Hair-Pulling Disorder (Trichotillomania):  

The lived experiences of Maltese sufferers  

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I hereby declare that I am the legitimate author of this Dissertation.

I further confirm that this work is original and unpublished.

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Abstract

Trichotillomania involves the recurrent pulling out of one’s own hair for pleasure, gratification or release of tension. This study utilises a qualitative approach to explore the effects that Trichotillomania has on the lived experiences of Maltese sufferers. The sample consisted of 5 Maltese individuals (4 females and 1 male) who have suffered from Trichotillomania. Interpretative Phenomenological Analysis was used to analyse the data obtained through semi-structured interviews. From the results, one could deduce that Trichotillomania is a complex disorder and can be experienced in different ways. Moreover, the results show that the relationships that the participants had with significant people had a particular role in the overall experience. The lack of public awareness was another prominent theme that emerged from the data.
To sufferers of Trichotillomania and their families
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Chapter 1: Introduction

Definition and History of Trichotillomania

Trichotillomania is characterised by the persistent urge to pull out one’s own hair (Parakh & Srivastava, 2010). Hair has been important to human beings at all times and in all cultures. Ancient stories and myths have used hair as a symbol of strength, magic and sexuality (Rabinowitz, 1984). In the current era, hair is still regarded to be a significant part of the human body and is treated as such by the various modes of hair styling that one may adopt. Such hair styling may also serve as an unconscious expression of the ideas, desires and conflicts of an individual (Koblenzer, 1999). As a result, one may think that it is rather irrational for a person to pull out his own hair, regardless of the feelings of despair that may be associated with the behaviour.

The person responsible for the launch of hair-pulling as an identifiable medical illness is considered to be Hallopeau (Christenson & Mansueto, 1999). Hallopeau, a French dermatologist, came up with the term Trichotillomania in 1889 to describe a young man who pulled out all of his body hair (Hallopeau, as cited in Parakh & Srivastava, 2010). At the time Hallopeau attributed the hair-pulling to pruritus and a type of “insanity” (Christenson & Mansueto, 1999, p. 2). The term Trichotillomania is derived from Greek words and literally means “a penchant for pulling one’s own hair” (Hallopeau, as cited in O’Sullivan, et al., 1997, p. 1442). This term has received several objections and controversies from a number of researchers (Christenson & Mansueto, 1999) but so far, is still being used to describe the hair-pulling disorder. Trichotillomania was formally recognised as a psychiatric disorder in 1987, when it was included in the DSM-III-R (Christenson & Mansueto, 1999).
However, historical accounts prove that the phenomenon of hair pulling has been in existence for several thousands of years. Furthermore, some of these accounts show that this behaviour was culturally sanctioned at times (Christenson & Mansueto, 1999). For example, the early Greeks pulled out hair from their scalp and put it upon the corpse of a friend or relative (Corson, as cited in Christenson & Mansueto, 1999). In our time, the members of a monastic sect of the Jain community in India symbolise their detachment from pain by plucking out all their hair (Shome, et al., as cited in Christenson & Mansueto, 1999). Likewise, new brides of the African Ila tribe pluck the pubic and chin hair of their husbands following consummations of their marriage (Gregersen, as cited in Christenson & Mansueto, 1999).

However, the examples of hair-pulling mentioned above are cultural customs and differ from the hair-pulling experienced by patients suffering from Trichotillomania. The latter is usually characterised by strong negative feelings such as frustration and boredom (Christenson & Mansueto, 1999). In fact a common Maltese idiom, “qatta’ xagħru”, meaning “he pulled out his hair”, is frequently used in our culture and expresses such negative emotions (Fenech, 1984, p. 295). Hair-pulling was also used as a description of grief and turmoil, in several literary works. One example is the biblical account of prophet Ezra: “When I had heard this thing, I tore my cloak and my mantle, plucked hair from my head and beard, and sat there stupefied” (Ezra 9:3, Living Word Edition). Shakespeare (1975), refers to the behaviour of hair-pulling in the play *Troilus and Cressida*, when Cressida exclaims: “Tear my bright hair and scratch my praised cheeks, crack my clear voice with sobs, and break my heart” (Shakespeare, 2007, p. 138).
Hair-pulling is also used to depict misery and emotional instability in art. The sculpture of seventeenth-century artist, Artus Quellinus de Oude, *The Women From the Mad House*, is one clear example (Christenson & Mansueto, 1999).

