For example, for Claire, hair pulling was a means of coping with an undiagnosed medical condition. The complications of Tourette’s, and not having a clear and defined diagnosis, understandably caused her significant distress. According to her, this was alleviated by her hair pulling. Cindy’s story demonstrates that for her, hair pulling was a means of exerting control in her life. However, hair pulling failed to meet her needs for control and eventually became a complicating factor in her life. For Penny, the pulling was a means of coping with ADD, a way for her to remain focused. However, she elaborated on the control issue by stating that hair pulling is in response to feeling out of control, i.e., is her attempt to assert control.

The remaining women, Trichster in Toronto, Kathleen, and Samantha provide interesting perspectives on the theme A Means of Coping. Trichster in Toronto speaks about hair pulling as an emotional outlet. For Kathleen, hair pulling is an avoidance strategy. For Samantha, the fact that she’s pulling is a signal to her that she’s undergoing stress. Taken
together, the experiences of these three women serve to highlight hair pulling as a means of coping, albeit in a broader sense.

Take the story of Trichster in Toronto. The excerpt given below demonstrates that for her, hair pulling is a way to express emotion. Growing up, she learned to suppress her emotions because of her perception that their expression was forbidden. Whether this was conveyed to her intentionally or not is unknown. Trichster in Toronto also speaks about her history of abuse and the silencing that she experienced as a result of it. Hair pulling served as a way of expressing her emotions that seemed more acceptable.

Because I had to keep all my feelings inside and I didn’t have an emotional outlet, in some way hair pulling became a way for me to get out all my pent up emotions. Whether it was anxiety or frustration, or just anger or sadness, it all came out in pulling. Keeping the abuse in for all those years from the time I was 12 and I think that brain chemistry or whatever, but I also think that because there were so many things that I wasn’t allowed to talk about in my house. I wasn’t really allowed to talk about the fact that I had an eating disorder and there were things that just weren’t tolerated, in terms of respecting yourself. And I think that’s directly related. I don’t know, if I hadn’t been abused would I have trichotillomania?

It appears that for Kathleen, hair pulling is an avoidance strategy, a means of coping with whatever is going on in her life. Like Trichster in Toronto, there is a productive aspect to the pulling. For Kathleen, hair pulling is a means of focusing to the task at hand.

I actually feel that when I’m doing it, I’m getting something done. I’m actually being productive. . . . It’s definitely an avoidance and I don’t know if it is a way to deal with stress because it causes me so much stress. My mom will call it self-stimulation. So while I’m working I’ll sit there and run piece, after piece, through my hair and it sort of, weirdly enough keeps me focused if
I’m not looking at it. But it is something I do that keeps me going while I’m working and I don’t know what it’s about, I actually feel like I’m organizing my hair and probably avoiding what is going on.

For Samantha, the role of hair pulling is dichotomous. On the one hand, Samantha views it as a means of coping with stress. At the same time, she also indicated that she pulls at times when she is not stressed. The excerpt talks about using hair pulling to maintain focus. This is similar to Penny’s and Kathleen’s experiences, however, Samantha elaborated on the experience to a greater extent.

Mostly for me, it’s almost like a marker, and indicator. Sometimes I’ll do it when I’m not feeling stressed or when I don’t think I’m feeling stressed at all but it’s almost like a distracter. It’s like I have a lot of stuff going on in my brain and I need some other outlet, to filter the noise. . . . There’s a lot of stuff going on in the brain and sometimes in order to focus on one thing I have to shift my fidgetiness or my nervous energy or whatever onto something else and that’s what ends up happening. . . . That’s sometimes what it feels like at least during those peaceful times. But I do find that just in general when my life is more stressful or there is more things going on that are upsetting even than in peaceful times, I will play with my hair more and that’s probably me trying not to focus on the stressful things because you can’t stress about things all the time. It’s very double-edged, but in a way I think it is a self-soothing thing.

*Catch-22*

The women were asked to address the question of whether or not they find that hair pulling helps them cope with the various stressors and challenges in their lives. Though all the women spoke of utilizing hair pulling as a means of coping, they also spoke about the negative impact that it has in their lives, both currently and in the past. In other words, using
hair pulling to relieve stress creates a catch-22 situation. The women indicated that, overall, hair pulling serves a purpose for them, however, at the same time, they spoke about its dichotomous nature. In other words, while initially it seemed to be a constructive way of coping, eventually, it came to be seen as unhealthy, even destructive.

The stories of these women demonstrate the evolution of their view of the role of hair pulling. Take the story of Cindy. She acknowledged that hair pulling is a means of addressing life stressors; however, she also spoke about the catch-22, asserting that there is a negative aspect to pulling. Cindy reported that overall it is not very helpful for coping with stress. She also described the current role of hair pulling in her life.

Anyway the role it served, it may have served some stress relief or comfort, but I am really at a loss for saying for sure. I’m not really sure because it was self-destructive. It wasn’t really comforting. I think it complicated my life growing up. It didn’t have a good role. Now it’s very habitual. It’s like a normal part of my life so, in a sense, if I stop, I would be a totally different person, which is okay, it’s just getting past that idea and just getting to start thinking I can be normal. I’m not sure, I’m just guessing. Currently, the role is, it’s just part of my life that has always been there, pretty much most all of my life. And now it’s just habitual. It’s not something that I necessarily do at the moments that I’m anxious but touching my face is still comforting to me. It’s also comforting to stroke my forehead where my eyebrows are or most of them should be because it’s so habitual it comforts me, it puts me back in my comfort zone, and I’m more secure and more aware.

Interestingly, the description offered by Cindy also alludes to the habitual nature of the pulling. Hair pulling is a part of her life, she doesn’t really know who she would be without it. It helps her to relieve stress, however, at the same time the fact of it causes her some discomfort.
Trichster in Toronto reported that for her, hair pulling is an outlet for unexpressed emotions, however, she also expressed regret that she hadn’t learned a healthier way to accomplish this.

I wished that I had learned at an earlier age in my life how to deal with issues differently and not to pull when I was stressed or upset or challenged. Even as an adult, I am no better now, I try to go to therapy but I still pull. I think it’s because . . . it’s like a build-up and I feel like I have to pull, I have to pull now.

Trichster in Toronto’s remarks highlight the catch-22 theme: for her, hair pulling helped to deal with challenging issues, however, she is also very much aware of its unhealthy and destructive nature.

Rachel also highlighted the catch-22 dilemma of trichotillomania by stating the following:

I mean it certainly brought more attention on me so that wasn’t good. I guess the pay-off was that I wasn’t crying all the time but I basically just emotionally shut down. They didn’t approve of me pulling my eyebrow but that activity wasn’t quite as “out there” as me crying every night before I had to go to bed and go back to school.

Rachel’s account of the catch-22 situation is quite clear. As a child, her emotional outbursts were not tolerated by her family, her parents in particular, and the pulling helped to prevent these. However, the dilemma it presented was that Rachel learned to shut herself off from her emotions, at least in the family home.
Claire indicated that her pulling helped to soothe her; she further described the manipulation of the pulled hair as a source of excitement for her.

It did soothe me. And it still does. I’m sure that you hear this alot. I’ve heard of people who put it in their mouth and bite off the root. When I pluck [laughter] it’s strange but I guess for people with trich it isn’t. When I pluck an eyebrow or an eyelash that has a big root, I don’t get excited, but I feel this excitement inside of me. It’s the pleasure of seeing the root. I remember years ago, when I first started putting the eyelashes on a shelf. Not that I was going to do anything with it but it was almost as if it was still a part of me. After that, for years and years, I used to put the eyelash in my eye. So it was kind of like keeping it and playing with it during the day. . . . I don’t know why. It’s funny, strange, but it’s like a pleasure thing. I play with them and it’s usually when there’s a big root. I’ve never bitten them, I’ve never swallowed them, never eaten them, never put them in my mouth. I’ve never had an interest in doing that.

Claire’s account of the catch-22 of hair pulling reveals an interesting aspect of this theme.

For her, hair pulling initially had a soothing quality to it, a comfort thing, begun in response to the stress caused by her Tourette’s disorder. While it is still soothing to her, she also revealed her feelings about the manipulation of the hair and the pleasure that it brings her.

The catch-22 for Claire is her need to engage in this activity while she also acknowledges the unhealthy aspect of it (quoted earlier).

Marion’s experience of hair pulling can also be characterized as a catch-22. She acknowledged that she uses it as a coping strategy, but it also contributes to her stress level:

At least I seem to be doing it a lot in stressful times. I seem to go to it. As we discussed, I think you’re right to say that it’s not direct. It’s not like an addict must feel when they inject a drug or something like that. I seem to be doing it, I think hoping that it will do something. I think that it is somewhat helpful.
It’s complicated to think about it. I think it’s something like when you are bored and you have to concentrate on something or when there is something that you are forcing yourself to do, like think about a stressful topic that you don’t want to think about. You are pushing yourself up to the wall to do it and it’s a little way of stepping away from it, without actually stepping away from it so that I still do it. So like if I was trying to work through a stressful problem, I might want to just go off and walk away from it and not do it anymore. I force myself to do it and I think the pulling starts to be a little out for me.

Marion clearly finds hair pulling to be helpful in times of stress, however, she also talks about searching for its benefits. She is not able to make a clear association between pulling and the need she feels it serves.

Likewise, Kathleen also describes the catch-22 aspect of her pulling:

I don’t know about that (if it helps), it makes me feel productive, but I snap out of that pretty quickly. I mean probably not because it is distressing to me. The one side that I do it on all the time, I can feel that all the hair on that side is shorter and finer and it comes out easily. It just that long-term the profession I’m going into, appearances mean too much. And also, I’ve found myself sitting in my office and not being able to control the urges to do it and being terrified that someone was going to walk by. You know catch me in the act. It’s not exactly professional.

For Kathleen, the catch-22 is that pulling seems to help in her work, i.e., it makes her feel productive, and yet she feels the pulling is also a threat to her career goals.

Samantha described how she currently views her hair pulling by stating:

At this point in my life, if I get into a trance or whatever you want to call it, and I pluck, that doesn’t feel like a helpful thing. I think that if I’m just being
restful like watching TV or something and I’m running my fingers through repetitively through that one spot that tends to be soothing for me.

Samantha’s experience highlights the dual role that hair pulling plays for her. Samantha views her pulling as helpful because it is soothing; however, she also described it as unhelpful, particularly if she does it without being aware of it. Samantha’s description demonstrates what catch-22 entails for her.

For Shanna there is a helpful aspect to her pulling, however, pulling also results in a vicious cycle of stress. She described it as follows:

I think it did help. I think it eased my tension, my stress initially and then I would look in the mirror and go, “Oh crap, this isn’t good.” I would just get more stressed out and I would end up pulling more, so it was like a catch-22 sort of thing.

Natalie spoke about the catch-22 aspect of pulling. She described it like this:

I mean when I find myself doing it, it more or less pisses me off for lack of a better word. But as a child it made me feel calmer, more relaxed almost. Then the other thing I struggled with, “Oh geez, now I’m going to have to go downstairs and my mother is going to notice tomorrow that I’ve pulled out more hair.

Like some of the other women in this study, when Natalie was a child, pulling offered her some relief from her otherwise stressful environment. However, pulling also caused considerable distress, particularly because of how others reacted to its visible consequences. Currently, she views her pulling as unhelpful. It makes her angry.
Another subtheme that was common in the participants’ experiences was the issue of control. Nine of the women described hair pulling as out of their control. The issues described highlight the uncontrollability of the pulling behavior and center on the addictive, biological, or compulsive nature of the hair pulling. The theme Out of My Control reflects the idea that individuals may be predisposed to hair pulling and that, “while stress can make hair pulling worse, this is by no means universally true for everyone with hair pulling” (Keuthen et al., 2001, p. 58).

The stories presented by the women suggest that there is an uncontrollable aspect to the pulling. This issue of control seems to shift the focus away from the women and towards the role of biological and genetic factors in their hair pulling. Words and phrases such as “addictive,” “compulsion,” “part of OCD,” “bad habit,” and “gating” were used in discussions of the issue of control. In addition, these provide possible explanations of why the condition persists in spite of the women’s continual struggle to have some control over their pulling.

One woman, Natalie, described the out of control aspect of pulling by stating the following:

And then it went downhill from there, I guess I became addicted, I don’t know what happened. . . . Obviously the impulse has been there from a very young age.

Natalie’s experience highlights the addictive nature of the pulling. She likens her experience of pulling to an addiction and thus, something that she can’t control.
Claire views hair pulling as a compulsion. Claire’s experience was complicated by the diagnoses of obsessive compulsive disorder and Tourette’s disorder.

My doctor indicated that I’ve got the compulsive side of OCD that intertwines with my Tourette’s. . . . I see trichotillomania as a bit of a compulsion. . . . I know that I feel this need to do it. It’s almost like the urge of a compulsion. I know it’s not necessary to do it and I know that I don’t need to do it, but I need to do it. I see it that way, but at the same time, I mean, I know that I have trichotillomania.

Claire, like Natalie, described her pulling as being out of her control. She offers a further perspective by connecting the pulling to her OCD and Tourette’s, two biological conditions.

Rachel, has obsessive compulsive disorder. Although initially she believed that her hair pulling was unrelated, currently she understands her hair pulling as a variant of OCD.

Over the years, I’ve done some research and I always found that it was nowhere near associated with OCD, that it was a bad habit that you had to break. So that situation actually lead to a lot of difficulties with my family, in that they treated trichotillomania as a bad habit, and not symptomatic of a larger problem. So I’m actually quite relieved that it is part of OCD because then I feel that there are treatment options. It’s not just a weird thing that you do, that you literally can’t stop doing, that you are absolutely compelled to do it.

Rachel’s remarks highlight her struggle to find an explanation for her pulling. Initially, she did not view it as biological, and this caused considerable difficulties with her family. So for her, not having an explanation put a lot of pressure on her to control what is essentially uncontrollable. Linking hair pulling to OCD takes the pressure off.
Trichster in Toronto, in remarks quoted earlier, also alludes to this idea, the possibility that brain chemistry plays a role in hair pulling; however, she also acknowledges the influence of other contributing factors such as stress, trauma, and suppressed emotions. In describing her feelings leading up to hair pulling, she noted that there is a “build up” that she is unable to stop.

I don’t know why, some days I don’t need to pull and some days I just have to pull... I pull when I’m happy or I pull when I’m sad, I pull when I’m bored, I pull when I’m lonely. There are many different reasons.

Trichster in Toronto’s description clearly demonstrates this uncontrollable aspect of pulling. Like the experiences of many of the women in this study, Trichster in Toronto experiences a compulsion to pull.

In contrast, Shanna initially described her pulling as a bad habit or behavior. Like Natalie, Shanna also views her pulling as an addiction.

I’m giving into these urges and I can’t stop or I don’t want to stop. Me and my doctor would look at it as a bad behavior like smoking or alcohol addiction or anything like that, where it is just a bad habit. It feels good and you know you don’t want to stop but you know how bad it is for your health, you know the things it does to you. Although it’s not life threatening in that sort of way like smoking or alcohol.

Shanna also offered another explanation for her hair pulling, suggesting that the behavior could be a form of “gating.”

My doctor told me that gating is basically when you are in pain and then you hit yourself in that area, it sort of makes you feel better. It is sort of why people cut their wrists or cut themselves. It sort of makes them feel better. That is what I attribute to my hair pulling. It’s sort of like gating, where it
hurts but it sort of feels good at the same time. . . . It’s weird but I guess it affects the same area of the brain. There is pleasure but there’s pain.

Both of Shanna’s explanations provide support for the idea that hair pulling is out of control for her. Similar to the experiences of the other women, the biological explanations offered by Shanna highlight her inability to control her pulling.

In an earlier excerpt, Marion explained her pulling as possibly resulting from the treatment she received for lice. She explained that the mechanical action associated with pulling nits out of her hair may have started her in that direction.

In relating her experience, Cindy offered an interesting perspective on the issue of control.

It’s usually at times when I’m tired, when I’m looking in the mirror and I’m like “Oh, I don’t want this eyebrow, it looks out of place, so I’m just going to pull it out. Then I pull too many of course. The mirror is usually my enemy, and being sleepy. If I’m tired at work, I find that just sitting there, if nobody else is in my office, I’ll pull. It’s harder to stop, it’s harder to control yourself when you don’t have the mental energy. It’s not really the stress, it’s different scenarios that make you more susceptible to pulling, looking in the mirror is a problem, being tired as well as reading, when I’m sitting down. The reading and being tired, if I read before going to bed before I go to sleep that is a big no–no, because I’ll pull a lot.

Rather than seeing her pulling as out of control due to biological factors, Cindy views it as being controllable except in circumstances where she’s not up to fighting the urge.
Being unaware of pulling also contributes to a lack of control. For example, Kathleen not only feels an irresistible compulsion to pull sometimes, she also sometimes pulls without being aware that she is doing so.

I just can’t help it sometimes. I do it in situations where it’s overwhelming and I can’t seem to stop myself from doing it. If I’m at home watching a movie and pulling my hair, I have no idea until my partner says to me, “Stop pulling your hair.” I won’t even notice. Or sitting in the car, I’ll do it looking out the window. I won’t even notice until he says it to me and within 5 seconds my hand is back up again and I’m doing it.

Kathleen, like so many of the other women, describes the helplessness that she feels as a result of her inability to control her pulling.

**An Avenue for Gaining Control**

Interestingly, while the women described the out of control nature of the hair pulling, they also spoke about hair pulling as an avenue for gaining control. This category, An Avenue for Gaining Control, is defined in a broader sense by the women’s experiences, i.e., gaining a sense of control over one’s life that was damaged in childhood. Several factors were identified by the women as contributing to their sense of gaining control. The first factor is the strategies that they utilized to distract themselves from actively pulling. The second factor is the maintenance of specific pulling sites. Two of the women indicated they gained a sense of control by restricting it to one site; this was not their scalp. For these women, the fact that they never pulled from the scalp provided them with some sense of control. The third factor was motivation. Two of the women indicated that they gain control of their pulling when they are motivated by an upcoming event coming up or visit by individuals from whom they want to conceal their pulling. Regardless of the factors the
women identified as being important in their attempts to gain some measure of control, this theme, “an avenue for gaining control,” helps to define the role of hair pulling for the women in this study.

In describing her experience Marion stated:

Well, I’ve noticed that when I’m in periods of some stress but also when I’m in periods of turmoil, when I’m doing a lot of work alone at a desk that can really be a trigger. Whereas I’ve been sort of on vacation for the last month and half and out doing stuff and out and about, around other people, I just don’t find myself ever doing it. Maybe I’ll find myself doing it once and it’s very easy to go “Oh” and not do it anymore.

Marion further described her control over her hair pulling as contributing to her sense of well-being with respect to the hair pulling.

I don’t suffer a lot of self-hatred about it either. I mean if it got really bad or raged out of control I would probably have more of an issue with it.

For Marion, being in different circumstances contributes to her control over her pulling. Key to her experience is the effect that this control has on how she thinks about herself.