**Objectives of Study**

The purpose of my study is to explore the perceived effect that Trichotillomania has on the lives of Maltese individuals suffering from the disorder. Previous research has suggested that Trichotillomania has a significant impact on the lives of the sufferers resulting in social and interpersonal impairment (Flessner, Woods, Franklin, Keuthen, & Piacentini, 2008). Trichotillomania and Impulse Control Disorders in general are being extensively researched internationally. However, to my knowledge the majority of such studies have focused on the descriptive characteristics and possible treatment interventions rather than on the lived experiences of the sufferers. Furthermore, following my reading on the subject of Trichotillomania, I believe that there are still some gaps regarding local research and awareness concerning this area. As a result, I have chosen to carry out a qualitative study using Interpretative Phenomenological Analysis to focus on the exploration of the lived experiences of Maltese participants.

**Layout of Study**

Following this introduction, the next chapter aims at providing a deeper investigation of the available literature regarding Trichotillomania and its effects. Chapter 3 then presents information about the methodology used in carrying out this particular study. Chapter 4 underlines the analysis of the common themes that have emerged from the interviews, which are then discussed and linked to the literature in chapter 5.
Chapter 2: Literature Review

Classification

The revised fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) describes Trichotillomania as the recurrent pulling out of one’s own hair resulting in noticeable hair loss (APA, 2000). However, not all cases of hair-pulling qualify for the diagnosis of Trichotillomania. The *DSM-IV-TR* has a strict set of diagnostic criteria and distinguishes Trichotillomania from the occasional hair-pulling that may be experienced during states of heightened anxiety (APA, 2000). The *DSM-IV-TR* states that a diagnosis of Trichotillomania can only be made when the individual feels an increasing sense of tension immediately before pulling out the hair or when attempting to resist the behaviour and a sense of pleasure or gratification while pulling out the hair (APA, 2000). Additionally, the disturbance caused by this disorder should not be better accounted for by another mental or general medical condition and the individual must experience significant distress or impairment in important areas of functioning. (APA, 2000).

At present, the *DSM-IV-TR* classifies Trichotillomania as an Impulse-Control Disorder Not Elsewhere Classified together with Intermittent Explosive Disorder, Kleptomania, Pathological Gambling and Pyromania (APA, 2000). All the disorders mentioned above are grouped together as they are all characterised by the failure to resist the impulse or temptation to perform a particular behaviour even though the individual performing the behaviour is aware of the harm being caused to self or others (APA, 2000). However, a number of researchers in the field have criticised this rationale and expressed the need for revision of our current understanding regarding this disorder. This is due to the complex and multi-faceted nature of hair-pulling (Parakh & Srivastava, 2010). In addition to being a
clinical syndrome in its own right, hair-pulling can also present itself as a behavioural symptom of various disorders (O'Sullivan, et al., 1997). As a result, Parakh and Srivastava (2010) insist that there should be a clearer understanding regarding the symptom versus the clinical syndrome. Furthermore, the classification of Trichotillomania as an impulse-control disorder has become rather controversial (Stanley & Cohen, 1999), and researchers are trying to come up with different views based on the research that has been carried out up to now. A leading view considers Trichotillomania to share a number of features with Obsessive-Compulsive Disorder (OCD). In fact, a consistent number of international researchers in the field of OCD are of the opinion that the fifth edition of the DSM should comprise of a new obsessive-compulsive spectrum disorder category in which Trichotillomania should be included (Mataix-Cols, Pertusa, & Leckman, 2007). This reasoning is based on the fact that OCD and Trichotillomania have similarities in a number of domains such as phenomenology, epidemiology, neurobiology and treatment (Stanley & Cohen, 1999). One striking similarity is the fact that both Trichotillomania and OCD patients suffer of similar urges and ritualistic behaviours (Stein, Simeon, Cohen & Hollander, 1995). Trichotillomania and OCD are both characterised by repetitive performance of a maladaptive behaviour which tends to decrease anxiety (Stanley & Cohen, 1999). Additionally, neurobiological similarities play an important role in the relationship of OCD and Trichotillomania (Stanley & Cohen, 1999). Both disorders are affected by serotonin probes, and brain imaging studies have shown evidence of basal ganglia and frontal lobe abnormalities in both disorders (Stanley & Cohen, 1999). Furthermore, Trichotillomania and OCD are associated with high rates of coexisting anxiety and affective disorders, and families of Trichotillomania patients tend to show higher rates of OCD occurrence when compared to the general population (Stanley & Cohen, 1999).
However, the current version of the DSM distinguishes Trichotillomania from OCD by emphasising that the repetitive hair-pulling in Trichotillomania is not performed in response to an obsession or according to rigid rules as is the case of people suffering from OCD (APA, 2000). As a matter of fact, several other differences exist between the two disorders. One such difference is that hair pulling tends to produce pleasurable feelings while compulsions do not (Stanley & Cohen, 1999). Other differences exist in the type of treatment used to treat the disorders including drugs and behavioural therapy (Stanley & Cohen, 1999).

In 2006, the American Psychiatric Association initiated the selection process of a group of individuals to form a task force consisting of thirteen work groups to plan and develop a fifth edition of the DSM, which is expected to be published in May 2013 (APA, 2010). Each work group is responsible for revising the diagnostic criteria of particular categories through analyses of existing data and development of new hypotheses. The Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders Work Group has been responsible for the revision of the diagnostic category, Impulse Control Disorders Not Elsewhere Classified (APA, 2010). To date, this particular work group has proposed a number of amendments regarding Trichotillomania and its diagnostic criteria. Firstly, it was proposed that the disorder be moved from Impulse Control Disorders Not Elsewhere Classified to Anxiety and Obsessive-Compulsive Spectrum Disorders (APA, 2010). This decision coincides with the findings and suggestions mentioned above. Additionally, the above mentioned DSM-5 work group is of the idea that the term Trichotillomania is inappropriate for such a disorder and should be changed to a more descriptive term such as Hair-Pulling Disorder (APA, 2010). Additional modifications include the idea that the
resulting hair loss does not need to be noticeable in order to be diagnosed as Trichotillomania (APA, 2010).

**Phenomenology and Descriptive Characteristics**

Traditionally, the main belief regarding the prevalence of Trichotillomania was that it is a relatively rare disorder (O’Sullivan et al., 1997). However, findings are slowly proving that it may not be as uncommon as it was thought to be (O’Sullivan et al., 1997). To date, there are no available systematic data regarding the prevalence of Trichotillomania (APA, 2000), but a number of researchers have tried to carry out quantitative surveys to produce prevalence estimates. One particular survey of 2579 college students found that according to strict DSM criteria, 0.6% of both male and female participants suffered from Trichotillomania at some point during their lives (Christenson, Pyle, & Mitchell as cited in O’Sullivan et al., 1997). This prevalence increases to 3.4% in females and 1.5% in males if the definition of Trichotillomania were to be broadened to include all repetitive hair pulling resulting in visible hair loss (Christenson, Pyle, & Mitchell as cited in O’Sullivan et al., 1997). Azrin and Nunn (as cited in Christenson & Mansueto, 1999) estimated a point prevalence of approximately 4%. This was based on their experience with the treatment of clients with Trichotillomania. Other studies that show that hair-pulling may not be uncommon include a survey carried out by Stanley and colleagues (1994), in which 15.3% of 288 college students acknowledged pulling out their hair in the previous year (Christenson & Mansueto, 1999). Unfortunately, none of the quantitative studies carried out so far have been conclusive due to a number of methodological limitations. (O’Sullivan et al., 1997). One such limitation, which may result in the under-estimation of the occurrence of this particular disorder, may be the fact that sufferers tend to deny and hide
their hair-pulling as much as possible (Sah, Koo, & Price, 2008). In fact, Szepietowski, Salomon, Pacan, Hrehorów and Zalewska (2009) claim that Trichotillomania is a relatively common disorder but its exact prevalence is difficult to establish due to the lack of sufficient epidemiological studies.

The DSM-IV-TR states that people suffering from Trichotillomania may pull hair from any region of the body in which hair may grow (APA, 2000). Such regions may include the axillaries, the pubic, and the peri-rectal areas, the scalp, eyebrows, and eyelashes (APA, 2010). The latter three tend to be the most common sites of hair pulling (APA, 2000). The frequency of hair pulling can differ from brief episodes scattered throughout the day to less frequent but more sustained periods (APA, 2000). Additionally, the hair pulling can either occur during relaxed states or during periods of elevated stress and tension (APA, 2000).