The use of distractions, i.e., engaging in activities that prevent pulling, is also demonstrated by the experience of Cindy. In summarizing her experience, Cindy stated:

If I keep myself physically busy, if I’m doing housework all day long, I won’t pull a single hair out. If I’m physically doing a lot of things or out shopping all day, I won’t have the urges because I’m physically engaging myself in other things rather than sitting there with my hands free.

Distracting herself with physical activity is a way for Cindy to gain a sense of control over her pulling.
Penny described the strategy that she uses to gain control over pulling.

Sometimes in class, if I’m typing my class notes I find it really helps because when I type, I often type verbatim so it keeps my hands busy because I’m not interested in doing it [pulling] in public. The compulsion is not as strong as when I’m on my own probably because my attention is focused elsewhere.

As in the case of Cindy, Penny described keeping herself busy to gain control.

Samantha utilizes a concrete strategy to help her minimize the effects of pulling and thus gain control. Samantha described her experience as follows:

It’s not controlled but it’s much more controlled than maybe in the past. The other thing is that I recently cut my hair because I found that it was starting to get thin and a little more noticeable.

Another kind of control is control of the sites of pulling, i.e., limiting the pulling to a specific site. For two of the women in this study, restricting their pulling to one and only one site gives them the sense that they have gained control over their pulling. Take the example of Rachel. She has never pulled from her scalp. For her this suggests a measure of control.

I’ve been really lucky. I’ve talked to people on line who have pulled from their head and their eyelashes and other spots and people who swallow the hair. I’ve only ever pulled my eyebrow.

Rachel’s experience demonstrates that her sense of control stems from not engaging in what she perceives as being an undesirable behavior.

Cindy, like Rachel, also pulls only from sites that are less conspicuous then pulling from her scalp.

I actually don’t pull my hair out on my head, I never knew about that until I read about it much later in life. I just naturally ended up pulling my eyebrows
and eyelashes; those are basically the two areas. [In a later part of her interview she states the following in relation to pulling.] I started touching my eyebrows and it turned into a huge problem; it never went to my hair though.

The third factor related to gaining control is motivation. Though this was not discussed by all of the women, the experiences of Rachel and Cindy demonstrate the importance of this factor for them. In describing her experience, Rachel stated:

When I was consciously trying to stop, what did I attribute this to? Sometimes I had a special event coming up where I didn’t want to be at the event with a hole in my eyebrow.

For Rachel, having to attend a special event is motivation enough for her to stop pulling her eyebrows, and a means of gaining control.

Likewise, Cindy indicated that she is motivated to stop pulling if there is a special event approaching or if people are coming to visit.

It’s hard to describe, but sometimes there’s major events in my life, like when I was getting married, I had huge motivational factors for not pulling because I didn’t want to look weird; wedding pictures are forever. Another example would be when I’m expecting visitors from out of town that have known me for a long time, for example, my parents. I don’t live near them and I guess they would come to visit and they would you purchase a ticket months in advance. It’s a huge motivational factor for me to stop pulling my eyebrows and eyelashes. I may pull less intensely, I might pull one or two here and there.

For Cindy, her wedding and her upcoming visit by her parents help her to gain a sense of control over pulling. Similar to the experiences of the other women, attempts to control pulling provide an opportunity for the women to look at the role that hair pulling plays.
Theme 5:
The Journey of Hair Pulling

The final major theme, The Journey of Hair Pulling, is the impact that hair pulling has on the lives of the women, and the thoughts and feelings that are associated with the behavior. The categories that emerged from the descriptions include: How I Feel About Myself, Self-Esteem and Other Psychological Difficulties, Self-Disclosure, Stigma, and Acceptance of Self. In addition, how the responses of others influence the feelings that the women have about their hair pulling is discussed.

All of the women expressed feelings of embarrassment, shame, and pain as a result of their hair pulling. All spoke about decreased self-esteem and other psychological difficulties that are common results of hair pulling. Their descriptions also suggest that though there is an eventual acceptance of self, these feelings do not negate the stigma associated with hair pulling that is felt. Finally, for four of the women, sharing their stories with others is cathartic. The process of self-disclosure is complex, involving a number of factors including the determination of when to disclose and to whom. Central to the process of self-disclosure is control and the acceptance of self. However, not all of the women have engaged in self-disclosure. Some described instances in which they shared the experience of pulling with others, in one case, the “outing” of hair pulling by others caused feelings of anger and humiliation.

Overall, the women’s journey of hair pulling describes the evolution of how they feel about hair pulling. Each of the women began by speaking about the negative impact of pulling on their lives. For some of the women, the middle of the journey reveals a move towards self-disclosure. The end is acceptance of self. The journey of hair pulling is not a
clear and simple process. Though the women learned to accept pulling, they acknowledged feeling angry about having to deal with it. Also, the women continue to have negative thoughts and feelings about pulling though they indicated that they accept it as one of many aspects of themselves.

*How I Feel About Myself*

Categorized under *How I Feel About Myself* are descriptions of how hair pulling affects the way that the women viewed or thought about themselves. This theme marks the beginning of the women’s journey of hair pulling. In describing this journey, the women spoke about how pulling has affected them, in particular, their feelings and thoughts about pulling. Words such as “pain,” “anger and frustration,” “hatred,” “embarrassment,” “shame,” and “not normal” were used by the women to describe these feelings. In general, the women have a negative view of themselves because of the pulling. This negative view often translates into frustration and anger at not being able to stop. Negative feelings were on occasion reinforced by well-meaning parents who attempted to stop the women’s pulling by pointing out how “pretty” or “normal” they would be if they stopped pulling.

In describing how she felt about herself, Trichster in Toronto focused on the pain of having trichotillomania and the anger and frustration she feels because she is unable to stop herself from pulling. She described her feelings as follows:

> It is painful. It is very hard. I can’t get my hair cut a lot of the time because I have bald patches. Going to the makeup counter is a horrific experience because people have made comments about my eyebrows. Even though I’ve had a hair transplant, it doesn’t necessarily look like other people’s eyebrows. I mean it’s hard. I hate it. I sometimes feel very frustrated and angry at myself. Why can’t I just stop? Especially when it gets really bad; there have been
periods when it’s been really bad and it angers me that I can’t stop, even though I know what the end result is going to be.

Later in the interview, Trichster in Toronto highlighted the damage to her sense of self. It made it a lot more difficult. I think there is a degree of shame. I often look back at pictures and think if only I hadn’t done that to myself. I mean to this day it’s not a good feeling to have to walk and not be able to wear your hair down and go to a salon. I think I’m reserved to start with but I think it’s added to my sense of low self-esteem at times and not feeling good about myself. It’s hard to say, because there are so many factors but I think maybe part of it is my reluctance to be in any kind of intimate relationship because how do you explain certain things to someone and the fear of opening up is really hard.

For Trichster in Toronto, her negative sense of self impacts her ability to participate in activities such as going to the makeup counter, having an intimate relationship, and simply walking down the street. Though she camouflages her hair loss, she continues to experience negative emotions, including hatred and frustration. Trichster in Toronto also highlights another aspect of the theme How I Feel About Myself by talking about the grief that she feels about losing who she could have been had she not had to identify herself as a hair puller to herself and others.

Cindy, like Trichster in Toronto, also reflected on the hatred she feels when describing how she feels about self. She, like the Trichster in Toronto, wishes she had never had trichotillomania.

It’s weird. I hate it and love it at the same time. It’s become a part of me. I hate it when I think about how ugly I look in reality without covering it up but then the instances that I pull are gratifying. But overall, my feelings towards it are that I wish that I had never had this in my life. It’s a struggle that I have to go through.
Cindy’s experience highlights the ugliness that is associated with pulling. However, she also acknowledged that she feels good when pulling.

Feelings of hatred were also expressed by Natalie and Shanna. For Natalie, the hatred is not so much towards self as it is at the fact that trichotillomania exists. In contrast, Shanna’s feelings are directed towards self.

More or less angry. Not angry at myself, just angry at the fact that it exists. If I looked at the spot and I focused on it, it used to make me really pissed. I would feel guilt inside and I would start to cry. But now, now I’m just frustrated. . . . When I find myself doing it, it sort of pisses me off, for lack of a better word. (Natalie)

I hate it. I want to grow my hair again and look a little bit more normal. I don’t have any hair on my eyebrows and eyelashes . . . . It just makes me feel bad, worse about myself. (Shanna)

The experiences of Natalie and Shanna highlight the range of emotions and turmoil experienced as a result of pulling. Like the women quoted earlier, they described wanting a return to normalcy; a life without pulling.

Another aspect of How I Feel About Myself is the embarrassment that is associated with pulling. The stories of Penny and Marion highlight this aspect of the theme. Take the case of Penny, for example.

How do I feel? It frustrates me because of course I would like to stop and of course it’s embarrassing. Time wasted. It sometimes feels unproductive. I wish that I could read without doing it, that’s a big problem because I am an academic.
Marion also spoke to the issue of embarrassment. However, for her embarrassment results from others noticing or making comments about the pulling.

I don’t really like it. I find it kind of embarrassing. I don’t really like it when people notice or comment on it. But I’m also sort of at peace with it and I feel it’s something that you know is 90% under my control. I’m not getting big bald spots or stuff from it. I also realize that it is something that seems to be triggered by stress. If I work on that, stress reduction, it certainly is ameliorated, but, you know, I don’t love it, but I don’t suffer a lot of self-hatred from it either.

Though Marion acknowledged being embarrassed about her pulling she is quick to point out that she does not suffer a great deal of emotional distress because of it. This is perhaps due to her sense that she has control over it and the lack of visible consequences associated with her pulling.

Shame was described by one participant, Rachel, as another aspect of How I Feel About Myself. However, for her, the shame came from an external source: her parents made her feel shame about pulling. They also reinforced the idea that she was not normal because she engaged in hair pulling.

They [my parents] would comment. They simply treated it as just another weird quirk, one more flaw that separated me from normal children and that if I use my will power I could stop it. They really just made it quite shameful. Comments like, “Oh, you would be such a pretty girl, if you didn’t have that hole in your face.”

This idea that hair pulling is not a normal is also highlighted by Samantha’s remarks. I feel okay about it. I feel like it’s definitely not, for a lack of a better word, a normal thing to do, and not necessarily a completely healthy thing to do. But I
feel that, right now anyway, it is under control enough that it doesn’t really cause me psychological upset.

Although Samantha also sees hair pulling as abnormal, because she feels that it is under control to some degree she is not ashamed by it.

In contrast to the experiences noted above, Kathleen described feeling distressed by her worries about her pulling, and her trichophagia. She described her feelings as follows:

It’s distressing because I get my hands slapped by the hair police, reminders from family and friends. It is kind of distressing when it comes to getting your hair cut and stuff like that. But my hairdresser is lovely. The first time I went to see her she sort of went, “Oh, my gosh, who cut your hair, because you have these chunks of really short hair, and everything else is long.” The whole hair-eating thing sort of freaks me out a little bit. I worry about these things. I worry about the behaviors, more than I should I guess. It adds to the stress.

Claire offers another perspective on the theme How I Feel About Myself. Claire reported that she doesn’t feel shame as a result of her pulling and she attributes this to her acceptance of it. Her experience is as follows:

Interviewer: So, when you actually look at yourself, for example, in the mirror, do you feel . . . ?

Claire: Shame?

Interviewer: Yes.

Claire: No. Maybe it’s part of accepting it.
Self-Esteem and Other Psychological Difficulties

The second category that emerged from the narratives of the 10 women is Self-Esteem and Other Psychological Difficulties. More specifically, low self-esteem and other psychological difficulties, in particular, obsessive compulsive disorder, depression, and anxiety, which are often associated with trichotillomania. The New Lexicon Webster’s Dictionary of the English Language (1987) defines self-esteem as, “one’s good opinion of one’s dignity or worth” (p. 905). A negative sense of self is all too common in individuals with trichotillomania. There is also a high correlation between trichotillomania and other psychological difficulties, particularly depression, anxiety disorders, and obsessive compulsive disorder. The prevalence of other psychological difficulties may be as high as 82% (Christenson, Mackenzie, & Mitchell, 1991; Christenson, Chernoff-Clementz, & Clementz, 1992). Whether the psychological difficulties and low self-esteem are caused by hair pulling is not clear, however, the experiences of these women suggest that these are all too common in individuals with trichotillomania. Cindy’s experience provides a typical example of low self-esteem experienced by an individual who pulls.

Maybe a slight lower self-esteem, it’s kind of hard to say, but maybe the feelings of not looking as beautiful and not being as normal as a normal person is always kind of left on the back of my mind.

Marion also acknowledged having difficulties such as low mood and low self-esteem. However, it is not clear if these difficulties are specifically due to the hair pulling.

I’ve certainly had periods of time when I’ve had low moods and I don’t always have 100% great self-esteem. I haven’t gone to a doctor to have treatment for low self-esteem but I have gone to a psychologist to talk about depression.
The experiences of Cindy and Marion highlight the difficulty of trying to establish a link between trichotillomania and low self-esteem. Cindy, for example, believes that her perception that she is unattractive and not normal contributes to her low self-esteem. Marion also speaks about her lack of self-esteem and low moods. The experiences described by these two women serve to demonstrate that low self-esteem is an aspect of trichotillomania.

As noted previously, a number of difficulties, including obsessive compulsive disorder, perfectionism, depression, and anxiety, have been associated with hair pulling. These difficulties can at times overshadow the trichotillomania. In an earlier excerpt, Trichster in Toronto spoke about her extensive treatment history for anxiety and depression.

Penny also described an experience typical of someone with trichotillomania and other psychological difficulties.

I was diagnosed last year; probably it’s been around longer. Exactly what you said, major depression and generalized anxiety disorder.

For one participant, Rachel, seeking treatment for her OCD and depression facilitated acknowledgment of her trichotillomania. She described her experience as follows:

Within the last 3 weeks I’ve been diagnosed with OCD and depression. . . . There have been a lot of issues coming up in terms of anxiety and perfectionism and they were having a huge impact on my life and so things came to a head this summer and I thought “Okay, I need to do something about this,” so I went to treatment and then as part of that I admitted I had trich.

In her description, Natalie stated that she went into treatment to address her unhealthy self-esteem but found that the treatment was not helpful for her pulling.
A few years ago in order to help with my self-esteem, I did start to see a cognitive behavior therapist, which was great for dealing with my own personal issues, but it didn’t really help with the trichotillomania at all.

In contrast to Natalie, Samantha reported that her trichotillomania improves when her other difficulties, in this case depression, are under control.

In the past I’ve been diagnosed with clinical depression and certainly when I’m in more down moods, my pulling and fidgeting or playing with my hair is noticeable as opposed to other times it doesn’t really occur. . . . and normally if my depression is under control I do not feel as anxious and unhappy and shameful and I tend to not be as interested in pulling my hair. I might still pluck, but again, not in the same way.

Shanna indicated that she also has some of the psychological difficulties, e.g., low self-esteem; however, she doesn’t let the effects of hair pulling keep her from going out.

If I have to go out or you know I want to go out, or I plan to go out, then it doesn’t keep me from going out. I can sort of try to forget about it or I cover it up a little bit with my glasses or my hair. I’ve always been shy and you know I’ve never cared for myself and things like that, I guess no eyelashes or eyebrows just makes it a little worse.

Claire indicated that she doesn’t experience difficulties such as anxiety or low mood because of her trichotillomania. For her these difficulties arise if she is prevented from pulling. As she remarked, in response to the question: “Sometimes people who pull have other psychological difficulties such as low mood, anxiety, low self-esteem, low self-confidence, embarrassment, or shame. Do you have any of these difficulties?”

Actually the opposite. I almost feel like I’ve lifted a weight off my shoulders because it’s almost like, during the day if I brush my hand against my
eyebrow, I feel anxiety because I feel eyebrows there. I feel stubble. I have to go home and get rid of it.

**Self-Disclosure**

The third subtheme that emerged as a result of reviewing the descriptions of the 10 women is that of Self-disclosure, that is, the women’s communication of their hair pulling to others. Self-disclosure involves two factors: deciding when to disclose, and to whom. Four of the women disclosed at school or work to peers and colleagues, respectively. Feelings such as anxiety, fear, and worry were identified as significantly contributing to their decisions to disclose or not. In addition, both previous reactions and anticipated reactions were identified as important indicators for self-disclosure. Claire disclosed to colleagues because not disclosing caused trouble in the past. Interestingly, the process of self-disclosure varied throughout the women’s lives. As evidenced by the narratives, women who self-disclosed were genuinely surprised to find that family, friends, and co-workers were understanding and supportive. This helped to ease their initial misgivings about self-disclosure. At the same time, there were women who did not disclose or for whom self-disclosure was a recent phenomenon.

Take the story of Natalie. Her self-disclosure did not occur until she was well into her teen years when she disclosed to her peers. When she did eventually disclose her pulling, the reactions of those she told were more positive than she expected they would be. In addition, she found that self-disclosure helped her to manage her pulling. Natalie describes her process of self-disclosure as follows:

Probably not in my early teens, probably maybe about Grade 11, I disclosed to my close friends. There was no reaction. That is why I think I grew
comfortable with it, because they didn’t treat me differently; they weren’t like “Oh wow, you are weird.” There was nothing, no reaction and if they noticed me pulling my hair they would tell me to stop. . . . I would think that for me it was the fear of how I thought people would react. I played that in my head so I wouldn’t tell anybody.

Shanna also disclosed to a friend with similar results.

In the past, I think I told a friend. They were pretty understanding. Funny because I was watching the Tyra Banks show and it was on OCD and they had someone on that had trichotillomania, she told her best friend. I don’t think that I would ever do that, go on TV, it’s a little too personal.

Trichster in Toronto also disclosed to her friends; however, she was quick to point out that this is not her usual mode.

I started pulling when I was 12, so some of my good friends know. It’s not something that I openly talk about.

For Claire, self-disclosure means being open to her colleagues at work. She provided this account when speaking to the issue of self-disclosure.

It can take up to a half hour to pluck my eyebrows in the morning and I am often late for work. I’m being accommodated. My supervisor knows about the symptoms. My Executive Director is understanding. I’ve been with the organization, the company, for about 5 years. . . . it’s not just about my trichotillomania or my compulsions. I get easily distracted in the morning and my Tourette’s I’m sometimes late for work. They have accommodations at work for other things but they’ve been understanding, I don’t like being late for work. I feel guilty but if something is in place that eases off a bit. . . . I am very open about disclosing about my Tourette’s because of the discrimination I had at one job so as a result I disclose right away. And as new staff come in I
I have something called coprapraxia that causes me to do gestures that are inappropriate. So I do that [self-disclosure] to protect myself and to make them feel comfortable. As well because of my hair pulling since working there I’m an open book and I feel comfortable telling people. I’ll joke around, stuff like that.