Authors are suggesting that hair-pulling may be divided into two predominant styles, namely automatic and focused hair-pulling (Flessner, Woods, Franklin, Keuthen, & Piacentini, 2008). In the case of focused hair-pulling, the attention of the patient is focused on the act of pulling and this usually results in mounting tension when the pulling is resisted (O’Sullivan et al., 1997). Patients suffering from focused hair-pulling tend to have specific rituals regarding the hair-pulling behaviour (Sah, Koo, & Price, 2008). Such rituals may include a need for hair-pulling symmetry (O’Sullivan et al., 1997). Other patients may examine the hair root, chew off the hair bulb or eat the hair (APA, 2000). These rituals have phenomenological similarities to compulsive rituals that occur in OCD (O’Sullivan et al., 1997). Automatic hair-pulling, which is also known as habitual hair pulling is not associated with an uncontrollable urge (O’Sullivan et al., 1997). Such pulling tends to occur while the patient is relaxed or distracted (Sah, Koo, & Price, 2008). Some activities
which may result in automatic hair-pulling are watching television, reading, driving, on the telephone or lying in bed (O’Sullivan et al., 1997). Many patients tend to have a mixture of both hair-pulling styles (O’Sullivan et al., 1997). However, research has suggested that only about 25% of pulling episodes are primarily focused (Christenson & Mackenzie, as cited in Norberg, Wetterneck, Woods, & Conlea, 2007). Other individuals feel the urge to pull out hair of other people. Such people try to find opportunities to do so covertly or may pull hairs from pets, dolls and materials such as carpets or sweaters (APA, 2000).

Trichotillomania may also be sub-divided on the basis of onset (Sah, Koo, & Price, 2008). The documented average age at onset of Trichotillomania is around 13 years (O’Sullivan et al., 1997). However, Trichotillomania may present itself at any age and this age of onset may have an effect on the prognosis and subsequent treatment (Sah, Koo, & Price, 2008). In the majority of cases of early-onset Trichotillomania, symptoms begin before 2 years of age and tend to occur during periods of boredom or intense stress (O’Sullivan et al., 1997). This kind of hair-pulling serves as a self-soothing behaviour and is often considered to be similar to habits such as nail biting or thumb sucking (Sah, Koo, & Price, 2008). This early onset typically results in the more benign form of Trichotillomania (Bruce, Barwick, & Wright, 2006) and young children tend to grow out of it as they get older (APA, 2000). Conversely, when the onset of Trichotillomania happens later in life, there is a tendency of a more chronic and relapsing course (APA, 2000). This type of hair-pulling is characterised by rituals and psychological distress (O’Sullivan et al., 1997).

Trichotillomania is a debilitating condition and has a significant impact on the lives of people with the disorder. Adults suffering from Trichotillomania tend to have deficits in psychological, social, academic, and occupational functioning. (Walther, Rickets, Conelea,
& Woods, 2010). People with large or obvious patches may experience severe distress (Stein & Christenson, 1999). Trichotillomania may also cause significant distress in children with the disorder. Children may develop feelings of anxiety, shame, guilt and low self-esteem (Bruce, Barwick, & Wright, 2006).

**Theories of Trichotillomania**

**Psychoanalytic perspective.** Traditionally, the majority of professionals used a psychoanalytic perspective to understand and explain the existence of Trichotillomania (Keuthen, Aronowitz, Badenoch, & Wilhelm, 1999). Such an approach focuses on the underlying psychopathology of hair-pulling. The understanding of the symbolic significance of hair may give a clearer picture of the psychoanalytic perspective of Trichotillomania. Physiologically, the growth of body and scalp hair occurs throughout the course of a person’s development, increasing at puberty (Koblenzer, 1999). Therefore, hair in a man has come to symbolise strength and virility (Koblenzer, 1999). Thus, the cutting or removal of hair symbolises castration (Rabinowitz, 1984). These symbols have been used in several literary works and myths, such as the biblical story of Samson and the myth of Medusa. According to Sigmund Freud, the latter addresses a number of unconscious issues (Koblenzer, 1999). In women, literature and myths show similar symbolic meanings. For example, the long hair used by Rapunzel to allow her mother and her lover into her tower (Andreson as cited in Koblenzer, 1999), may symbolise the female genitals and any related unconscious issues (Koblenzer, 1999). Similarly, African girls of certain tribes, surrender their hair at marriage to symbolise surrender of the genitals (Koblenzer, 1999). Trichotillomania may also be interpreted in a similar manner in the sense that the removal
of one’s own hair may symbolise the attempt of resolving conflicts of a sexual and aggressive nature (Koblenzer, 1999).

**Behavioural perspective.** On the contrary to theorists who explain Trichotillomania by using a psychoanalytic perspective, behavioural theorists focus on the hair pulling behaviour itself rather than hypothesizing possible unconscious conflicts (Keuthen, Aronowitz, Badenoch, & Wilhelm, 1999). The behavioural perspective defines hair-pulling as the primary problem and not as a symptom of a more fundamental issue. Such an approach allows the attention to focus on situational and emotional variables that may trigger the behaviour and on the mechanisms of reinforcement by which the behaviour is maintained (Keuthen, et al., 1999). For example, the pleasure experienced when pulling out the hair may reinforce further pulling.

**Cognitive-behavioural perspective.** Cognitive-behavioural theories of Trichotillomania are based on the belief that dysfunctional behaviour can be mediated or intensified by specific maladaptive thoughts (Keuthen, Aronowitz, Badenoch, & Wilhelm, 1999). Consequently, such an approach gives equal importance to the cognitive processes of the individual and to the overt hair-pulling behaviour (Keuthen et al., 1999). Several cognitive variables such as irrational beliefs about hairpulling, can be involved in Trichotillomania (Ottens as cited in Keuthen et al., 1999). These thoughts and beliefs may act as coping techniques by sustaining and reinforcing hair pulling (Gluhoski, as cited in Keuthen et al., 1999). “Pulling will make me feel better” (Gluhoski as cited in Keuthen et al., 1999, p. 153) is an example of such thoughts.
Treatment of Trichotillomania

The complexity of Trichotillomania (Grant, Odlaug, & Potenza, 2007) and the fact that research in the field is still in its inception has limited the development of interventions for the disorder (Walther, Ricketts, Conelea, & Woods, 2010). Generally, the perspective used to understand and explain Trichotillomania has an influence on the treatment chosen. However, behaviour models have predicted and documented better treatment outcomes (Keuthen, Aronowitz, Badenoch, & Wilhelm, 1999). Behavioural treatments that may be used to treat Trichotillomania include self-monitoring, punishment and aversive techniques and reinforcement. (Keuthen et al., 1999). On the other hand, cognitive-behavioural treatment focuses on both covert and overt coping techniques to increase the awareness of certain maladaptive thoughts and to try to replace these with more adaptive beliefs (Keuthen, et al., 1999). Additionally, such treatment focuses on removing reinforcement through programmes such as Exposure and Response Prevention (E+RP). Certain drugs such as serotonin reuptake inhibitors may also be used to treat Trichotillomania (O’Sullivan, Christenson, & Stein, 1999).

At present, habit reversal therapy-based behaviour therapy and clomipramine are the most efficacious types of treatment (Rothbaum & Ninan, 1999). However, these are limited in their efficacy, maintenance and scope and therefore not all patients improve after given such treatment (Walther, Ricketts, Conelea, Woods, 2010). Recent findings have shown that the addition of N-acetylcysteine to behavioural therapy may improve the treatment outcomes of the disorder (Grant, Odlaug, Kim, 2009). Additionally, Koblenzer (1999) has demonstrated the effectiveness of psychodynamic psychotherapy in the treatment of people with Trichotillomania. Another type of treatment used is hypnosis. Cohen, Barzilai, and
Lahat (1999) believe that hypnotherapy may be an effective treatment for Trichotillomania in children without associated emotional disorders.

**Conclusion**

From my readings, I felt that although there is a wealth of knowledge regarding the phenomenology and descriptive characteristics of Trichotillomania it seems that there is a lack in information regarding the subjective experiences of the sufferers. As a result, I chose to conduct such a study.
Chapter 3: Methodology

Philosophical underpinnings of Interpretative Phenomenological Analysis

Unlike quantitative research, a qualitative approach allows the researcher to enter the particular world of the participant by exploring and understanding subjective experiences (Biggerstaff & Thompson, 2008). This can be done through various methodologies which have different philosophical underpinnings and focus on different theories and methods (Smith, 2004). Interpretative Phenomenological Analysis (IPA) is a specific qualitative methodology developed by Jonathan Smith and its main aim is to allow thorough exploration of “subjective experiences and social cognitions” (Biggerstaff & Thompson, 2008, p. 215) to ultimately understand how individuals make sense of a significant experience (Smith, Flowers & Larkin, 2009). IPA has theoretical underpinnings in phenomenology, hermeneutics (Smith, 2010) and social-interactionism (Biggerstaff & Thompson, 2008). The former was originated by Husserl and enables the researcher to construct a “philosophical science of consciousness” (Biggerstaff & Thompson, 2008, p. 215). The application of phenomenology to psychological research allows the researcher to understand the individual’s perception of the world and its effects on the lived experience (Langdridge, 2004). Phenomenology is concerned with individual subjective reports rather than objective accounts as it assumes that human beings do not perceive reality in a passive way, but they interpret and understand the world by creating their own biographical stories to be able to make sense of their own experiences (Brocki & Wearden, 2006).