Four of the women also spoke about their feelings with regards to this issue of self-disclosure. This is another important aspect of this theme. Feelings of anger, anxiety and fear were commonly expressed by these women as important indicators of whether or not to disclose, and if disclosing, when to do it. These feelings become more pronounced when the women’s trichotillomania is revealed. Revealing the hair pulling to specific people, such as family and friends, and in specific situations is also common. On the other hand, Kathleen, for example, would not be comfortable revealing her hair pulling to her colleagues. Indeed she expressed a constant fear of being discovered. This differs from the experience of Claire who has taken a proactive stance, particularly in her work environment.

Penny’s remarks reveal an anxiety that is common in many individuals with compulsive hair pulling, particularly with respect to self-disclosure. For Penny, the anticipated reactions of others and their actual responses when she did disclose differed significantly.

People don’t really care. I’ve noticed that a few times in my life, where I will bring it up and they just don’t really care. I’m sure that women probably care as much as I do. I mean, from my understanding that is the biggest problem with trichotillomania is that it causes such anxiety and shame which is irrational because other people that you are worried about caring, don’t actually care. But that doesn’t make it less problematic just because I know it’s not rational.
Interestingly, Penny also described an incident that occurred when she was a young child. She was confronted by her mother about the hair pulling, and rather than reveal the behavior, Penny chose to reveal that she was engaged in another equally embarrassing behavior.

I have one memory; I don’t remember how old I was. I must have been quite young but we were in some store and I was off on my own and I was picking an eyelash out. She asked me later, “Were you picking your eyelashes out or were you picking your nose?” and I said, “I was picking my nose.” I remember thinking to myself, I didn’t realize the irony but I thought it was funny how many times in your life do you want people to think that you’re picking your nose.

Claire also expressed displeasure at the negative reactions of others. Being “outed” by a stranger made her angry, and propelled her to take action.

I’m protective and defensive of myself if someone makes comments, and I’ve had that where I was at the CNE years ago and I was looking at some beauty products and I was so upset by this woman who worked at this booth. She loudly says, “Oh, my gosh, you have no eyebrows.” I was absolutely shocked and stunned that she would say that. And I said back to her, I said, “You are the rudest person, you work in the beauty industry and you just offended me,” and I yelled out to other people, “Don’t come here, she is rude, she’ll pick on your imperfections.” That is the rudest thing that somebody can do. I take it personally obviously. . . . Nobody noticed until she said it.

In describing their feelings about self-disclosure, Kathleen’s and Rachel’s descriptions highlight the fear that is associated with others finding out their secret. For example, Kathleen spoke to the issue of a work colleague finding out about her pulling. For her, revealing this particular aspect of her life would disrupt her professional identity.
As quoted earlier, she described the need to maintain a professional demeanor at her place of work.

I’m terrified that someone was going to walk by and catch me in the act; it’s not exactly professional.

Rachel described similar feelings; however she continues to engage in the behavior around people or in situations that she is comfortable with.

My mom is always aware of when I’m doing it and comments on it. And my boyfriend he notices too but he is more supportive than my mom. Within the last year I left a full-time job and started freelancing at home. I noticed that revved up my pulling. My anxiety has increased since starting my business, but also I don’t have the constant threat of someone seeing me pulling in an office setting. Sometimes if I am really agitated I will do it in front of someone, but mostly it’s people I am most comfortable with.

While in the cases discussed above disclosure of their trichotillomania is part of the women’s lives, this was not the case for all participants. For Samantha and Cindy, it was a work in progress. Samantha reported that she had never purposely disclosed to family and friends while Cindy said that although she disclosed to family, it was a topic that was avoided and not readily discussed. For one woman, Marion, self-disclosure was a new experience.

Though her mother may have had an inkling of Marion’s hair pulling, it was not something that was openly discussed. Her recent disclosure was met with an expression of disbelief from her mother.

I remember when I was younger my brother actually would say, “Why are you pulling out your hair?” “What are you doing that for?” and he told my mom
about it, when I was quite a bit younger. But then interestingly enough, I told my mom that I was doing this study and why and she was like “What! What are you talking about, you don’t have that.” And I told her, actually I do.

Self-disclosure is not something that Samantha actively pursues.

With my ex, like back in university age we never talked about it. But I think she was pretty aware of it. Because she would sometimes point it out “You are doing it again.” That kind of thing, it was unpleasant.

When I asked her if she had ever disclosed to her family, she replied in the negative: They [the family] saw my bald spot; I made up a lie to cover it up.

In contrast, Cindy did disclose to her family, but it was never openly discussed and for Cindy, this was disappointing. She had hoped to receive support and understanding as a result of the disclosure.

Like my family doesn’t really talk about it, they know I have this problem but it’s weird, they don’t understand you can’t just stop. So they avoid the subject altogether, which is sometimes harder because they are really the only ones that know about it. I keep it to myself very, very much about it.

Stigma

The fourth subtheme that emerged from the descriptions was the stigma associated with hair pulling, and the impact of this on the lives of the women. The experiences of the women in this study highlight the considerable emotional distress associated with having a debilitating and chronic condition such as trichotillomania. Lack of public awareness and insufficient understanding contribute to the stigma experienced by many. In reviewing their experiences, one finds stigma associated with a number of different factors. For example, the
degree of hair loss, in particular, how visible the hair loss is to others, impacts the level of stigma that the person perceives. In other words, the greater the ability of the individual to blend the less the stigma. Therefore, concealing the hair loss was identified as a factor associated with stigma. Treatment-seeking behaviors are also affected. A significant number of the women had never sought treatment for their trichotillomania. The lack of effective treatment and the lack of understanding from the medical profession contribute to the stigma of trichotillomania.

Though all of the women talked about the stigma associated with trichotillomania, many also tried to lessen it by engaging in proactive activities. Engagement in proactive strategies has been documented elsewhere, specifically, in individuals with certain other stigmatized conditions, such as OCD (Fennell & Liberato, 2007). In the present study, raising the public profile of trichotillomania was a common theme discussed by the women. They spoke about wanting to educate others about this condition and the impact that it has on sufferers. This theme was echoed in the words of Shanna who stated that her primary reason for participating in this study was to educate others afflicted with trichotillomania. Interestingly, when the women volunteered for this study, they expressed a willingness to discuss issues as they related to the hair pulling because of the anonymity of the study. In other words, there was no face-to-face contact between the women and myself. The women further indicated that the personal connection that I had to the issue helped to momentarily lessen the stigma associated with hair pulling in their eyes. For one woman, Claire, self-disclosure in her work setting was an important first step to minimizing the stigma attached to pulling. Though the women tried to distance themselves from the stigma, this was difficult for them to accomplish. For example, participating in the study allowed them to educate
others and thereby reduce the stigma of trichotillomania, and yet, ensuring that confidentiality was maintained in this study was important to the women. In general, all of the women were affected by stigma and try in various ways not to let it define who they are.

Concealment of hair loss is one way that the women try to lessen the stigma associated with trichotillomania. They spoke about a number of different strategies that they utilized to “hide” the visible consequences of pulling. In addition, two of the women indicated that they often created false explanations for their hair loss.

Natalie’s experience offers an important insight into stigma. Natalie’s hair loss is less visible on her scalp, not noticeable by others, and therefore she is comfortable not concealing it. However, she frequently conceals the loss of her eyelashes because it is more noticeable. Natalie described her situation as follows:

The hair on my head, the crown, has never been noticeable to the public eye. You would only know if I told you and if you were looking for it. If you passed me on the street, you would never know. I’ve been fortunate that it’s [the bald patch] always ended up being a perfect rectangle. But my eyelashes you obviously would notice. . . . My friend who is in hair dressing, a woman that she actually works with has a lot of clients who went to her to get caps made to cover up [their bald spots]. I went there when I completely fried my hair because it was platinum. I went to this woman to get color correction done and when she saw the size of the square [bald spot] on my head she said, “Oh God, that’s nothing to what we have come in here.” But I realize that I’m probably lucky that it hasn’t spread and affected my entire head. At least it’s not in the front of my head. I think there is something that goes on at the back of my mind that says, “Don’t do it because than everyone will notice.” I think that maybe part of it is just that I know it’s not normal behavior and there is
still a part of me that doesn’t want everyone to know, or else I wouldn’t bother to cover it up.

Penny also covers up her hair loss, specifically her eyelashes.

I won’t leave the house without eyeliner. I have a dark brown eyeliner that I put on every day when I go out and it’s quite effective. You have to come up pretty close in order to see that. I have eyelashes on the bottom layer, on the bottom lids, and I sometimes pick out of there but that’s part of the mask so I don’t really go there. It’s almost like at this point in my life, it’s changed around depending on the year.

In addition to covering up hair loss, avoiding situations where the hair loss is noticeable is another strategy that they implemented to lessen the stigma. Examples of this included avoiding the dentist, or not telling certain people, simply because it would reveal the hair pulling behavior. Cindy’s remarks illustrate this way of dealing with the stigma.

I prefer to avoid the dentist, although I do force myself but for me the dentist is worse than the hair stylist because my hair is normal but you know when I sit in the dentist chair and they are looking at you with this really bright light and they are looking straight into your face, they are going to see beyond the makeup. They are going to see the missing eyebrows and eyelashes, 2 inches away from your face. So the dentist was never a favorite for myself and now that I’m an adult, I don’t have to go. When I was younger my parents wanted me to go every 6 months . . . so it was always awkward for me but I tried to hide it as best as I could. I had bangs all through high school, all through seventh, eighth grade, high school; bangs to just right down to my eyebrows so that I could hide it for the most part. It was an adaptive mechanism as well as putting some eyebrow liner on my eyebrows where it was missing and eyeliner where my eyelashes were missing. But there was probably a huge gap if anyone actually noticed. Probably they did but nobody ever commented.
Penny offered another experience in relation to the stigma of trichotillomania. Unlike Cindy, Penny does not avoid medical professionals, but she has managed to avoid talking about her pulling to her doctor. It is only recently that her doctor has commented on it. Penny also engages in strategies to make her hair loss less noticeable.

But for the past year or so I’ve been able to keep a layer on the bottom then just keep a thick layer of eyeliner almost eye shadow on the top. When I was at the doctor the last time, maybe a month ago for a check-up, she asked me about halfway through, about the eyelashes and she mentioned that she only noticed when she came up close to do the rest of the check-up. I was pretty proud.

Cindy noted that she has never told her doctor about her trichotillomania; she explained that this is because it “didn’t seem important enough at the time and now it seems awkward.” However, she did state that trichotillomania would now have to become a topic of discussion with her doctor because she wants a referral to a specialist.

Offering alternative explanations for the effects of hair pulling is another way of avoiding the stigma that was described by two of the women, Penny and Samantha. Penny described her ploy.

I wouldn’t say that I avoid but there are ones that bring me anxiety so going to the hairdresser’s is always awkward because the back of my head, it’s not even that there are bald spots but there are really, really short there are sections that I’ve lost that have really, really short hairs. It’s really difficult to explain so I make up stories like “oh, yeah, I got gum in my hair.”
Samantha has also used the “gum in my hair” explanation for her hair loss. For her, this explanation is much more acceptable than the truth. And, in the situation described, she feared that admitting to the pulling would result in a negative reaction from her parents.

I told them, it was partly true, that we were on some school bus trip or something and I got some gum in my hair and this girl had sort of just pulled the clump out and I just said that was the cause of the bald spot. They were shocked and horrified because the bald spot was really big and they were like wow, how could she do that to you. And I’m like, no, no, it’s okay, it’s okay [laughter].

Reluctance to discuss hair pulling with others is another effect of stigma. Marion describes her hesitation to discuss her hair pulling with others.

I’ve never really gone to the doctor’s and said “I do this weird thing” [nervous laughter] . . . I did a little Wikipedia on it and it was talking about how people pull and eat their hair, which is really interesting. So it’s funny that it’s not talked about more. It’s definitely not something that I ever talked to anybody about or even had a conversation about or heard about in pop culture or anything except for that expression “pulling your hair out.”

For Kathleen, her need to maintain a professional identity reinforces the need to avoid the stigma associated with hair pulling.

It just sort of long-term and the profession that I’m going into, appearances mean so much. I have found myself sitting at work in my office and not being able to control the urge to do it.

In describing her experiences, Trichster in Toronto focused on the stigma that hair pulling has in relation to appearance. Trichster in Toronto views her trichotillomania as a much more stigmatizing condition than the emotional issues that she is dealing with.
It’s funny because I have a number of issues and I’ve dealt with a lot of things in my life, but for me it’s much easier for me to talk about some of the other things. I think that a lot of people would consider those issues to have just as much stigma, but for me the pulling has a lot more stigma. For some reason, it seems more shameful. I think especially because of the world we live in and everything seems to be predicated upon how we look like and it is hard to be different in any way.

Rachel wrote about the effects of the stigma associated with trichotillomania in a note sent with the revisions of her transcript:

I’ve only ever met one other person who has trich [meeting was on the phone], and it was a guy in his 20s. Years ago we were seeing the same therapist and she thought it would be beneficial if we started our own support group, if you will. We spoke on the phone once, but I don’t think it helped either one of us that much. We were both so ashamed and preferred to stay anonymous. I used to participate in online Trich support groups in the mid 90’s, but eventually stopped because the pressure to count no pull days and admit failures became too stressful.

Acceptance of Self

The final subtheme, Acceptance of Self, includes a number of different factors such as the empowerment to engage in everyday activities and not be governed by the negative attitudes of others. As well, acceptance of self also seemed to depend on the length of time that the participant had engaged in hair pulling and the degree to which she could successfully overcome the complications of pulling. All of the women had engaged in pulling from a young age. Given that the women ranged in age from 21 to 40, trichotillomania has been a part of their lives for a significant length of time. But the visibility of the hair loss was also reported to be an important influence on acceptance of self. Women who had less
noticeable hair loss tended to be more accepting of themselves. The support of others, in particular, family and friends, was another determining factor in acceptance of self. Women who felt accepted for who they are were more likely to accept the pulling as another aspect of self.

Claire’s experience highlights acceptance of self, in particular, the empowerment she feels from engaging in activities freely and not letting the negative reactions of others define her. She offers this example:

I’m a big socializer, I go out. I figure if someone doesn’t like the way that I look, too bad. I don’t have the perfect face, I don’t have a perfect body, but you know, if they don’t accept me as I am, then they’re not worth chatting to.

Natalie, like Claire, does not avoid activities or events because of her hair pulling. However, she takes this one step further by not covering up the hair loss from those close to her.

I used to avoid hair salons; I don’t anymore because most hair salons are actually familiar with it. I’ve never been to a hairdresser that has been like “Oh, wow, you are a total freak.” They’ve always been very understanding. But I do avoid swimming. When I was younger, I used to avoid intimate situations. But now, after about 22, maybe, I kind of accepted that, you know this is what I have and you can’t really tell unless you totally mess up my hair. I used to go to great lengths to hide it with my partner.

But Natalie also speaks of resignation, which is coupled with acceptance of self. This resignation was clearly evident in the experiences of both Natalie and Samantha. Natalie believes that acceptance of self is related to the number of years that she has engaged in the
behavior. Coupled with this acceptance is resignation: the notion that there is really nothing that can be done.

For me I’ve kind of given up and been like you know what, it’s a part of me and who I am and it is just going to stay there. In a way, I’m fortunate because I started when I was a little kid, so it’s just been a part of my life basically. I’ve lived almost my entire life with it.

Samantha describes a similar experience to Natalie’s. She is resigned to her pulling and thus accepting of herself. She attributes this acceptance of self to the fact that her trichotillomania is not severe and the fact that it is out of her control. She describes her experience as follows:

To me anyway it sounds like a very mild case so it sounds ridiculous in a way I feel lucky. It’s a milder version and also it’s something that I’ve thought of a lot and consider and yet I am still unable to control it. So what do you do with things you can’t control and can’t change, you either accept them or go insane [laughter].

Acceptance of self is by no means an easy process. While Natalie, Claire, and Samantha have been able to accept themselves and their pulling, Shanna still finds self-acceptance to be a struggle.

You know I’m 40 years old and I’ve been doing this for a long time, half accepting this is who I am, but the other half is saying, “No, I don’t want to do this. This is enough!”

Another factor that is important in the process of acceptance of self is the support of others, particularly family and intimate partners. Three of the women described experiences that suggest that when families and intimate partners are accepting, regardless
of the pulling, this helps to lessen the shame and isolation that they experience because of the trichotillomania. In addition, supportive actions on the part of families and intimate partners are more helpful than criticisms and seem to help the women manage their hair-pulling behavior.

Rachel’s experience highlights the importance of support from others and how this support intertwines with her acceptance of self. Though her experience provides an example of acceptance of self, it is important to note that Rachel is currently in a pull-free period and is in treatment to stop her behavior.

I have gone through spells where I see it as . . . I accept it as being just who I am and just try to move on. . . . But right now I seem to be more at peace.

My boyfriend, he notices too, but he is a bit more supportive than my mom. . . . He won’t so much say anything, he’ll just sort of take my hand and hold it. It’s more gentle.

Cindy also speaks about the support of her husband as being integral to her acceptance of herself. His positive attitude helps her deal with the challenges of her pulling as does knowing that his love for her is not contingent on her stopping the pulling.

My husband, he is very, very supportive and I’ve had some good success with at least stopping the intensity of my pulling. He was very supportive of me getting private counseling. It was a social worker but she was quite good. This was in the US; it was a little bit different. When I had a job in the US, I had medical coverage. I went ahead and tried it for a few months. Then we moved. That worked out fairly well, especially when you pay. When you pay, it’s a huge motivational factor. He’s [husband] very supportive even though I’m at a point right now where I go through highs and lows as far as this is concerned, some months I’ll look really beautiful and he really appreciates that and says,
“You look really nice,” and then other months, he’s seen me with probably not a single eyebrow on my whole face maybe a few eyelashes and he still says how beautiful I am and to just try harder to not pull and he is very supportive. If we’re sitting together, he’ll slap my hand down and just keep my hands down; physically supportive of helping me to remind myself of what is needed. But he can’t always physically be by my side 24/7 so it’s still my struggle. His doing those things, it shows me that he really is supportive, his feelings for me are not that different, so it’s a good situation.

In Penny’s case, the reactions of others has helped her deal with this condition in a more positive manner and has greatly contributed to acceptance of self. She interprets people’s polite responses to her hair pulling as acceptance, which increases her level of comfort in talking about her condition.

Throughout the majority of my life, people are pretty polite. That’s the great thing about Canadian society, everyone is so polite. They don’t want to mention my lack of eyelashes for the sake of being polite. When I was younger, it was an issue because kids were mean. They were more likely to bring up the eyelash thing in a fight, for example. I can’t even say that and justifiably say that I had a lot of problems with kids because of the hair, but I’ve tried to bring it up with other people because I want to be the kind of person that is comfortable talking about everything. I force myself to talk about it sometimes to people that are close to me. It doesn’t really come up in conversation.
Chapter 6:
Discussion:
Towards an Understanding of Trichotillomania:
A Grounded Theory Approach

The purpose of this study is to explore the childhood environment and experiences of women with trichotillomania in an attempt to identify the events and circumstances that coincided with the onset of hair pulling, in order to advance our understanding of this complex condition and to provide a description of it from the perspective of those living with it. In this chapter, I discuss the findings of my study in relation to a grounded theory approach to trichotillomania. In addition to using the grounded theory approach to create a model to understand the childhood environment and experiences of women with trichotillomania, the study findings are discussed in relation to the current literature on this condition. Given that this is the first study to specifically examine the childhood environment and experiences of women with trichotillomania, I draw on literature from other relevant areas of research as well as the trichotillomania-related literature.