Additionally, this approach holds that consciousness is not a private domain and that the world and the mind are essentially correlated with each other. Therefore, the focus of any phenomenological investigation should always be the “public realm of experience”
(Langdridge, 2004, p. 276), that is the relationship between the individual and the world around him. Furthermore, the phenomenological position presupposes that the researcher can gain insight into the individual’s world through interrogation (Langdridge, 2004). This will provide the researcher with a first-person account of the life experience. Husserl as cited in Langdridge (2004), stressed that a researcher carrying out a phenomenological investigation should strive to describe the actual accounts as experienced by the individual, setting aside the natural attitudes and biases of everyday knowledge. This process is known as epoché and requires the researcher to be aware of his prejudices and biases and to examine the individual’s experiences from different perspectives (Langdridge, 2004). This approach to phenomenology, which is referred to as the transcendental approach (Langdridge, 2004), suggests that by bracketing the habitual ways of perceiving the world, the researcher will be able to understand the phenomenon in its essence (Finlay, 2009). This process is a demanding operation and requires a certain level of reflection and concentration (Giorgi, as cited in Finlay, 2009). Other theorists, such as Heidegger, Sartre and Merleu-Ponty were in agreement with the significance of the epoché but believed that an individual’s presuppositions can never be truly bracketed (Langdridge, 2004). This existential approach to phenomenology takes into consideration the idea that the individual’s unique experiences, knowledge and perspective will shape one’s understanding of the world. (Finlay, 2009). Therefore, in research applying such an approach, the process of bracketing recommended by Husserl is seen to be less relevant. Conversely, more importance is given to reflexivity and awareness of how the previous experience, knowledge and assumptions might have affected the research (Finlay, 2009).
Throughout the years, different approaches to phenomenology have been developed, all having their own emphases, philosophical underpinnings and methodological concerns. However all phenomenological investigations share a key factor, that is the focus on the way that people perceive their experiences and the world that they inhabit (Langdridge, 2004). IPA and other interpretative versions of phenomenology have emerged from the work of hermeneutic philosophers such as Heidegger, Gadamder and Ricoeur (Finlay, 2009) and therefore adopt an existential approach (Langdridge, 2004). IPA gives importance to the interpretative role of the researcher. As mentioned above, IPA has philosophical underpinnings in social interactionism in addition to phenomenology and hermeneutics. Therefore, IPA acknowledges the idea that meanings can only be accessed through interpretation (Biggerstaff & Thompson, 2008). Smith (2004), describes IPA as an idiographic, inductive and interrogative approach to qualitative research. In other words, IPA allows the researcher to understand and analyse the meaning of subjective experiences while taking into account and emphasising the interpretative role of the researcher (Brocki & Wearden, 2006). Smith (2004) suggests that IPA involves a double hermeneutic, that is, while “the participant is trying to make sense of their personal and social world, the researcher is trying to make sense of the participant trying to make sense of their personal and social world” (Smith, 2004, p. 40).

**Rationale**

The aim of this study is to understand the lived experiences of sufferers of Trichotillomania in Malta. The focus is on obtaining a clear picture of what it means to suffer from such a disorder by entering the lives of the individuals. A qualitative approach was selected as my interest was to understand the subjective experiences of the participants.
Additionally, such an approach gave me the opportunity to interact with the participants directly and thus enabled me to understand their experience from their unique perspective.

I believe that individuals suffering from Trichotillomania have their unique way of perceiving and making sense of the world they live in. For this reason, I decided to use IPA as it aims to understand the unique perceptions of individuals going through significant experiences by engaging with their reflections (Smith, 2004). Moreover, I have been through a similar experience myself and therefore I am conscious of my prior knowledge and perception regarding Trichotillomania. My personal experience has provided me with a particular frame of mind and I am aware that this will not necessarily coincide with the subjective experiences and understandings of the individuals participating in the research. For this reason, I feel that my experience and my consequent perception regarding Trichotillomania may have an impact on the study. This impact may have both positive and negative effects. My experience may provide me with certain prejudices that may narrow my focus of the subject matter during the data collection process and thus restrict my ability to enter the personal world of the participants. This will have an effect on the results obtained and subsequent interpretation. Additionally, my predetermined perception may obscure my judgment during the process of data analysis and interpretation. On the other hand, in view of the fact that IPA gives importance to the interpretative role of the researcher, I believe that by being aware of my preconceived notions throughout the process and by carefully bracketing these ideas during the data collection and data analysis, my experience may enrich the interpretation of the results by offering a different point of view while keeping the focus on the unique lived experiences of the participants.
Data Collection

Participant recruitment. According to Smith, Flowers and Larkin (2009), participants of an IPA study should be “selected on the basis that they can grant us access to a particular perspective on the phenomena under study”, (p. 49). The aim of this study is to explore the lived experiences of Maltese sufferers of Trichotillomania. For that reason, the participants of my study needed to be Maltese individuals who have been through this particular experience themselves and who were willing to discuss their experiences with me, i.e. purposive sampling. Initially, the participants were to be recruited by the help of psychologists acting as intermediaries. Therefore, my initial search for participants involved sending an e-mail to the Maltese Psychological Association (MPA), and to several other psychologists and psychiatrists, explaining the purpose of my study while requesting assistance in finding participants (see Appendix A). The e-mail sent to the MPA was then forwarded to the members of the association. Moreover, this e-mail specified that the participants should be over the age of 18 and have not exhibited any symptoms of this disorder for the last two years. The latter was included to ensure that none of the participants risk any type of harm by participating in this research. However, none of the professionals I contacted were able to help me find participants. This was mainly because most of the professionals were not in contact with individuals suffering from this particular disorder. Other professionals informed me that their clients were either not in remission or unavailable to undergo the interview process. Additionally, I was told that the clients who stop engaging in the behaviour tend to cease therapy and thus lose any contact with the professional. Consequently, I had to recruit participants through opportunity sampling by explaining my study and my need for willing participants to friends and other university
students. People who knew of individuals interested in participating acted as intermediaries, by forwarding a copy of the information sheet with all the necessary information regarding the study together with my contact details to the interested individual. These information sheets were prepared in Maltese and English, to make sure that all potential participants understand what participation entails (see Appendix B).

Subsequently, interested potential participants contacted me themselves after reading the information sheet and ensuring that they would like to participate. Two participants were obtained in this way while the other three participants were contacted by the other participants themselves, through snowball sampling. However, not all of the individuals interested in participating were in a complete state of remission. This may be due to the nature of the disorder. In fact, Trichotillomania is frequently chronic and unremitting (Swedo, Leonard, Lenane, Rettew as cited in O’Sullivan et al., 1997), especially if the onset is in early adolescence (APA, 2000). This situation put forward an ethical dilemma since I wanted to make sure that participation does not harm the individuals in any way. After consulting with my dissertation supervisor, Dott. Darmanin Kissaun, and ensuring that the interested individuals were not suffering from severe emotional distress, I made sure that the potential participants understood what the research process involved and that they were participating voluntarily. The sample consisted of four females and one male.

Additionally, the participants manifested different types of behaviours related to hair-pulling. The male participant and two of the female participants stated that they engage in a behaviour similar to the one mentioned in the DSM-IV-TR. However, the other two participants affirmed that they tear their hair rather than pull it out, causing damage to the hair but not hair loss. As mentioned before, the current version of the DSM describes
Trichotillomania as the recurrent pulling out of one’s own hair resulting in noticeable hair loss (APA, 2000). Therefore, the behaviour of the latter two participants cannot be classified as Trichotillomania according to strict *DSM-IV-TR* criteria. Consequently, I was uncertain whether these individuals should be included in the sample. However, one of the proposed amendments of the DSM-5 work group is the idea that the hair loss does not have to be noticeable for a diagnosis of Trichotillomania to be made. For this reason, I decided that the inclusion of these participants is appropriate since their behaviour can be considered to be related to hair-pulling. Furthermore, I thought that their accounts may offer additional important information which would shed further light on the phenomenon under study.

**The interview.** Data was collected through semi-structured interviews. According to Smith and Osborn (2003) semi-structured interviews are the best way of collecting data for IPA analysis since they allow the participant and the researcher to engage in a dialogue that can be modified according to the personal experience of the participant. The interviews were guided by an interview schedule with a limited number of open-ended questions so as to make sure that the interview takes the direction of the participants rather of my presupposed notions (see Appendix C). These interview schedules were prepared in both English and Maltese to enable the participants to express themselves in the language that they feel most comfortable using. However, all participants chose to talk in English. The interviews were tape recorded to enable transcription and data analysis at a later stage.

The interviews were held on different dates and at places chosen by the participants themselves. I began the interviews by giving an overview of my study and information regarding participation. I assured them that confidentiality would be kept and that the
recordings of the interview will be erased after completion of my study. Additionally, I obtained their informed and written consent through a consent form (see Appendix D).

While conducting the interviews I attempted to bracket my preconceived knowledge so as to make sure that I fully understand the subjective experiences of the participants. This was rather challenging, especially since some of the views of the participants were different than mine.

Data Analysis

The data analysis was conducted by following IPA guidelines proposed by Smith and Osborn (2003). The aim of this type of data analysis is to try to understand the content and complexity of the meaning that emerged from the interviews (Smith & Osborn, 2003).