To facilitate an understanding of the study topic, the discussion is organized in terms of the five major themes and subsequent categories that emerged from the data analysis. The themes and categories are presented separately to provide the reader with a structured and thorough discussion. The discussion begins with a summary of the women’s experiences and then addresses the issues in relation to the relevant literature. The five major themes of the study are: Looking Back: How It All Began; Childhood Environment; Relationship Between Specific Experiences and the Discovery of Hair Pulling; The Role of Hair Pulling; and The
Journey of Hair Pulling. In addition to the five major themes, included categories are discussed when appropriate.

Taken together, the major themes and categories identified in this study are used to describe the process of discovering trichotillomania. Selected excerpts are utilized to highlight some of the issues presented. The process of discovering trichotillomania is discussed further later in the chapter, where I outline the grounded theory approach to trichotillomania.

**Theme 1:**  
*Looking Back: How It All Began*

All of the women in this study recalled the age at which they began to pull their hair and the context of the initial pulling episode. These recollections are categorized under the theme Looking Back: How It All Began. What becomes evident from the events described is that they vary both in their nature and their intensity, suggesting that hair pulling cannot be attributed to a particular kind of event. In addition, the events described are not uniquely associated with this condition, but may also be found at the root of equally devastating conditions such as eating disorders, body dysmorphic disorder, and obsessive compulsive disorder, to name just a few.

Age of onset for the women was identified as childhood. The experiences of the women, in particular, when they first began to pull, are not statistically different from what is reported in the literature. Christenson, Mackenzie, and Mitchell (1991) suggest that the average age of onset is 13. The study by Cohen et al. (1995) reports a mean age of 11 years. It is well established that generally adult trichotillomania is a condition that begins in late
childhood or early adolescence, between 11 to 13 years of age (Christenson, Mackenzie, & Mitchell, 1991).

The events coinciding with the onset of pulling described by the women in the study range from simple and mundane to complex and sophisticated. For Cindy, the innocent act of wearing makeup precipitated the process of pulling by making her more aware of her eyes, in particular, her eyelashes. Other events described by the women included: academic situations, onset of Tourette’s disorder, infestation by lice, watching a hockey game, a habit, and becoming obsessed with trying to find the bulb at the end of the hair shaft.

Events coinciding with onset of trichotillomania have been reported in the literature, though there are no studies that specifically address this issue. According to Christenson and Mansueto (1999), “it often develops in the context of loss or perceived loss” (p. 8). For example, Keuthen et al. (2001) describe this possible loss as:

Death of close relative or friend, family break up from divorce, loss of companionship due to geographic move, decrease in attention received due to the birth of a sibling, loss of health due to sickness, or loss of mobility due to confinement in a hospital or other setting, and leaving home to attend college is another time when hair pulling can occur in young adults. (p. 12)

The issue of how trichotillomania gets started is also discussed by Penzel (2003). According to this author, “some connect the start up of their pulling with events they describe as stressful and which are often connected to some major change or transition” (p. 23).

To further complicate the discussion about what causes trichotillomania is the fact that not everyone exposed to events such as those mentioned develops chronic hair pulling. In discussing their research on eating disorders, specifically, factors that may predispose an individual to this condition, Garfinkel and Garner (1982) note:
While knowledge of predisposing factors helps explain why a particular illness is “chosen” it does not account for timing of the illness. It is well known that illnesses do not occur at random but coincide with events in an individual’s life and with his emotional state (Petrich & Holmes, 1977; Rahe, McKean and Arthur, 1967). (p. 191)

Having said this, it is likely that trichotillomania is the result of factors interacting with one another to make an individual more vulnerable to developing this condition. Nevertheless, the importance of identifying these events cannot be emphasized enough. Identifying factors that perpetuate hair pulling is an important first step in helping to delineate the various factors and specific interactions among these factors that form a template for the development of trichotillomania.

In the present study, women described a number of different events as precipitants of hair pulling. That these events are heterogenic in nature serves to highlight the complexity of attempting to identify precipitants of hair pulling. The issue of identifying events that coincide with trichotillomania is an important one given the current disagreement about what treatment is appropriate for chronic hair pulling and the inconsistent results of treatment studies. In general, what becomes clear in this current study is the specific initiating events leading to onset of trichotillomania in any one individual are external and highly varied. Marion, for example, stated that her and her family’s move to a new country, the culture shock, and subsequent head lice all contributed to her initial hair-pulling episode. In addition, the overall theme of these experiences seems to be that it is not so much the identified event that causes trichotillomania but that the individual perceives this external event as distressing and uncontrollable and that hair pulling is a means of attempting to regain control. This issue becomes more pronounced when we examine the childhood environment and experiences of the participants in this study. In addition, the role of hair pulling and the feelings surrounding
Hair pulling are evidence for the conclusion that it is a coping strategy utilized by these participants to deal with what they perceive as uncontrollable and stressful life events.

**Theme 2:**

*Childhood Environment*

The childhood environment of the women in this study is categorized under the following two sub-themes: Family Experiences and the Women’s Responses to the Family Experiences. Family Experiences is defined by the following factors: who I grew up with, family dynamics, styles of communication, early life experiences, and traumatic stress. The second subtheme, Women’s Responses to the Family Experiences comprises two factors: silencing the emotional self and perceptions of self. Of particular interest is the relative normalcy of the childhood environments and experiences of some of these women, suggesting that the exact role that these experiences play in the development of trichotillomania will be difficult to determine. However, this study does suggest that there is a relationship between the childhood environment and the discovery of trichotillomania for some of the women in this study.

**Family Experiences**

This subtheme of Family Experiences includes the factors: who I grew up with, family dynamics, styles of communication, early life experiences, and traumatic stress, which were identified by the women as significant to their experience of their home environment.

**Who I grew up with.**

The women in this study described a number of different family constellations. Seven of the women described growing up in intact families. Three of the 10 women (Natalie,
Rachel, and Samantha) indicated that they grew up in intact families for a significant portion of their lives. For Natalie, however, her parents separated when she was an adolescent, resulting in a single-parent family. Rachel recalled her father leaving and her stepfather entering the picture when she was 12. Samantha characterized her family as consisting of a stepfather and stepsiblings.

Studies examining the family constellation of individuals with trichotillomania have focused on children and adolescents with trichotillomania. I am not aware of any studies that have provided a retrospective analysis of this for women with trichotillomania. Of the available studies, the findings indicate that the majority of these children and adolescents come from intact homes, and that there does not appear to be any difference between their families and others (Delgado & Mannino, 1969; Reeve, 1999; Reeve, Bernstein, & Christenson, 1992). Overall, the present study is consistent with the above studies: there does not seem to be one specific family constellation that predisposes someone to develop trichotillomania.

**Family dynamics.**

In the present study, the women described three aspects of family dynamics. The first aspect is the parents’ relationship with one another. Seven of the women described their parents’ relationship as supportive and healthy. Three of the women described dysfunctional and chaotic relationships between their parents, ranging from the mild to more severe forms, the latter of which included physical and emotional violence.

Another aspect of family dynamics is the women’s relationship with the parents. One type of relationship described by some of the women was one of openness and support. Six
of the women indicated that they had a positive relationship with their parents. Two of these women, Kathleen and Trichster in Toronto, described being closer to one parent than the other, mother and father respectively. In contrast, four of the women characterized their relationship with their parents as being conflictual and distant. Natalie’s experience is typical of this type of relationship.

The third aspect of family dynamics is the women’s relationship with siblings. Four of the women characterized the relationship with their siblings as positive and close. Three women described the relationship with their siblings as distant and manipulative. Marion, for example, described her relationship with her brother as one of co-existence. In contrast, three of the women described the relationship as evolving. For Rachel, this change in the relationship was positive whereas for Kathleen and Trichster in Toronto, the relationship was described as changing for the worse.

The literature on family relationships and family functioning of individuals with trichotillomania is scarce. Of the available literature, the focus has been on the personality types of the parents. I am not aware of any studies that have examined the relationship of individuals with trichotillomania to parents and siblings. One study by Delgado and Mannino (1969) suggests that the family of an individual with trichotillomania might be one in which the mother is the decision-maker and the father is less involved. This family dynamic is also noted by Greenberg and Sarner (1965). Greenberg and Sarner report that,

The family structure in many cases was characterized by reversal of parental role-playing. Mothers were highly ambivalent and aggressive, fathers passive and inadequate. A mother-daughter mode of interaction, fraught with mutual dependency and provocation is described and characterized as a “hair pulling symbiosis.” (p. 489)
An additional, more recent study, though not specifically addressing family functioning of individuals with trichotillomania, does shed some light on the types of family and the interactions of family members. In their study investigating the relationship of violence and trichotillomania, Boughn and Jaarsma Holdom (2003) found that, “in most cases, the onset of trichotillomania correlated with violence occurring in childhood. Of special interest is the significant association of family chaos during childhood and the development of TTM” (p. 169). Given the conclusions of the Boughn and Jaarsma Holdom study, it would seem that the family relationships of these women with trichotillomania were significantly damaged and could possibly be described as dysfunctional.

In my study, the dynamics of the families of origin of the participants vary. Also, in my examination of the TTM literature, what becomes clear is that there has been no determination of how these various aspects of family dynamics influence the development of trichotillomania.

*Styles of communication.*

The women in the present study identified three styles of communication: non-confrontational, verbal aggression, and denial. The non-confrontational pattern was reported by Claire, Shanna, Marion, and Trichster in Toronto. For these women, the non-confrontational pattern was instantiated by the shielding of the children from problematic family issues and the parents taking the role of primary decision-makers. However, for Marion and Trichster in Toronto, there seemed to have been a shift as they grew older, when discussion and negotiation were added to the communication style of the family. For Natalie, Samantha, Cindy, and Penny, verbal aggression was characteristic of how the families
managed their conflicts. These women indicated that dealing with conflicts involved yelling to get one’s point across.

In Rachel and Kathleen’s experience, a pattern of denial was exhibited by the parents in dealing with conflict in the home. Rachel’s family was very concerned about appearing to be the ideal family, and this was accomplished through denial (see the excerpt from Rachel’s interview on (page 102). Similarly, in Kathleen’s family, her father responded to conflict and crises by denying that things were as bad as they really were.

The women also spoke about who they could turn to for support during moments of conflict and crisis. All of the women except Penny indicated that there was at least one person that they could turn to during difficult times. Penny was the only woman who said that she had had to learn to rely on herself.

In the literature on trichotillomania, there are no studies specific to the area of styles of communication. However, early studies have demonstrated that over involvement of the family and patterns of communication between family members play a role in trichotillomania. Glaski (1983), for example, suggests that the family environment of his two patients were such that the mother was overly involved in the lives of her children under the guise of protecting them from the dangers of the outside world. According to Glaski:

> It could therefore be hypothesized that Lucy’s [one of his patients] trichotillomania was an incidental symptom of her co-morbid condition, which centered upon her maladaptive responses to “needs not being met” as a result of the inadequate parenting she considered that she had received and her consequent dysfunctional relationships. (p. 257)

Having said this, it is interesting that the women in my study identified a variety of styles of communication that are not unique to this particular group. Indeed, these styles are
commonly found associated with other psychiatric conditions and are not necessarily predominant in the families of individuals with trichotillomania. Nevertheless, regardless of which patterns were described by the women, style of communication was identified as an important issue in their childhood environments.

*Early Life Experiences*

The early life experiences described by the women can be categorized into three different types: supportive and healthy, dysfunctional and chaotic, and involving mental health issues of family members. Though the experiences of the women varied, the overall theme is that early life experiences may have influenced the subsequent development of trichotillomania.

*Supportive and healthy.*

Some of the women described an early life that was not a negative experience. Seven of the women (Claire, Cindy, Trichster in Toronto, Penny, Kathleen, Shanna, and Marion) perceive their home environment to have been supportive and family members as having been there for them. In the cases of some of these women, their earlier remarks suggest that their family environment was not entirely supportive and yet the women reported that in general their home environment was supportive and healthy.

In connecting the findings of the present study to the trichotillomania-related literature, there is no research that specifically addresses this issue. Anecdotally, individuals with trichotillomania frequently report that they grew up in supportive and healthy environments. What is clear from the present study is that overall the women reported that there early life experiences were largely supportive and healthy, though at times they
acknowledged that this was not entirely the case. This is interesting because it highlights the complexity involved in attempting to define what contributes to trichotillomania. As the experiences of these seven women illustrate, while the experiences described vary, their early life experiences are perceived as contributing to an overwhelmingly supportive and healthy environment. Having said this, the question is what factors in this kind of environment give rise to the expression of trichotillomania in some and not others.

*Dysfunctional and chaotic.*

Early life was described by 3 participants (Natalie, Samantha, and Rachel) as dysfunctional and chaotic. Circumstances identified by these women include financial instability, emotionally unavailable parents, disorganization, and a critical and non-supportive environment. For these three women, the early life circumstances contributed to an overall negative environment.

It is not known whether specific family problems can be associated with the development of trichotillomania. The literature provides case studies suggesting possible causes of trichotillomania, however, these studies have not specifically focused on the relation between specific types of problems and trichotillomania. Nevertheless, the studies offer some insight into the possible role of these events in the onset of trichotillomania. Many of these studies have already been discussed in Chapter 2 (“Review of the Literature”) and will not be elaborated on in this section; however, two additional studies are worth mentioning.

A study by Chang, Lee, Chiang, and Lu (1991) identifies the primary stressor for their sample of 36 patients as school difficulties. The authors further note that a majority of
their sample had no difficulty identifying a specific stressor for their hair pulling. These results are consistent with the findings of Bhatia et al. (1991) who found that in addition to academic responsibilities, parental dynamics, separation from parents, death, physical illness, and over protectiveness of parents, for example, were identified as important stressors by their participants.

In the present study, the experiences highlighted by three of the women are consistent with what is reported in the literature. In other words, though the specific stressors differ somewhat from what is reported in the literature, all of these described events alter the balance within the family and this seems to contribute to the discovery expression of trichotillomania. This once again highlights the difficulty that is encountered when trying to provide an understanding of the interactions that contribute to the discovery of trichotillomania. Nevertheless, the importance of addressing this issue cannot be overstated and, indeed, it is apparent that little is known about the specific role that early life circumstances play in the development of trichotillomania. One possibility is that trichotillomania is a heterogeneous condition with multiple avenues contributing to its development, and defining particular causal events will be difficult, if not impossible.

*Mental health issues.*

Another factor that was described by the women is mental health issues in self and in family members. Many of the women had been diagnosed with other psychiatric disorders, namely, depression, anxiety, eating disorders, obsessive compulsive disorder, and Tourette’s disorder. As well, seven women (Natalie, Rachel, Samantha, Kathleen, Shanna, Marion, and Penny) reported that members of their families had been diagnosed with depression, anxiety, or obsessive compulsive disorder. Substance abuse was also identified as an issue.
The literature on mental health issues in individuals with trichotillomania suggests that the two most common disorders are depression and anxiety (Christenson, 1995). Other psychological disorders that co-exist with trichotillomania include other mood disorders (e.g., dysthymia, bipolar disorder not otherwise specified), psychotic disorders, other anxiety disorders (e.g., panic disorders, obsessive compulsive disorders, phobias, and generalized anxiety disorder), substance abuse, eating disorders, and tic disorders (Christenson, 1995). As well, Cohen et al. (1995) report that among their subjects with trichotillomania, 15 % also had anxiety disorders, 14 % had depressive disorders, 13 % had obsessive compulsive disorder, 7 % had substance abuse disorder, 3 % had bipolar disorder, and 1% had schizophrenia. These findings are consistent with other studies that show that other psychological difficulties are present in individuals with trichotillomania.

With respect to mental illness and family members, the present findings are consistent with the literature. For example, in a study by Cohen et al. (1995) of the families of people with trichotillomania, 29% of family members were found to have substance abuse disorders, 20% depressive disorders, 10% anxiety disorders, 7% obsessive compulsive disorders, 7% schizophrenia, and 5% bipolar disorder. Other family studies have shown comparable results, particularly with respect to the rate of obsessive compulsive disorder (Lenane et al. 1992; Swedo & Leonard, 1992). What is less clear is how a family member’s psychiatric illness impacts the rest of the family. The literature on the relationship of psychiatric illnesses and family suggests that it is an overwhelmingly challenging matter, for both the individual with the psychiatric illness and his or her family. Regardless of the diagnosis, feelings of anger, frustration, emptiness, and grief are the norm. For example, living with someone with obsessive compulsive disorder means having to endure rituals or compulsions without fully
understanding the purpose of these acts. The person with the OCD may want to participate in family events or social activities but be unable to do so because he or she can’t control the rituals or compulsions. Family members may try to be understanding but quickly lose patience. Given these challenges, it is not unreasonable to suggest that the impact of mental illness on family members is enormous.

Clearly, in the present study, the experiences of the women are consistent with the findings in the literature. Psychiatric conditions are present in the family members of many individuals with trichotillomania suggesting that mental health issues in family members play a role in the journey of discovering hair pulling.

**Traumatic stress.**

Seven women (Trichster in Toronto, Rachel, Natalie, Penny, Samantha, Marion, and Shanna) described a number of experiences that fall under the category of traumatic stress. For example, sexual, physical, and, in particular, emotional abuses were identified as being important factors in the experiences of these women. Though the type and intensity of traumatic stress varied among the women, they nevertheless described experiences that can be categorized as traumatic.

In recent years, traumatic stress has been associated with a number of psychiatric disorders including: self-cutting and other self-injurious behaviors (Berger, 2003; Favaro et al., 2007), depression (Brown & Moran, 1997), and obsessive compulsive disorder (Cormier, Schmidt, & Murphy, 2007), to name just a few. Traumatic stress, in particular, sexual and physical abuse, and its impact on the individual has been well documented. In general, studies suggest that individuals who experience sexual abuse as children are at an increased
risk of developing psychiatric illnesses as adults (Fergusson, Horwood, & Lynskey, 1996; Hutchings & Dutton, 1997). Much of the work that has been done examining the relationship between risk factors and the development of a psychiatric disorder has been in the area of anxiety disorders (Kessler, Davis, & Kendler, 1997; Raskin et al., 1989). However, questions still remain about the causal relationship. According to Kessler et al. (1997):

The effects of childhood adversity on initial disorder onset and subsequent course have not been distinguished in most previous studies. This has created uncertainty regarding causal pathways. One widely held notion is that childhood adversities create enduring intrapsychological vulnerabilities that create heightened emotional reactivity to adult stress (Harris et al. 1990). Loss events early in life, for example, might lead not only to early-onset depression but also to disturbed attachment styles that create a depressogenic reaction to loss events throughout life. If this is so, though, we would expect that childhood adversities are associated not only with risk of lifetime psychiatric disorder but also with illness course. (p. 1102)

With respect to the role of traumatic stress in trichotillomania, studies have not conclusively established that trauma causes trichotillomania. Several investigators have suggested that trauma plays a role in trichotillomania (Boughn & Jaarsma Holdom, 2003; Lochner et al., 2002; Singh & Maguire, 1989). However, this association was not found to hold in a 1992 study by Christenson, Mackenzie et al. Recently, a study by Gershuny et al. (2006) examined the issue of trauma and post-traumatic stress disorder among 42 individuals with trichotillomania being seen at the Massachusetts General Hospital TTM Clinic. Trauma included: “accidents, witnessing violence and sexual violations (in both childhood and adulthood)” (Gershuny et al., 2006, p. 1524). The authors found that 76.3% of individuals seen in the clinic had a history of trauma and 19% met the criteria for post-traumatic stress disorder. In addition, the duration and site of pulling was associated with the number of traumas experienced. “Individuals who experienced two or more types of traumas (compared to those who experienced either no trauma at all or only one type of trauma) more frequently
reported their scalp as the primary hair pulling site and reported longer duration TTM (≥13 years)” (Gershuny et al., 2006, p. 1526).

In the present study, the definition of traumatic stress is broadened to include not only physical and sexual violence, but other types of stress, such as emotional abuse and bullying, as well. Seven of the women identified traumatic stress, in particular, emotional abuse, as being an important factor in their childhood experiences. However, none of the women met the criteria for post-traumatic stress disorder. In the context of my study, the importance of emotional abuse cannot be overstated. What remains unknown is the exact relationship between traumatic stress and trichotillomania, and why the focus is on hair. These are all questions that remain unanswered. What is clear from the present study is that traumatic stress is part of the experience of some women with trichotillomania. This is consistent with the studies mentioned above.

Women’s Responses to the Family Experiences

The circumstances described by the women, provoked two types of responses: silencing the emotional self and changes in perceptions of self. These responses are discussed next.

Silencing the emotional self.

Half of the women in this study described a number of experiences that were categorized as an inability to express their emotional needs to family members. These women learned at a young age that the expression of emotion is unacceptable, and so they developed strategies to cope with their unexpressed emotions. For example, Rachel and Natalie reported that they developed a guarded and wary persona, while Trichster in Toronto struggled with
an eating disorder and multiple suicide attempts. Though this strategy of silencing the emotional self was not adopted by all the participants, it is nevertheless an important aspect of the lives of some of the women in this study.

Dana Crowley Jack (1993) first introduced the concept of silencing the self to refer to the phenomenon of individuals, predominantly women, concealing their emotions, thoughts, and needs in order to maintain the approval of others, in large part due to a cultural definition of goodness. This self-silencing strategy creates a situation in which women feel a loss of self, particularly in interpersonal relationships, that makes them susceptible to psychological difficulties.

Self-silencing as it relates to trichotillomania is not explored in the literature. But the psychological difficulties associated with self-silencing have been well documented for other conditions (e.g., Ali et al., 2000; DeMarco, Johnson, Fukuda, & Deffenbaugh, 2001; Piran & Cormier, 2005). The studies demonstrate a relationship between self-silencing and the emotional well-being and health of women. The experiences of some of the women in this study demonstrate the impact that silencing their emotional self had on their overall childhood experiences. The narrative of Trichster in Toronto highlights the importance of being allowed a “safe place” to speak about feelings without feeling judged or being ostracized. In addition, her narrative highlights the difficulty she and her parents faced in dealing with her sexual abuse together. When Trichster in Toronto was sexually abused as a child she felt unable to speak about her experience. Years later she revealed her abuse to a therapist. Having worked through the psychological ramifications of the abuse with her therapist, she reached a point where she decided to disclose to her parents. According to
Trichster in Toronto, “when I was 18, I came out to my parents: I asked the therapist to tell my parents and we walked out of the office and we never talked about it.”

Trichster in Toronto’s narrative also reveals what happened on occasion, when she did attempt to voice her feelings.

When I started to pull out my hair, I said there was something wrong and my father said, “it’s nothing, don’t worry about it.” When I said, I think I have an eating disorder, I think there is something wrong, my parents felt like it’s nothing, don’t worry about it.

On these occasions, the indifference and failure to explore her concerns left Trichster in Toronto with no other avenue except to silence herself. Consequently, she learned to suppress her needs and concerns for fear of rejection; and felt very much alone. “I felt like an outsider. . . . I didn’t feel like part of the family, especially as an adolescent, when everything kind of came to the forefront.”

The other women also described how they were kept from expressing themselves in the home environment. As noted by Jack (1993), “additional fears that lead women to inhibit their voices are learned from specific experiences within their own families of origin” (p. 139). For example, Rachel learned early that the expression of emotions, particularly her own, was not tolerated in her family. Natalie also spoke about the manner in which she self-silenced, and she acknowledged that there are still situations in which she feels unable or unwilling to address her feelings and needs with others, in particular her mother. In the cases of Samantha and Kathleen, experiences they described suggest that the needs of others were placed before their own. As observed by Jack (1993), “women silence themselves out of fear that their feelings and perceptions are somehow wrong and, if revealed, will give others
reasons to reject them” (p. 138). Interestingly, Kathleen reported that she did not feel less valued in her family but rather the opposite; she felt loved and supported.

**Perceptions of self.**

The women utilized a number of terms to describe themselves. Shanna, Trichster in Toronto, and Samantha referred to themselves as being socially introverted, shy, and a loner, respectively. Kathleen stated that she was the peacekeeper of the family. And others (Penny and Rachel) were at the other end of the spectrum, describing themselves as instigators and inflexible. Trichster in Toronto also perceived herself as a perfectionist, influenced by self and by others.

An examination of the literature reveals that the relationship between perception of self and hair pulling has not been formally addressed. The literature has instead focused on personality traits of individuals with trichotillomania. The association between different personality traits and trichotillomania is still not fully understood, although several studies have suggested that personality disturbances in individuals with trichotillomania are quite common (Schlosser et al., 1994; Swedo & Leonard, 1992). For example, Christenson, Chernoff-Clementz, et al. (1992) report that 42% of the trichotillomania patients in their study met criteria for a personality disorder; however, the authors were unable to attribute a specific personality type to women with trichotillomania. As well, the authors note that individuals with trichotillomania who present to psychiatric clinics seem to be more psychologically well-adjusted than other psychiatrically defined groups.
Theme 3: Relationship Between Specific Experiences and the Discovery of Hair Pulling

Respondents were asked about a potential relationship between the circumstances they described and the discovery of hair pulling. Two subcategories emerged: stress and a shift. Given that this is the first study to examine this issue, the trichotillomania-related literature has little to say about it. Nevertheless, there are two important issues that emerged from the study that must be addressed.

Stress

Natalie, Claire, Rachel, Shanna, Trichster in Toronto, and Kathleen felt strongly that childhood circumstances or events acted as a catalyst for the discovery of their hair pulling. Indeed, the events that some of the women described suggest that stress was the main factor in the onset of their pulling and it helped to reinforce subsequent pulling episodes. Having said this, there are a number of hair pullers who have a different experience. How then do we explain why some hair pullers engage in pulling during non-stressful periods or why some hair pullers do not associate stress to onset of hair pulling?

The research examining stress and its possible role in hair pulling remains speculative at best. Though anecdotal evidence does suggest that stress exacerbates pulling, and indeed, several authors have noted that for some hair pullers, stress was a precipitant of trichotillomania, the exact association between the two remains unknown (e.g., Christenson & Mansueto, 1999; Penzel, 2003).

Given these research findings and the extensive research on the influence of stress on the development of other psychiatric disorders, it should not be surprising that stress has a
role in the onset of hair pulling. Six of the women in this study agreed that stress and trichotillomania are related. In addressing this issue, Penzel (2003) offers this unique perspective:

All human beings are constantly receiving stimulation from their environment. If this stimulation is too great, it results in stress. If it is too low, the individual falls into a state of sensory deprivation. In order to function at an optimum level, we all need a certain level of stimulation that is neither too high nor too low. . . . In disorders such as TTM, because this mechanism is no longer working properly, the individual is forced to try to find a way to manage it externally. (p. 69)

A Shift

Marion and Cindy indicated that the events that occurred at the onset of the hair pulling precipitated what could be described as a shift. There was an internal shift resulting from an external event that led to the women becoming more aware of their hair and more focused on it. Marion’s experience provides an example of how this works: an infestation of lice made her more focused on her hair. Cindy, likewise, stated that for her there was a shift from wearing mascara to a focus on the hair (i.e., lashes).

This is consistent with anecdotal evidence that indicates that, at least for some hair pullers, there are identifiable precipitants that led to a shift to a focus on the hair that facilitated the development of hair pulling. However, the TTM literature does not address this issue of a shift. Nevertheless, the experiences of the two women outlined suggest that there is an association between a shift of focus to the hair and the development of trichotillomania.

One woman in the study, Penny, attributes her pulling to her attention deficit disorder. Her experience highlights the relationship between pulling and the ability to concentrate.
Samantha had difficulty connecting an event or circumstance to the onset of her hair pulling. She summed up her response:

I kind of feel like it’s just a mix of nature or nurture and circumstances. I don’t think that I would have developed something else or I hope not anyway. I would have just found a different, possibly more healthy coping tool.

**Theme 4:**

*The Role of Hair Pulling*

The women described four important roles of hair pulling: first, as a means of coping; second, as a catch-22; third, as a behavior or response that was out of their control and fourth, as an avenue for regaining control. Regardless of how the women described the role of hair pulling in their lives, all of them indicated that they felt that it served a purpose. They further indicated that they felt that the hair pulling was an out-of-control behavior and that although they might on occasion have some control over it, they acknowledged that more often than not the hair pulling was out of their control.

*A Means of Coping*

Seven of the 10 women indicated that compulsive hair pulling was used as a means of reducing the anxiety and tension they felt in response to stressful events. For Claire and Penny, hair pulling was characterized as a means of coping with a medical condition. However, the two differ in the exact manner in which hair pulling facilitated the process of coping. For Claire pulling alleviates the stress and anxiety resulting from the emotional complications of Tourette’s disorder. Penny, on the other hand, uses it as a means of coping with attention deficit disorder: pulling increases her ability to focus. Though both women
said that hair pulling helps them deal with their medical issue, the means by which it does so are conceptually different.

A means of coping also arose from the self-soothing and comforting aspects of hair pulling. Trichster in Toronto indicated that it helps her focus and deal with emotional upsets. Samantha spoke about how her hair pulling helps her understand and appreciate when she is having a particularly stressful time. For Kathleen, hair pulling can act as a comforter by allowing her to escape difficult situations for a moment to allow her to find a way to deal with whatever is going on.

Hair pulling as a coping mechanism has not been specifically researched. As previously discussed and again worth mentioning, several studies have suggested that stress plays an important role in the exacerbation of hair pulling and that pulling is in part used as a means of dealing with stressful life events (Diefenbach et al., 2000; Keuthen et al., 2001; White Kress, Kelly, & McCormick, 2004). However, this does not fully explain why individuals use hair pulling as a means of coping. Stress is a common experience and each one of us has encountered situations that we would define as stressful, however, not all of us use hair pulling to respond to this experience. What then causes someone to pull as a mean of coping?

Some investigators have documented the association of extreme forms of stress, such as a history of abuse, and trichotillomania (Boughn & Jaarsma Holdom, 2003; Gershuny et al., 2006; Lochner et al., 2002). It is reasonable to assume that individuals with a history of trauma, in particular, an abuse history, would develop coping strategies to minimize their internal and external upsets (Gershuny et al., 2006). Stress in general, arising from difficult
but not necessarily traumatic events, has been associated with other psychological and physical disorders. According to Matthieu and Ivanoff (2006), “the stress response begins with a stressor, which is defined as any real or imagined event, condition, situation, or stimulus that instigates the onset of the human stress response process within an individual (Everly & Lating, 2002)” (p. 21). As well, how an individual copes with a stressor is dependent on a number of factors including how they appraise the situation and the resources available to them (Folkman & Lazarus, 1980).

Anecdotally, hair pullers have reported that their trichotillomania is a coping strategy, that it helps to alleviate the unpleasant feelings associated with distress and trauma. A recent study by Shusterman, Feld, Baer, and Keuthen (as cited in Anestis, 2009) also suggests that at least for some individuals with trichotillomania, hair pulling is used as a means of regulating emotions, particularly negative emotions. Thus the very emotion that the pulling serves to regulate becomes itself a precipitant to the pulling (Shusterman et al., as cited in Anestis, 2009). “In other words, if an individual who pulls his hair struggles to regulate feelings of boredom, then boredom is likely to be a particularly salient cue that prompts him to pull his hair” (Anestis, 2009, para. 7). In addition, a recurrent theme in the literature about precipitating events and triggers is that trichotillomania is often exacerbated by stress (e.g., Christenson & Mansueto, 1999; Keuthen et al., 2001; Penzel, 2003). Regardless of the possible precipitants of trichotillomania, the descriptions highlight the role that pulling plays in helping the women in the study cope with stress.
**Catch-22**

A second subtheme related to the role of hair pulling is the issue of whether the pulling is both helpful and unhelpful to the women, described as a catch-22 situation. The women reported that hair pulling is temporarily helpful in alleviating the distress and emotional upset of stressful life events. In addition, Marion, Penny, Kathleen reported that when they engage in hair pulling, it gives them a purpose, it is productive. To quote Kathleen, “I feel like I’m doing something productive when I’m pulling. Afterwards, I’m more focused and can get on with the other work that needs to be done.” But Cindy, Trichster in Toronto, Rachel, Claire, Samantha, Natalie, and Shanna view hair pulling as an unhealthy way of dealing with worries.

Additionally, all of the women spoke about the negative aspects of pulling. In particular, the consequences of pulling, for example, the changes in appearance due to pulling, and the interference with day-to-day living were some of the difficulties that the women reported. Natalie, for example, spoke about the difficulties that arise when her mother notices that she had pulled. Others indicated that although they do not let their hair pulling interfere with social situations, they are self-conscious and uncomfortable in situations in which it might be noticed. Kathleen, for example, remarked that on occasion she finds herself sitting in her office, pulling, and terrified that someone will walk by and notice. For her, her hair pulling conflicts with her need to maintain a professional image at work.

The literature does not specifically address the issue of whether or not hair pullers find their behavior helpful or unhelpful. Indeed, I am not aware of any study that examines this issue. Anecdotally, some hair pullers do describe some positive aspects of hair pulling,
particularly in helping to reduce their anxiety and deal with stressful events. For these hair pullers, there is a self-soothing aspect to their behavior. However, all hair pullers can identify the negative consequences of trichotillomania. Generally, these consequences are associated with the social functioning of the individual and, in part, with self-acceptance. Hair pullers may avoid developing relationships, choosing instead to remain alone for fear of rejection and ridicule. They may never marry, or if they do, they may conceal their hair pulling from their spouses (Penzel, 2003). In addition, school, work, and career aspirations can be affected by the hair puller’s fear of discovery. These issues in turn significantly impact how individuals with trichotillomania feel about themselves. Low self-esteem and shame, for example, are just some of the difficulties that hair pullers experience. This topic is addressed more fully in a later section, “The Journey of Hair Pulling.”

**Out of My Control**

A third subtheme related to the role of hair pulling is the lack of control that Natalie, Claire, Rachel, Trichster in Toronto, Shanna, Marion, Cindy, and Kathleen reported having over their behavior. Excerpts highlighted in other themes of this study suggest that the women do have some control over their hair pulling, in particular, when and where they pull, but overall the experiences they described seem to suggest that there is also a lack of control in the sense that they cannot permanently stop their pulling. In addition, Natalie, Claire, Rachel, and Shanna offered biological and genetic explanations for their hair pulling. This implies that hair pulling is out of their control and that although, on occasion, all of the women are able to implement strategies to minimize their pulling, this seems to be momentary or limited over the long term.
The lack of control experienced by hair pullers is evident when one takes a look at the overwhelming number of individuals who have been unable to stop their hair pulling. The experiences of the eight women in this study who reported that they were unable to completely control their hair pulling are consistent with the TTM literature. Hair pulling is overwhelmingly a chronic condition. In addition, the specific issue of a lack of control over pulling has been formally addressed in the study by Casati et al. (2000). In that study, participants indicated an inability to control hair pulling and a lack of awareness of when they are pulling. Though the literature does report on the success some individuals with trichotillomania have had in stopping their pulling, investigators have also highlighted a “waxing and waning” pattern that is characteristic of trichotillomania (Christenson, Mackenzie, & Mitchell, 1994). Complicating this issue is the matter of focused versus unfocused hair pulling (Christenson & Crow, 1996; Penzel, 2003). Several investigators, for example, have reported that many individuals with trichotillomania are engaged in unfocused or automatic hair pulling, while a minority are engaged in focused pulling, i.e., are aware of what they are doing (Christenson & Mackenzie, 1994). It is reasonable to assume that at least for unfocused pulling, there is a lack of control of the pulling.

In the present study, the experiences of eight of the women also indicate a lack of control. As well, the descriptions highlight a growing array of literature emphasizing the varied ways in which lack of control is characteristic of trichotillomania. Many factors have been implicated as potentially contributing to the development of trichotillomania and while the descriptions of these women provide further evidence of the biological, genetic, and addictive aspects of trichotillomania, they also highlight the complex relationship that is
undoubtedly evident among these factors. As one woman remarked, “if I knew how to stop it, I would.”

**An Avenue for Gaining Control**

The final subtheme categorized under the role of hair pulling for participants is an avenue for gaining control. Seven of the 10 women indicated that for them gaining control includes developing strategies that enable them to stop pulling, maintaining specific pulling sites, and finding motivation to stop pulling. Marion, Cindy, Penny, and Samantha reported developing and engaging in strategies that enable them to limit or minimize their pulling. Physical acts of distraction, for example, including going on vacation, keeping busy with housework, typing class notes verbatim, and cutting the hair. All of these strategies enabled the women to gain some control over their pulling through a disruption of the hair-pulling cycle. Overall, the descriptions presented by these women reveal that while they are able to control it to some degree, they are not able to completely stop the pulling. Samantha summed this up by stating: “It’s not controlled but it’s much more controlled than maybe in the past.”

Maintenance of specific pulling sites was reported by Rachel, Cindy, and Claire as an important strategy for gaining control. These women indicated that they pull from a specific area and that the pulling is regulated to this area. They also said that in all the years of pulling they had never pulled their scalp hair, which would be more noticeable. “I’ve talked to people who have pulled from their head and their eyelashes and other spots, and I mean people who swallow their hair, I’ve only ever been eyebrow,” reported Rachel. The women who reported maintaining specific pulling sites feel that this represents a degree of control over their pulling. Their sense of gaining control was also evident in their perception that
because they were pulling in sites where it is less conspicuous than pulling from the scalp is, they had some control over the effects of their trichotillomania.

Motivation was described by Rachel and Cindy as an important factor in gaining control. An upcoming special event or visit from relatives was identified as motivation to temporarily stop pulling. The event or visit was usually scheduled months in advance, which enabled the participants to actively plan to disrupt the pulling cycle. Interestingly, though gaining control for Rachel and Cindy was driven by motivation, it was short lived. Once the special event or visit from relatives was over, the women reverted to pulling.

It doesn’t appear that this subtheme, An Avenue for Gaining Control, as it is outlined above, has been specifically investigated in the trichotillomania literature. The literature does address the issue of strategies employed by individuals to minimize their hair pulling. Wearing a scarf, putting on a hat, tying up the hair, for example, are some strategies used by individuals with trichotillomania to reduce pulling (Christenson, Mackenzie, & Mitchell, 1991; Penzel, 2003). Physical and competing distractions have also been utilized to limit opportunities for pulling (Keuthen et al., 2001). In the Christenson, Mackenzie, and Mitchell (1991) study, adults with trichotillomania reported a number of different physical strategies, including removing themselves from potentially risky situations (e.g., watching television or reading) and engaging in other activities so as to minimize the time that they spend “hands free.”
Theme 5:
The Journey of Hair Pulling

In this section, the journey of hair pulling is characterized by five subthemes: How I Feel About My Hair Pulling, Self-Esteem and Other Psychological Difficulties, Stigma, Self-disclosure, and Acceptance of Self. The study participants shared what it feels like to have this condition. Individuals with trichotillomania are often reluctant to share their experiences of trichotillomania. Indeed, it is particularly difficult for people without trichotillomania to fully understand the struggles and feelings of shame and embarrassment that hair pullers experience.

How I Feel About Myself

It has been well documented that trichotillomania has a significant impact on how hair pullers view themselves. Anecdotal evidence suggests that individuals with trichotillomania view themselves as unattractive, have significant body image issues, and feel shame and embarrassment. People with trichotillomania also experience anger, at times directed towards self and on occasion towards the condition. Cindy, for example, is angry at herself for her inability to stop her pulling. She spoke about the struggles and challenges that she faces as a consequence of pulling. This was echoed by Trichster in Toronto and Shanna who both described the anger they feel when they see the consequences of their pulling. Conversely, Natalie is angry that the condition even exists. Penny and Marion spoke about the embarrassment associated with trichotillomania. For Rachel, shame is predominant in her feelings about her hair pulling. Rachel also spoke about not feeling normal because of her pulling. This was echoed by Samantha who said that pulling is unhealthy and abnormal. All of the women used negative terms to describe how hair pulling makes them feel. In addition,
all of the women spoke, directly or indirectly, about “turning back” the hands of time to a point before their hair pulling began. “I wish I didn’t have this,” is a theme that was echoed in the interview with each woman.

Research on the role that trichotillomania plays in how people feel about themselves suggests that it should not be surprising and indeed it is to be expected that hair pullers feel emotional distress. Previously mentioned studies, for example, Casati et al. (2000) and Townsley-Stemberger et al. (2000), clearly demonstrate that hair pullers experience negative emotions and interpersonal difficulties. In addition, other investigators (e.g., Keuthen et al., 2001; Penzel, 2003) also provide descriptions of the shame, embarrassment, and emotional pain experienced by individuals with trichotillomania. For the most part, hair pullers lead relatively normal lives; however, they continue to struggle with the need to conceal their secret. The experiences of the women in this study exemplify the struggle and challenges faced by many hair pullers, particularly with respect to how hair pulling makes them feel about themselves.

**Self-Esteem and Other Psychological Difficulties**

The second subtheme related to the journey of hair pulling is Self-esteem and Other Psychological Difficulties. The women in this study acknowledged having low self-esteem, though many indicated that they function relatively well. That is, for some of the women, low self-esteem is not perceived as having a significant impact on their lives. For example, Shanna stated that her hair pulling prevents her from swimming, however, she doesn’t swim and therefore, she feels that hair loss doesn’t really influence her decisions about the activities she engages in. Samantha reported that negative emotions influence her hair
pulling and that if these emotions are under control, then she is less likely to pull her hair. Claire offered a different perspective on this issue. For her, negative emotions are the result of being prevented from pulling. If she is able to engage in pulling, this helps alleviate her tension and anxiety. Overall, the women in this study consistently described experiences that demonstrate the shame and embarrassment that hair pulling causes them and the influence it has on their self-esteem.

The women also described other psychological difficulties. Trichster in Toronto spoke about her other diagnoses: eating disorder, depression, and anxiety. Rachel indicated that she also has obsessive-compulsive disorder. Penny reported that she has problems with depression and generalized anxiety. Samantha and Kathleen also described some other difficulties, however, for them, these difficulties also directly influence the pulling. Kathleen, for example, indicated that when she is anxious, she tends to pull more. For Samantha, when her depression is not being well managed, she notices because she tends to engage in more pulling.

In the TTM literature, several studies suggest that low self-esteem is common among individuals with trichotillomania (e.g., Casati et al., 2000; Keuthen et al., 2001; Townsley-Stemberger et al., 2000). According to Penzel (2003), self-esteem is particularly problematic for hair pullers because the psychosocial complications of the condition make it difficult for them to maintain good self-esteem. For example, embarrassment, shame, and the visible signs of pulling directly contribute to a negative sense of self. However, Penzel argues that given the complexity of human beings it is difficult to attribute self-esteem to any one factor. “Each individual is made up of thousands of different traits and characteristics. The idea of singling out any one of them, such as hair pulling, and rating your entire self as good or bad
because of it, is absurd (Penzel, 2003, p. 36). Indeed, a review of the literature with respect to self-esteem in conjunction with hair pulling reveals that low self-esteem is not consistently found among sufferers of trichotillomania. For example, the study by Soriano et al. (1996), which systematically examined self-esteem in a sample of women with trichotillomania, found that overall there is no direct correlation between specific factors associated with trichotillomania (such as age of the participant, age of onset, duration of pulling, severity of hair loss, history of remission, and treatment) and low self-esteem. Indeed, the people in this study reported medium levels of self-esteem. Clearly, the relationship between trichotillomania and low self-esteem is an issue requiring further research.

It should not be surprising that hair pullers exhibit psychological distress given the relationship between shame and embarrassment and trichotillomania. The visible consequences of pulling (e.g., hair loss and bald spots) can be expected to impact the hair pullers’ overall sense of themselves. The participants in this study spoke to this issue by highlighting that low self-esteem and other psychological difficulties are common aspects of living with trichotillomania.

**Self-Disclosure**

The third subtheme is Self-Disclosure, defined as the willingness of the hair puller to reveal and/or discuss the condition with others. This can be daunting. Self-disclosure experiences vary: some hair pullers freely disclose and others conceal the hair pulling. In the cases of Natalie, Shanna, and Trichster in Toronto, there were instances where they had disclosed to peers, however, overall this was not something they actively engaged in. In contrast, Penny, Kathleen, and Rachel spoke about needing to conceal their pulling.
Interestingly, for Claire, self-disclosure was a proactive action designed to alleviate potential problems, for example, discrimination at work. She acknowledged that her self-disclosure is partly due to past discrimination and the complications of her diagnoses of trichotillomania and Tourette’s disorder. However, Claire also described being “outed” by someone she did not know, and feeling angry. Conversely, Marion and Kathleen reported that self-disclosure in the workplace would not be appropriate for them given the importance of appearance in their chosen professions. Revealing their secret to family and, in particular, close friends did not necessarily result in negative reactions. Marion had only recently disclosed her trichotillomania to her mother. Cindy had disclosed to her family but the topic is avoided among them. Overall, self-disclosure seems to be an individual decision, not necessarily taken by all. Samantha, for example, to this day, has never disclosed to her family that she is a hair puller.

The issue of self-disclosure and trichotillomania has been addressed by relatively few investigators (Casati et al., 2000; Marcks, Woods, & Ridosko, 2005; Penzel, 2003). Nevertheless, as evidenced by the experiences of the women in the present study, disclosure appears to be dependent on a number of factors. For example, the relationship with the person to whom you are disclosing, the reaction of others, and choice were all significant factors that help to determine whether the women would self-disclose. The experiences of these women suggest that self-disclosure is not the norm. Indeed, what little is known about self-disclosure and trichotillomania does seem to suggest that those with the condition do have legitimate concerns. A study by Marcks et al. (2005) that examined the effect of self-disclosure on peer perceptions notes that, “it led to an increase in negative social perceptions compared to non-disclosure” (p. 304). Interestingly, the authors note that, “while disclosure
decreased the positive social perceptions, the overall perceptions were not negative" (Marcks et al., 2005, p. 304). Thus, given what we already know about the psychological complications of trichotillomania and society’s obsession with beauty, it should not be surprising that there is reluctance to disclose.

**Stigma**

The fourth subtheme, Stigma, was discussed by Natalie, Penny, Cindy, Samantha, Marion, Kathleen, Trichster in Toronto, and Rachel. Concealment of the hair loss was one method utilized to avoid stigma. Concealment ranged from refusing to leave the house without eyeliner to wearing the hair a specific way to cover up hair loss. Natalie and Penny, for example, reported that they routinely cover up the results of their pulling. In their cases the texture of their hair makes it difficult, if not impossible, for others to know that they are hair pullers. As Natalie stated: “If you passed me on the street, you would never know.”

Attempts to avoid the stigma attached to hair pulling also led to the avoidance of activities that would increase the likelihood of discovery. Cindy, for example, stated that she avoids the dentist because she feels that the loss of her eyelashes and eyebrows would be more noticeable given the close proximity dental work requires. Conversely, Penny indicated that the hair pulling and resulting hair loss does not prevent her from participating in activities; however, as she got older, she became increasingly anxious and fearful about being discovered. In addition, when the hair loss is noticed, Penny and Samantha acknowledged that they offer plausible, false explanations for it. For example, they both reported having used the story that they had gotten gum in their hair to explain a bald patch in order to avoid revealing the hair pulling.
Participants also described a number of other strategies that help to reduce the stigma of trichotillomania. As discussed in Chapter 3, under the heading “The Women: Brief Biographies,” a significant number of the women chose to participate in this study to bring awareness to this condition in hopes that this would lessen the shame and stigma of hair pulling. In addition, Claire took a proactive stance with respect to getting accommodations in her job she needs because of her trichotillomania and Tourette’s disorder. Conversely, not all the participants have chosen to engage in actions that would help to dispel the stigma associated with trichotillomania. For some (e.g., Kathleen and Marion), their chosen profession makes it difficult to actively take a stance. Rachel noted that an attempt had been made by a therapist to connect her with another individual with trichotillomania. They spoke only once, via telephone, but the shame was too overwhelming and they both preferred to remain alone. Another participant, Trichster in Toronto, stated that it is much easier to talk to others about her other problems than it is to discuss her hair pulling. There is too much shame associated with hair pulling.

The existence of stigma has been well documented in the literature, particularly with respect to mental illness in general (Corrigan, 2004; Corrigan et al., 2000; Overton & Medina, 2008). It is widely accepted that individuals with a mental illness are stigmatized in society (Overton & Medina, 2008). In recent years, however, the expanding clinical literature on various psychiatric disorders and the increasing number of individuals with mental health difficulties who are sharing their stories with others, suggests that the stigma associated with mental health difficulties is starting to fade.

Trichotillomania is very much a stigmatized condition. “I believe that it would be an understatement to say that TTM is, for a majority of sufferers, a disorder of shame, silent
agony, inner grief, and isolation” (Penzel, 2003, p. 31). Though the stigma associated with trichotillomania has not been well documented, several studies have highlighted the interpersonal difficulties of individuals with trichotillomania (Casati et al., 2000; Penzel, 2003; Townsley-Stemberger et al., 2000). The experiences described above provide evidence that is consistent with the informal accounts of day-to-day living with trichotillomania. Also, though the literature reveals how individuals with trichotillomania perceive themselves, a study by Boudjouk et al. (2000) reports that trichotillomania is less socially accepted than tic disorders. Shame, embarrassment, fear of discovery, and society’s idea of beauty all work together to stigmatize trichotillomania. Indeed, Penzel (2003) argues that because the damage resulting from trichotillomania is self-inflicted, it is difficult for family, friends, and even society to comprehend the behavior, much less respond with empathy.

The obvious result of such a situation is for TTM sufferers to jump to the conclusion that they are weak and defective human beings and to blame themselves, and for others to also see it as their fault in some way. (Penzel, 2003, p. 31)

Given how individuals with trichotillomania view themselves, and how they are often viewed by others, it should not be surprising that there is a stigma attached to the condition. The experiences of the women in this study highlight the varied aspects of this connection and suggest that the stigma attached to hair pulling continues to foster a negative perception among sufferers, one of self-loathing and self-hatred.

**Acceptance of Self**

The final subtheme in the journey of hair pulling is Acceptance of Self. In general, the women in this study have more or less accepted their hair pulling. They have learned to distinguish their trichotillomania symptoms from their identities. In other words, they have
defined themselves as first and foremost people, and second as hair pullers. Claire and Natalie provide examples of this. For Claire, the idea that others may view her negatively does not seem to affect her: “I figure if someone doesn’t like the way I look, too bad.” Natalie revealed acceptance of self by stating that for her there is no avoidance of the fact of her pulling and, for example, she doesn’t hide the hair loss from her partner. For both of these women, acceptance of self has resulted in a lack of concealment.

Another factor involved in acceptance of self is the number of years respondents had been living with this condition. Many had started pulling in late childhood. Overall, they had been living with trichotillomania for a significant portion of their lives. Natalie, for example, has engaged in pulling for a relatively long time, and as such, for her, acceptance of self is due in large part to resignation to the condition. Samantha, likewise, accepts herself because it is the only thing to do. According to her, “What do you do with things that you can’t control and can’t change; you either accept them or go insane.” Acceptance is not necessarily wholehearted. Rather they continue to struggle with the consequences of their pulling. Shanna, for example, stated that she struggles with accepting her hair pulling. Because of the duration of her pulling, she does accept it as an aspect of herself; however, she also acknowledged having difficulty resigning herself to her situation.

Support of family and friends is another important factor in self-acceptance. The more support the women received the more likely they were to accept themselves. Keuthen et al. (2001) offers this advice to family and friends of hair pullers:

> We all have problems of our own that we expect our partners to accept and learn to live with. The sooner you adopt this same stance for the hair pulling, the sooner you will be helping your loved one as well as yourself. It is important that you accept, but not resign yourself, to your loved one’s hair pulling. (p. 164)
This theme is echoed in the experiences of Rachel, Cindy, and Penny. The support from their intimate partners is a significant factor for Rachel and Cindy and makes the process of acceptance of self somewhat easier. For Penny, the support of the general public makes it easier for her to accept herself and her pulling behavior.

Acceptance of self is also related to the process of being open and educating others about the condition. Indeed, when the women were asked in the follow-up interview to outline the reasons for their participation, an overwhelming majority stated that they wanted to provide public education about trichotillomania in addition to furthering research in the area. Participation in this study, i.e., volunteering to tell their stories, was another way for the women to further their acceptance of self.

Acceptance of self is a difficult and complicated state to achieve, particularly for hair pullers. To accept yourself means to accept the hair pulling as an aspect of yourself (Penzel, 2003). It means letting go of the negative emotions that so often accompany trichotillomania. It also means moving forward with your life without continually dwelling on what your life might have been had you not engaged in hair pulling (Penzel, 2003).

According to Penzel (2003):

> Given the nature of society’s response to hair pulling, its emphasis on perfect appearance, and the effects upon us of social conditioning, it is not surprising that so many fall into this trap, and choose to respond in self-disturbing and extreme ways. (p. 43)

In the present study, the women’s experiences highlight the various aspects of acceptance of self. “I’ve had this for so long, I don’t know what it’s like to be any other way, and I’ve learned to accept it as part of me,” was echoed in the descriptions of these women. Overall, their accounts indicate that it is remarkably difficult for a hair puller to go through
the process of acceptance of self, however, not letting hair pulling define you, the length of
time that the person has engaged in pulling, and support of others are all factors that enable
individuals with trichotillomania to move towards accepting themselves and their pulling.

Having summarized the major themes and subthemes and their relationship to the
trichotillomania literature, in the next section I will present the grounded theory model of
trichotillomania. This model is constructed from an interpretation of the themes and
subthemes that describe the women’s recollections of their childhood environment and
experiences on the road to discovering trichotillomania.

**Grounded Theory Model of Trichotillomania**

The primary objective of this study is to provide a detailed qualitative examination of
the early childhood experiences and environment of women with trichotillomania. This study
highlights the complexity of the process of discovering trichotillomania. The analysis clearly
suggests that there is a journey that the women engage in on the road to discovering
trichotillomania. Taken together, the five major themes and related subthemes described
above all contributed to the onset of trichotillomania for each of the women, the underlying
lack of control evident in the lives of the women, and the attempt that each has made to
regain control.

Given that this is the first study to systematically examine the childhood environment
and experiences of women with trichotillomania, more specifically, what events and
experiences potentially influence the onset of hair pulling, I did not begin with a hypothesis.
Rather, the theory emerged from the data. Below I outline the model that emerged from the
present study.
According to Strauss and Corbin (1998), using a grounded theory approach requires one to review the themes and subthemes that emerge from the data, the purpose of which is to identify a “core theme” that explains the findings and ties them all together. As noted by Lincoln and Guba (1985): “Grounded theory, that is, theory that follows from data rather than preceding them (as in conventional inquiry) is a necessary consequence of the naturalistic paradigm that posits multiple realities and makes transferability dependent on local contextual factors” (p. 205). In effect, the model emerged from my analysis of the women’s recollections of their childhood experiences and environment.

The core category that emerged is The Road to Discovering Trichotillomania: The Issue of Control. The women described a number of childhood experiences and circumstances that facilitated their discovery of trichotillomania. These experiences and circumstances include Who I Grew Up with, Family Dynamics, Styles of Communication, Early Life Experiences, and Traumatic Stress. Though the events and experiences described by the women varied, the pulling occurred in the context of a perceived loss of control in the environment. As well, the described experiences and circumstances resulted in a pervasive inability to express themselves, therefore resulting in a silencing of the emotional self. This subsequently contributed to changing perceptions of self. Eight of the women felt strongly that there was an association between hair pulling and childhood circumstances and events. For some the association was attributable to stress whereas for others it was attributable to a shift. Only two of the women felt that there was no association. Half of the women described hair pulling as an avenue to gain control of their situation. Hair pulling became a means to self-soothe, a coping mechanism for the distress and emotional upset they were experiencing. Overall, the women experienced relief when pulling and thus found it to be helpful. In
general, hair pulling served as a coping mechanism; there was a sense that the pulling helped to keep them focused and aided in relieving the stress that resulted from the perceived loss of control. Conversely, the catch-22 and out of control aspects of pulling were also identified by the women as being an important part of the role of hair pulling. The Road to Discovering Trichotillomania ends with the Journey of Hair Pulling. On this journey, negative emotions, the destructive nature of the pulling, self-disclosure, and the stigma associated with the condition were all identified as factors affecting the overall quality of life of the women. But all of the women reported eventually achieving at least some degree of self-acceptance. This was by no means an easy process. Paradoxically, what initially developed in response to a sense of being out of control became itself a contributor to that feeling. This highlights the complexity of trichotillomania and the challenges faced by individuals with this condition.

The model described above seeks to explain the relationship between childhood environment and experiences of women with trichotillomania and their condition. The model also highlights the importance of the childhood environment and experiences on the road to discovering trichotillomania. More specifically, based on the lived experiences of the women in this study, a theory was extrapolated from the women’s reconstruction of their childhood environment and experiences. The stories of the women highlight the direct, and on occasion subtle, experiences that taken together illustrate the perceived loss of control over their environment and experiences. Thus, tracing the various pathways to the discovery of trichotillomania requires an understanding of each of these experiences and the relationship among them.

Having said this, it is also important to note that this theory does not take into account the other factors that may be involved in the development of trichotillomania, namely,
biological factors. It also does not explain why some people living the same experiences do not go on to develop trichotillomania. My intent in this study is not to discount other explanations. Indeed, psychiatric discourse has provided extensive explanations as to the possible factors that may contribute to trichotillomania. However, I would argue that within this discourse there is too little attention paid to the lived experiences of individuals with trichotillomania. In addition, the very fact that a substantial portion of the current literature on trichotillomania continues to highlight psychiatric aspects of the condition suggests a need for a more inclusive explanation of the road to discovering trichotillomania. Many of the women in my study demonstrated great resilience in spite of the difficulties of their past and present situations. As I have illustrated in this study, trichotillomania is meaningful for these women and it is important to understand the feelings that it invokes and the purpose that it serves. Though this study does not specifically address the cultural and social context of hair pulling, it does highlight the importance of addressing these issues when discussing trichotillomania. White Kress et al. (2004) also contend that, “as is true when considering all mental disorders, trichotillomania should be considered in relation to its sociohistorical context” (p. 188). People do not live in a vacuum and, as such, it would not be possible to fully understand trichotillomania without at least acknowledging its cultural and social context. Trichotillomania is shrouded in silence and secrecy, and culture, for example, silences it sufferers further. Society’s emphasis on an ideal standard of beauty (including beautiful hair), and the stigma associated with trichotillomania reinforce the shame associated with pulling. As well, the TTM literature defines trichotillomania as a psychopathological disorder with no regard to the cultural or social factors that may contribute to its expression. Of interest is the fact that until the 1950s, trichotillomania was a
subject for the dermatological literature; then there was a shift in its conceptualization
making it a psychiatric disorder (Bordnick, 1997; White Kress et al., 2004). Pathologizing
hair pullers continues to be common in psychiatric and medical discourses, though not all
investigators agree with characterization. In a letter to the editor of the *American Journal of
Psychiatry*, Friman (1992) outlines his arguments as follows:

> The point of this letter is that at least some (perhaps many) human beings who
> engage in hair pulling are otherwise normal. Many papers on hair pulling (not
> just the one by Dr. Christensen [*sic*] and associates) ignore this well-
documented point and argue that psychopathology is a necessary co-condition
> of hair pulling. I assert that such papers do little to help any hair pullers and
> may actually do harm to those who are otherwise normal. (p. 284)

The experiences of the women that I interviewed provide evidence for Friman’s arguments.
They challenge the assumption that hair pullers are “psychiatrically disabled.” Their stories,
told in their own words, challenge the current conceptualization of trichotillomania by
examining the condition from the perspective of the women living with trichotillomania.

> The model that emerged from my analysis of the data offers a plausible alternative
> explanation for hair pulling and seeks to make a meaningful contribution to this relatively
> understudied area. It does this in a sensitive manner by emphasizing the lived experiences of
> these 10 women.
Chapter 7: Limitations and Implications

In this chapter, I discuss the limitations of this study, the importance of the research, and the implications that the findings have for future research and for clinical interventions. It is important to address these issues in order to put the study findings into the context for which they are intended. This study highlights the importance of examining the childhood and social experiences of women with trichotillomania and it provides further evidence of the contribution of this study to the trichotillomania-related literature.

Limitations

In conducting this study, several methodological limitations are noted. First, a small number of participants were utilized in the study: a total of 10 women agreed to be interviewed. The small sample size makes it difficult to generalize the findings. In addition, it was not possible to fully explore the range of childhood experiences of women with trichotillomania given the relatively small number of women in this study. Therefore, the study findings should be interpreted with caution, particularly in extending these findings to other individuals with trichotillomania. As Corbin and Strauss (2008) point out, qualitative research is not about producing replicable or generalizable findings but rather about obtaining an in-depth understanding of a phenomenon from those living it. “Remember, the primary purpose of doing qualitative research is discovery, not hypothesis testing” (p. 317). That being said, given the overlapping themes that emerged from the data, it is reasonable to assume that the findings of the study accurately represent the subjects interviewed.
Furthermore, the richness of the data and the vast number of experiences presented suggests that the sample size was sufficient for achieving the goal of discovery.

A second methodological limitation of the study is that the participants are all female; male participants were not recruited. My reason for focusing on women with trichotillomania is that it has been well documented that far more women than men are hair pullers (Christenson, Mackenzie, & Mitchell, 1991; White Kress et al., 2004). A consequence of this choice is that it is unknown whether the findings of this study can provide insight into the situation of males with trichotillomania. An area for future research would be to explore the childhood and social experiences of males and examine their various pathways to discovering trichotillomania in order to determine what similarities and differences exist, if any.

A third limitation concerns the lack of diversity in the sample. Ethnically, all of the women self-identified as Caucasian. In addition, the majority of the women were socio-economically advantaged and well educated. On the other hand, the sample is diverse with respect to age. Future studies could extend the findings of this study by thoroughly investigating the issue of childhood and social experiences of women with trichotillomania using a more culturally and socially diverse sample.

A fourth methodological limitation is the retrospective nature of the study. Retrospective research is often criticized because of recall bias: the difficulty that the participant might have in recalling past events; thereby increasing the potential for inaccuracies and distortion of information (Hassan, 2006). Results from this study are based on information from the perspectives of the women and their perceptions of their experiences. Given that experiences do not occur in a vacuum but rather are influenced by
other factors and that these events may be recollected differently by the others involved, it might be instructive to include the perspectives of others, not just the individual affected. That being said, Seidman (1991) points out that, “reconstruction is based partially on memory and partially on what the participant now senses is important about the past event” (p. 67). In the current study the focus has been on the meanings that the women make of their recalled experiences (Seidman, 1991).

A fifth methodological limitation is the lack of control with respect to the diagnosis of trichotillomania. Because all interviews were conducted via telephone, it was not possible to visually confirm that the participant had trichotillomania. Eight of the women reported that they were given a formal diagnosis by a health care professional, while two were self-diagnosed. In addition, the pre-screening interview contained questions intended to confirm the diagnosis of trichotillomania. This method of inquiry has been utilized previously with good results (Casati et al., 2000). And because only 40% of individuals with trichotillomania are formally diagnosed with the condition (Cohen et al., 1995), requiring a formal diagnosis might have eliminated many potential participants. In addition, given the similarities of the participants’ reported experiences, it is highly unlikely that an individual without trichotillomania participated in this study.

Finally, this study was limited in terms of the data collection methods used. As previously outlined, each of the women took part in a 1- to 2-hour semi-structured interview, and most took part in a 15- to 30-minute follow-up interview. They were also asked to complete a single self-report measure (Keuthen et al., 1995). My reasons for utilizing these specific data collection methods are outlined elsewhere (see Chapter 3). As previously mentioned, I wanted to provide the women with a forum in which they could share their
experiences in their own words and voices. TTM research has, for the most part, provided very few opportunities for women to be able to share their stories and the meanings that they bring to them. However, given this limited collection of data, it could be argued that the information gathered limits the validity of the study. In other words, by using additional data sources (e.g., interviewing experts in the field, focus group, quantitative measures), one could strengthen data triangulation and increase the reliability and validity of the study. However, according to Creswell (2007), who provides a description of the validation process, the researcher is not expected to engage in all these strategies. He notes the following:

Examining these eight procedures as a whole, I recommend that qualitative researchers engage in at least two of them in any given study. Unquestionably, procedures such as triangulating among different data sources (assuming that the investigator collects more than one), writing with detailed and thick description, and taking the entire written narrative back to participants in member checking all are reasonably easy procedures to conduct. Other procedures, such as peer audits and external audits, are more time consuming in their application and may also involve substantial costs to the researcher. (Creswell, 2007, p. 209)

That being said, I would argue that while my data collection is limited according to quantitative standards, qualitatively, the richness of the data, the range of experiences presented, and the use of other validation procedures (e.g., member checks, independent coder, establishment of an audit trial, to name just a few) all help to ensure that the rigor and standards of this type of methodology have been met.

**Importance of this Study**

Despite the limitations noted above, this study is important for a number of reasons. First, the present study is the first qualitative study to investigate the childhood and social recollections of women with trichotillomania and the various pathways to discovering
trichotillomania. Utilizing this type of approach facilitates an understanding of trichotillomania of a kind not commonly seen in the current TTM literature. Second, it allowed the participants the opportunity to speak about their experiences; for some, this is the first time that they have discussed their hair pulling; for others, it lessened the shame, embarrassment, and isolation they feel as a result of their trichotillomania. And third, the exploration of the experiences of these women provides information useful to clinicians. It highlights the importance of addressing this issue in the context of the multiple factors associated with the discovery of trichotillomania. In the next section, I discuss the clinical implications of the study findings.

Implications for Clinical Treatment

The findings of this study reveal several important issues that ought to be addressed in the treatment of trichotillomania. First and foremost, the majority of the women in this study repeatedly mentioned the lack of support and appropriate treatment that is available to them in Ontario. Many also expressed concern about the lack of education among health care professionals with respect to the assessment and treatment of trichotillomania. This confirms the findings of other studies that conclude that health care providers are still very much unaware of this condition (Marcks, Wetterneck, & Woods, 2006; White Kress et al., 2004). In the present study, one participant noted that she wants treatment specific to her hair pulling but does not want to spend her valuable time educating a therapist about the condition. Others reported a lack of professionalism among health care providers. Of paramount importance is the need to provide health professionals with an understanding that trichotillomania is a significant condition that has far reaching implications for the
sufferer. Addressing the sequelae of trichotillomania may provide additional useful information for treatment.

Another significant issue to consider in the development of assessment and treatment protocols is that of gender. It continues to be the case that far more people with trichotillomania are female than male. And, for example, gender has been shown to have a significant influence on treatment, particularly in the area of cognitive behavior therapies (Davis & Padesky, 1989, as cited in Toner, Segal, Emmott, & Myran, 2000, p. 44). The nature of the experiences described by the women highlights the complexity of the reasons why women pull their hair out. And the lived experiences of women in general are vastly different than those of men. “For instance, several writers have suggested that in some fundamental ways, women experience a different social reality than men (Blechman, 1984; Resick, 1985; Shaef, 1985)” (Toner et al., 2000, p. 44). All of which suggests that a gender-specific approach must be taken in the development of treatment and assessment protocols. And yet, some investigators have argued against this suggesting that there is no current evidence to support the implementation of gender specific treatments for trichotillomania (Christenson et al., 1994).

The findings also provide support for the need to take into consideration the multifaceted and individualistic nature of trichotillomania, particularly in the assessment and treatment of the condition. It is important that treatment providers be cognizant of the limitations of the current treatments for trichotillomania and be willing to work to come to an understanding that incorporates the meanings that women bring to their histories and an understanding of the functions that hair pulling serves. Although this study does not fully address the treatment history of the participants, the findings provide support to the current
treatment literature that suggests the need for alternative means of addressing trichotillomania (Boughn & Jaarsma Holdom, 2002).

In a comprehensive treatment strategy, a factor to be recognized is that not everyone is willing to pursue an approach that includes medication. For example, one participant in the study stated that she has not sought treatment because she knows that it would involve taking medications and she does not feel that this would be an appropriate avenue for her to explore. Another participant, Claire, speaks about self acceptance and also points out that this might not necessarily be the case if she had sought treatment for her trichotillomania. In other words, Claire has learned to self manage her pulling and has coped well with it. This study strongly contends that the individualistic nature of trichotillomania makes it unlikely that any one treatment will be effective for all individuals with the condition.

In addition, the findings suggest that treatment should involve a careful consideration of the relationship between the factors that facilitate the discovery of trichotillomania. The present study is the only study to specifically examine childhood and social experiences of women with trichotillomania from the perspective of the individual, and the findings provide support for the need to examine the issues related to the onset of compulsive hair pulling. In so doing, treatment can acknowledge the unique experiences of women who engage in compulsive hair pulling and thereby begin to address the complexities of trichotillomania.

Clinicians and other service providers will need to work collaboratively with the client to examine and address issues related to compulsive hair pulling. An important clinical strategy for therapists and other service providers will be to elicit the client’s experience through an exploration of his or her physical, psychological, and social worlds and to listen
and encourage the client in this exploration in an empathetic and understanding way (White Kress et al., 2004). As has been previously stated, hair pulling serves a meaningful purpose for these women. The women in this study exemplify the phenomenon of shared coping\(^2\) with a perceived sense of loss of control in the environment. As such, clinicians must be cognizant of and accepting of the contexts within which women with trichotillomania make meaning of their lives and respect the women’s experiences and journey of hair pulling.

As well, this research, and previous research, highlights an important aspect of assessing and treating women with trichotillomania: the importance of not trivializing their experiences. Oftentimes, clinicians unfamiliar with trichotillomania, while attempting to provide well-meaning advice about compulsive hair pulling, inadvertently trivialize the experiences of the women who engage in it. This further adds to the isolation that is felt by many of these women and discourages them from seeking treatment. Education is an important avenue that clinicians and other health care providers must take when attempting to understand their client’s experience of trichotillomania.

While this study does not specifically address issues of stigma and shame associated with trichotillomania, it became quite evident during the course of the research that these are an integral part of the lives of the women interviewed. Many of these women stated that they feel like they are the only ones with the condition and expressed relief when they were told about the estimated number of women with trichotillomania.

The issue of stigmatization in clinical settings needs to be addressed. One of the ways that this can be accomplished is by facilitating a more comprehensive understanding of this

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\(^2\) A concept that describes how individuals can better cope with their own difficult experiences when they are able to share them with others who have had the same or similar experiences.
condition among treatment providers. Stengler-Wenzke, Trosbach, Dietrich, and Angermeyer (2004) discuss the issue of stigmatization as it relates to obsessive compulsive disorder and note the following: “if professionals learn about stigmatizing processes and also how to avoid stigmatizing behavior during their education and training, then they could avoid these from the beginning of their professional career” (p. 95). The findings of the current study also point to the need for public education about trichotillomania, with a specific focus on acceptance of self and on alleviating the isolation that is felt by so many of these women. The TLC has been and continues to be a tremendous resource for individuals with compulsive hair pulling and their families. They have helped to facilitate the development of a more comprehensive understanding of hair pulling and a shift away from the psychopathological view of the condition. For many of the women who engage in compulsive hair pulling this will likely facilitate a move away from self-hatred and towards seeking appropriate and effective treatment.

Finally, the classification of trichotillomania has become a matter of some controversy (Christenson & Mansueto, 1999; Diefenbach et al., 2000). As previously mentioned, trichotillomania is currently classified as an impulse control disorder not otherwise specified (American Psychiatric Association, 2004). This diagnostic category does not adequately address the many contexts and realities of individuals living with trichotillomania. As previously noted, the tension reduction cycle (i.e., criteria B and C) is not evident in all individuals with trichotillomania and yet it is an essential feature for the diagnosis (Christenson, Mackenzie, & Mitchell, 1991). Many investigators in the field do not make these criteria a requirement in their clinical samples, choosing instead to have a less restrictive definition of this condition (Christenson & Mansueto, 1999; Diefenbach et al.,
That being said, it will certainly be interesting, to see exactly what criteria are associated with trichotillomania and where it is categorized in the 5th edition of the DSM (to be launched in 2012). Discussions have centered on whether trichotillomania should be classified under a new, narrower category of OCD Spectrum Disorders (Mataix-Cols, Pertusa, & Leckman, 2007) or under the boarder category of Anxiety and Obsessive Compulsive Spectrum Disorders (Phillips, 2009). At issue is whether the OCD related disorders should be classified separately or continue to be subsumed under the anxiety disorders category (Phillips, 2009). Modifications to the diagnostic criteria and inclusion of subtypes have also been discussed (Phillips, 2009). Another possibility is that trichotillomania be left as it is currently classified, but the category it is in, impulse control disorders, would be subdivided into self-defeating and self-soothing behaviors (Peele, n.d.).

Classification of trichotillomania is only one aspect of this condition. Context, meanings and the gendered nature of trichotillomania needs to also be addressed.

Relatedly, a name change for trichotillomania is also being considered (Phillips, 2009).

The word trichotillomania is derived from the Greek *thrix*, hair; *tillein*, to pull; and *mania*, madness or frenzy. The name is somewhat of a misnomer in that people with trichotillomania are not “mad,” ”psychotic” or ”crazy” as the name suggests [italics in original]. (Anders & Jefferson, 1994, p. 1)

One of the names being considered is Hairpulling Disorder (Phillips, 2009). The proposed name change has given rise to much debate. According to recent postings on Christina Pearson’s Personal Blog on the TLC website (2009), several individuals with trichotillomania have argued that the new name is too simplistic and reductionist whereas others have suggested that it is demeaning in that it highlights the psychiatric connotations
of the condition while failing to further public education or understanding. I would argue that the name trichotillomania does create a barrier to an understanding of the diagnosis. I cannot begin to tell you the number of times that I have been asked how to pronounce trichotillomania and subsequently to explain what it means. Changing the name of trichotillomania is a step in the right direction. That being said, I agree with others who have argued that the new name proposed will not advance the cause nor will it facilitate an understanding of this complicated phenomenon. Instead, the proposed name will add to the confusion and shame that the majority of individuals with trichotillomania already experience.

**Final Thoughts**

When I first began to think about study topics for my dissertation, I knew without hesitation that I wanted to examine the area of trichotillomania. As someone who has had and continues to have a personal connection to this issue, I understand the importance of furthering research in this area. I didn’t know what specific issue I wanted to address, but I knew that I wanted to provide women who engage in compulsive hair pulling with a voice, an opportunity to speak to their own experiences. So often when conducting research we rely on having participants complete questionnaires forcing them to answer predefined questions. Though this traditional quantitative method of data collection does provide excellent findings, it does not allow participants to speak to issues in their own voices. This study is the result of my desire to provide women who engage in compulsive hair pulling with a forum to speak about their early recollections of this condition, and to further research on the issue of childhood and social experiences and discovery of trichotillomania. In reviewing my previous work on trichotillomania, in particular, the psychosocial complications of
compulsive hair pulling, the objective of this present study slowly began to emerge. Childhood and social experiences of women with trichotillomania is an area that has not been investigated. Though previous researchers have mentioned it in the context of other research questions, and there are anecdotal reports, no studies have formally addressed the issue of childhood and social experiences of women with trichotillomania. This is the first study to specifically examine this topic and to give women who engage in compulsive hair pulling the opportunity to provide in-depth narratives of their early experiences of trichotillomania.

During the study, I was overwhelmed by the generosity of the women who participated. Not only did they take time out of their busy lives to participate, but they were open about the issues that they discussed. The anonymity provided by the use of telephone interviews and the pseudonyms utilized throughout the study allowed many of these women to address issues they may otherwise have not discussed. In addition, for some of the women in the study, this was the first opportunity to discuss compulsive hair pulling in a non-judgmental and supportive context. When I disclosed my personal connection with this issue, the women expressed feelings of disbelief, relief, and appreciation. Feelings of disbelief that they were not the only ones with trichotillomania, relief that they could talk about these issues without, as one participant put it, “feeling like a freak,” and appreciation that research was being conducted in this relatively understudied area.

After completing the study, I had a better understanding of the impact that compulsive hair pulling has in the lives of these women. I was also struck by the urgent need for treatment in Ontario. Many of the women interviewed asked for referral information for treatment. Whereas hospitals and other health care agencies in the United States have clinics devoted specifically to trichotillomania, in Ontario these resources are sorely lacking. In
addition, there are few experts in the area of trichotillomania in Ontario. Lack of education among clinicians continues to be a problem.

This study also reveals the resilient nature of these women. Through their lived experiences, these women are challenging the stigma attached to this condition. Trichotillomania affects women from all socio-economic spheres (Cohen et al., 1995), marital statuses, and cultural backgrounds (Christenson, Mackenzie, & Mitchell, 1991). The conceptualization of trichotillomania must shift away from its current basis in biology and behavior and move towards a more inclusive conceptualization that takes into account both past and present life experiences and the meanings that women give to these experiences. Education about trichotillomania, particularly the damage that it can cause emotionally and psychologically, needs to be improved. The resources allocated to this area are steadily increasing; however, more research is urgently needed. Given that it is estimated that 2 to 4% or 5 to 10 million Americans (Anders & Jefferson, 1994; Azrin & Nunn, 1977) have this condition, it is imperative that clinicians educate themselves about trichotillomania. Though no Canadian statistics exist, based on similarities between the two countries, one can assume that the between 500,000 and 1 million Canadians suffer from trichotillomania. This further highlights the importance of addressing this issue. This study serves to provide preliminary findings on the childhood and social experiences of women with trichotillomania and the various pathways they took to its discovery. The voices of the women in this study helped to facilitate an exploration and understanding of this common but still very much understudied area and to convey to readers what it is like to live with trichotillomania.


Trichotillomania Learning Centre, Inc. (n.d). *One in fifty people suffer from Trichotillomania (chronic repetitive hair pulling)* [Brochure]. Santa Cruz, CA: Author.


Appendix A
Invitation to Participate and Consent Form

Understanding the Complexities of Trichotillomania:
A Qualitative Investigation of Childhood Experiences
of Women with Trichotillomania

Invitation to Participate and Consent Form

I agree to participate in a study being conducted by Ms. Josee Casati, a doctoral student in the Department of Adult Education and Counselling Psychology at the Ontario Institute for Studies in Education of the University of Toronto in Toronto, Ontario Canada. This study is supervised by Dr. Mary Alice Guttman, Professor at the Ontario Institute for Studies in Education of the University of Toronto. This study is being conducted in partial fulfillment for the Doctor of Philosophy degree.

Purpose of the Study:

I understand that I am being asked to participate in a study examining the childhood experiences of women with trichotillomania. The overall objective of this study is to improve how trichotillomania is conceptualized and treated. In order to achieve this goal, it is important to better define the role that childhood events and experiences may have on the development of trichotillomania.

Eligibility:

I understand that to participate in this study, I need to meet the following criteria: (1) have trichotillomania, (2) 18 years of age or over, (3) be willing to participate in a 1 to 2 hour telephone interview and (4) be able and willing to provide consent.

Procedure:

I understand that my participation in this study requires that I complete a telephone interview with the principal investigator (Ms. Josee Casati). The interview will take approximately 1 to 2 hours and will be telerecorded. The telephone interview will focus on three areas: demographics, characteristics of hair pulling, and my recollection of events and experiences that coincided with my hair pulling. I will also be asked to complete a follow-up interview during which time any concerns and/or questions that I might have will be addressed. I understand that the audiotapes will be transcribed by a professional transcriber and I will be provided with a hard copy of the transcript for editorial revisions and input. Upon completion
of the study, the audiotapes will be destroyed. All costs related to this study (long distance charges, postage) will be incurred by the principal investigator.

Confidentiality:

During the study reasonable efforts will be utilized to maintain confidentiality, however, limits of confidentiality will be maintained. Ethical and legal obligations require that if during the course of the study, I intent to harm myself (i.e., suicide) or someone else or I report that a child is being sexually, physically, or emotionally abused, the appropriate agencies will be contacted. I understand that the information that I provide will be kept in a locked filing cabinet and stored in a locked office at the Ontario Institute for Studies in education of the University of Toronto. The audiotapes will be transcribed by a professional transcriber who will be required to sign a confidentiality agreement. The transcriber typist agrees to keep all research information confidential and to not discuss this information with anyone other than the principal investigator and study supervisor. The transcriber agrees to keep the research information in a secure location (i.e., locked filing cabinet) and if the information is on a computer, it is only done so for the duration of the study and the information is password protected. All research information is to be returned to the principal investigator and all electronic files are to be deleted. Prior to my participation in the study, I will be assigned an identification number. In the tapes, transcripts and reports, I will be referred by an identification number. The professional transcriber will know me by my identification number. After the transcription process, the principal investigator and study supervisor will be the only personnel to have access to the data. The information will be kept for 7 years, after which it will be destroyed. The audiotapes and transcripts will be kept separately to ensure anonymity.

Potential Risks and Benefits:

I understand that there is no direct harm associated with this study. However, in sharing my story, it is possible that I may experience some discomfort or distress. As such, I am under no obligation to continue with the study. I understand that I will not directly benefit from participation in this study. There is no monetary compensation for my participation in this study. It is also important to note that I will not be provided with any treatment options. However, I may request a referral/resource information sheet. A potential benefit of participating in this study is that I will help further research in the area of trichotillomania, in how it is conceptualized and treated.

Rights of Research Participants

It is my right to have my concerns and questions addressed at any point during my participation in this study. Should any questions and concerns arise, I may contact Ms. Josee Casati (416-XXX-XXXX), Dr. Mary Alice Guttman (416-978-0685) or the Ethics Review Office (416-946-3273).
Dissemination of Results:

The information collected during this study will be written up in the form of a doctoral dissertation in partial fulfillment for the principal’s investigator’s (Ms. Josee Casati) doctoral degree. In publications and presentations, all identifying information will be removed and the results will be pooled together to maintain confidentiality, however, verbatim excerpts may be used. Pseudonyms will be utilized in all publications and presentations. I will also be given an opportunity to request a summary of the results of the study.

Participation and Withdrawal:

My participation in this study is voluntary. I have the right to refuse to answer any interview questions. If I decide to withdraw from this study, I have the right to withdraw my data up to the time that the findings are written up for publication. My refusal to answer interview questions and/or my withdrawal from this study will have no negative consequences. I have read the consent form, and I agree to participate in this study and to sign two consent forms, one of which will be kept in my research file, and one of which will be for my personal file. I have also been given an opportunity to ask questions and have my concerns addressed in a satisfactory manner.

Participant Name: _________________________

Participant Signature: _________________________

Date: _________________________
Appendix B

Transcriber Confidentiality Agreement

Title of Study: Understanding the Complexities of Trichotillomania: A Qualitative Investigation of the Childhood Experiences of Women with Trichotillomania

Principal Investigator: Josee Casati, M.Ed
PhD Candidate, OISE/UT

Supervisor: Mary Alice Guttman, PhD, C. Psych
Adult Education and Counselling Psychology
OISE/UT
(416) 923-6641, Ext. 2551

The purpose of this study is to investigate the childhood experiences of women with trichotillomania. My role in this study is to transcribe audiotapes and provide a detailed verbatim account of the audiotapes. The information contained on the audiotapes is of a personal and sensitive nature.

I agree not to discuss the information on the tapes with anyone except for the principal investigator and study supervisor. I agree to keep the tapes, disks, and transcripts in a locked filing cabinet. Because the transcripts will be stored on the computer, I will create a password, known only to me. Once I have transcribed the tapes, I will return the tapes and transcripts to the study investigator. I agree to destroy or delete all electronic files associated with this study.

I have read and understand this agreement and I will abide by the terms.

___________________________________ ______________________________
Signature of Transcriber Date

___________________________________ _________________
Principal Investigator Date
Appendix C
Resources for Individuals with Trichotillomania

Organizations
The Trichotillomania Learning Centre
303 Potrero Street, Suite 51
Santa Cruz, CA. 95060
Phone: 831-457-1004
Email: trichster@aol.com
Website: www.trich.org

Suggested Books (available at Amazon.ca or Indigo.ca)


Suggested Videos (these videos are available through the Trichotillomania Learning Centre for a fee).

The Truth of Trichotillomania: Our Personal Stories
Trichotillomania: Overview and introduction to Habit Reversal Therapy
Bad Hair Life
Understanding the Complexities of Trichotillomania:
A Qualitative Investigation into the Childhood Experiences
of Women with Trichotillomania

I am a doctoral student in the Department of Adult Education and Counselling Psychology at the Ontario Institute for Studies in Education of the University of Toronto. I am examining the childhood experiences of women with trichotillomania. I am interested in interviewing women who would be willing to discuss the experiences and events at the onset of the hair pulling. All interviews will be conducted via telephone and all costs will be incurred by this writer. To be eligible to participate in this study, you must meet the following criteria: (1) Must have Trichotillomania; (2) Must be 18 years of age or over; (3) Must be willing and able to provide consent and (4) Must be interested in participating in a 1 to 2 hour telephone interview.

If you would like information about this study or are interested in participating, please contact Josee Casati at jcasati@oise.utoronto.ca or 1-800-XXX-XXXX. All inquiries will be kept confidential.
Appendix E
Pre-Screening Interview

E-Mail Script:

Outline of Study:

The purpose of this study is to examine the childhood events/circumstances that occurred at the onset of your compulsive hair pulling and how you think that these childhood events/circumstances affected your life. This study is being completed as partial fulfillment for my Doctoral degree in Counselling psychology. This study is a research study and therefore it is not intended to provide treatment options or resolution of the hair pulling.

This study will involve participating in a pre-screening interview, a 1 to 2 hour in depth interview, and follow-up contact with this writer. All interviews will be conducted by telephone and tele-recorded. You will be provided with a hard copy of the transcripts to enable you to make any editorial changes. All costs incurred as a result of this study (for example, long distance charges and postage) will be paid by this writer. The information that you will provide will be kept confidential and anonymity will be maintained by assigning you with a numerical code.

I would like to ask you a few questions that will determine you’re eligibility for this study. If it is determined that you do not meet eligibility criteria, the information that you have provided in this pre-screening interview will be destroyed.

Pre screening Questions:

1. How did you find out about the Study?
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

2. Are you over 18 years of age?
   ______

3. Do you have a formal diagnosis of trichotillomania? If not, could you please answer the following questions?

   (1) Have you ever pulled out your hair resulting in noticeable hair loss? _____
   (2) Prior to pulling, do you feel a sense of tension? ______
   (3) When pulling, do you feel a sense of pleasure or gratification? ______
   (4) Do you have a medical or psychiatric condition that could explain your pulling? _____
   (5) Does your pulling cause distress or prevent you from doing things in your life? _____

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4. At what age did you begin to pull out your hair? ________

5. Are you currently experiencing any problems that would make it difficult for you to participate in this study? _______

Details:________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

6. Would you be willing to participate in this study? ________

7. Would you also be willing to read a summary of the transcripts and provide editorial revisions and input? Would you be willing to participate in a follow-up telephone interview? ________
Appendix F
Eligibility Criteria

To be eligible for the study, the following criteria must be met:

(1) Must have trichotillomania
(2) Must be 18 years of age and over
(3) Must be willing and able to provide consent
(4) Must be interested in participating in a 1 to 2 hour telephone interview

Decision criteria:

1. Ineligible:

If the participant is not eligible for the study, they will be thanked for their interest in the study. The purpose of the study will be reviewed. If interested, they will be given a copy of the referral/resource page.

2. Eligible:

If the participant meets the eligibility criteria, they will be asked for their mailing address. A package consisting of two copies of the consent form and a stamped, self-addressed envelope will be mailed to them. They will be asked to read over the information, and if interested, to sign one copy of the consent form. They will also be asked to keep one copy of the consent form for their personal file. The second copy will be mailed to this writer. Once the consent form is received by this writer, a call will be placed to the participant to schedule the telephone interview.

3. Eligible but not Interested:

The participant will be thanked for their interest in the study, and will be asked if they are interested in receiving a referral/resource page on trichotillomania. They will also be asked if they would like to receive it via email or mail.

Mailing Address: __________________________
____________________________
____________________________
Appendix G

Interview Questions

**Demographic Information:**

1. How old are you?
2. What is your marital status? Do you have any children?
3. What ethnic group do you identify with?
4. What is the highest level of education obtained?
5. Are you currently working? If so, what is your occupation?
6. What category describes your household income? Under $10,000, $10,001 to $20,000, $20,001 to $30,000, $30,001 to $40,000, $40,001 to $50,000, greater than $50,000.

**Trichotillomania Information:**

The following categories will be explored
7. Sites of pulling, past and present.
8. Pulling methods and sequelae.
9. Other repetitive behaviors.
10. Is the pulling chronic or were there periods when you were able to stop? Duration? What do you attribute this to?
11. Impact of pulling on everyday activities (e.g., relationships, work, school).
12. Interference and avoidance of activities.
13. Severity of hair loss and methods used to cover up hair loss?
14. Other psychological difficulties and their impact.
15. Treatment (psychological and medications), current and past.
17. Current feelings about hair pulling.

**General family background questions:**

Areas to be explored include:
18. Constellation of family
19. Relationship of family members (parent’s relationship with one another, participant’s relationship with parents and siblings).
20. People you could approach if you had a problem.
21. How did the family handle moments of crisis and stress?

**Main study questions:**

22. Describe for me when was the last time that you had a normal relationship with your hair?
23. Tell me as best as you can what was going on in your life at the time of your hair pulling?
24. Describe for me how these events affected your life?
25. Describe for me what your childhood environment was like? (query separation from family, addiction and medical issues both in self and family, violence-physical, emotional, and sexual).
26. Do you think that there is a relationship between these events and the onset of your pulling? Please explain.
27. What was and is the role of the behavior for you?
28. Did pulling help? If yes, please describe for me how it helped you? If not, please explain how it did not help you?
29. Is there anything else that i haven’t addressed that you would like to discuss?

Follow-up Probes:

To obtain details and clarification of the information presented by each participant, the following probes will be utilized when appropriate:
1. Who was present?
2. What was the context?
3. What were you doing? And then what happened?
4. Can you tell me more about that? Can you give me an example?
Appendix H
The Massachusetts General Hospital (MGH) Hairpulling Scale

Name: __________________________     Date: __________________

Instructions: For each question, pick the one statement in that group which best describes your behaviors and/or feelings over the past week. If you have been having ups and downs, try to estimate an average for the past week. Be sure to read all the statements in each group before making your choice.

For the next three questions, rate only the urges to pull your hair.

1. Frequency of urges. On an average day, how often did you feel the urge to pull your hair?

0   This week I felt no urges to pull my hair.
1   This week I felt an occasional urge to pull my hair.
2   This week I felt an urge to pull my hair often.
3   This week I felt an urge to pull my hair very often.
4   This week I felt near constant urges to pull my hair.

2. Intensity of urges. On an average day, how intense or "strong" were the urges to pull your hair?

0   This week I did not feel any urges to pull my hair.
1   This week I felt mild urges to pull my hair.
2   This week I felt moderate urges to pull my hair.
3   This week I felt severe urges to pull my hair.
4   This week I felt extreme urges to pull my hair.

3. Ability to control the urges. On an average day, how much control do you have over the urges to pull your hair?

0   This week I could always control the urges, or I did not feel any urges to pull my hair.
1   This week I was able to distract myself from the urges to pull my hair most of the time.
2   This week I was able to distract myself from the urges to pull my hair some of the time.
3   This week I was able to distract myself from the urges to pull my hair rarely.
4   This week I was never able to distract myself from the urges to pull my hair.
For the next three questions, rate only the actual hairpulling.

4. Frequency of hairpulling. On an average day, how often did you actually pull your hair?

0 This week I did not pull my hair.
1 This week I pulled my hair occasionally.
2 This week I pulled my hair often.
3 This week I pulled my hair very often.
4 This week I pulled my hair so often it felt like I was always doing it.

5. Attempts to resist hairpulling. On an average day, how often did you make an attempt to stop yourself from actually pulling your hair?

0 This week I felt no urges to pull my hair.
1 This week I tried to resist the urge to pull my hair almost all of the time.
2 This week I tried to resist the urge to pull my hair some of the time.
3 This week I tried to resist the urge to pull my hair rarely.
4 This week I never tried to resist the urge to pull my hair.

6. Control over hairpulling. On an average day, how often were you successful at actually stopping yourself from pulling your hair?

0 This week I did not pull my hair.
1 This week I was able to resist pulling my hair almost all of the time.
2 This week I was able to resist pulling my hair most of the time.
3 This week I was able to resist pulling my hair some of the time.
4 This week I was rarely able to resist pulling my hair.

For the last question, rate the consequences of your hairpulling.

7. Associated distress. Hairpulling can make some people feel moody, "on edge," or sad. During the past week, how uncomfortable did your hairpulling make you feel?

0 This week I did not feel uncomfortable about my hairpulling.
1 This week I felt vaguely uncomfortable about my hairpulling.
2 This week I felt noticeably uncomfortable about my hairpulling.
3 This week I felt significantly uncomfortable about my hairpulling.
4 This week I felt intensely uncomfortable about my hairpulling.

This scale has been reprinted from Keuthen at al. (1995), The Massachusetts General Hospital (MGH) Hair Pulling Scale. 1: Development and Factor Analysis. *Psychotherapy and Psychosomatics*, 64, 141-145. Used with permission of the publisher: S. Karger AG, Basel.
Appendix I

Follow-Up Interview Questions

(1) Since the interview, is there anything else that you would like to talk about or anything that you remembered that you forgot to mention?

(2) Do you have any additional comments about the transcripts? Is there anything that I can clarify for you? Are there any additional revisions that you would like to make?

(3) How did you feel about participating in the study and sharing your story? What were your reasons for participating in this study?