After reading the transcripts a number of times, I began to familiarise myself with the accounts of the individuals. During this stage I attempted to understanding the actual meaning that emerged from the interviews while taking notes and annotations of what I found to be interesting or significant. At this point I began to emerge themes from the accounts and I tried to ensure that these reflected the actual views and feelings of the individuals. The emergent themes from each transcript were clustered and connections were made between the different themes and clusters of themes. This was followed by the production of a table of themes for each transcript. This process was done for each transcript. The clusters of themes that emerged from each transcript were than integrated to form a set of results which are presented in chapter 4. For an example of the analysis of the transcriptions, please refer to Appendix E.
Chapter 4: Results

The following results focus on the main themes that emerged from the data analysis. The key themes are:

1. Stages
2. Reasons for engaging in the behaviour
3. Need for control
4. Personal beliefs and attitudes related to the behaviour
5. Relationships
6. Public awareness and perception
7. Professional services

Stages

From the interviews I realised that the participants seemed to go through a number of common stages:

i. Onset. It seemed that none of the participants could recall the first time that they engaged in the behaviour. In fact, any questions about onset where mostly answered by responses such as “I have no idea how it started” and “At some stage this thing came in, the Trichotillomania”. Nevertheless, it appeared that throughout the years the participants tried to gain a better understanding of the possible contributions to the onset of the behaviour. Kate associates the hair tearing with an effort to stop biting her nails while Emily states: “What I do know is that I used to suck my thumb till I was about 10 and that same year I started pulling my hair” Susan suggests that the tearing of her hair may have been a result of her observing her sister Kate and other people engaging in similar behaviours.
However, all the participants could give a rough age of onset. All the female participants reported an onset between late childhood and early adolescence, mainly between the age of 7 and 13 and the male participant stated that he started to engage in the behaviour in early childhood, between the age of 4 and 5.

**ii. Hair pulling as a coping mechanism.** After onset the behaviour seemed to function as a self-soothing mechanism during periods of intense emotions such as stress, anxiety, concentration and boredom. In fact, participants described the behaviour as “relaxing”, a stress-reliever”, “a way of bringing out anxiety”, and “a channel of letting off energy”. As a result the worst phases during this stage seemed to be during times of elevated stress and anxiety such as exam periods or “intense moments”. In fact, Tom states that “during exams it’s the worst”. This stage is also characterised by the lack of knowledge regarding the diagnosis of Trichotillomania. None of the participants related their behaviour to a mental disorder at this stage. “I used to think it was just fidgeting”. Conversely, most of the participants compared the behaviour to nail biting. “I never really felt like it’s a condition, as in it’s like when people bite their nails”. This may have led to the fact that participants did not feel the need to seek professional help at this stage. “I didn’t know it was a problem. I mean, when you don’t know it’s a problem you can’t seek help”.

**iii. Progression.** I observed that the behaviour may progress after some time. During this stage the behaviour becomes more pervasive and happens rather “automatically”. Three participants talked about this progression and felt that during this stage the behaviour was no longer restricted to private moments. “Before I used to pull just at home but now I pull everywhere, even in front of strangers”. Furthermore, one of these three participants added
“whereas before I used to say exams and particular moments of stress will increase [the behaviour] I can no longer see that pattern”.

iv. Awareness of behaviour as a problem. During this stage the individuals became aware of the behaviour and started to feel that it may be causing some kind of problem. All the participants agreed that the main problem caused by the behaviour is the damage inflicted on the hair which has a subsequent effect on the self-image. Additionally, Susan felt that the behaviour may create embarrassing moments when she engages in the behaviour in public. However, the participants expressed this awareness in different ways. Tom and Erica decided to control the behaviour themselves while Emily sought professional help. “I was very conscious of my problem back then and I was very willing to stop so I wanted input [from a professional]”. On the other hand, Susan and Kate would like to stop engaging in the behaviour but do not feel that it has “got to such a state that it is hampering”. Kate adds “I would like to stop but if stopping it means that my anxiety will get worse and that it will come out in another way I think I’d rather keep picking at my hair than have other problems”.

v. Maintenance and relapse. This stage refers to the processes involved in controlling the behaviour. From the interviews I noticed that the participants felt that controlling the behaviour requires a considerable amount of effort. “Every time I used to stop a few months later I would fall back on it”. Even the participants that claimed to be controlling the behaviour successfully feel susceptible to relapse. “During university years whenever I know exams are approaching I cut it [my hair]”.
vi. Help others. Erica seems to have moved to a stage where she feels confident about managing the behaviour and uses her experience to help others going through similar experiences.

These stages seemed to be common amongst all the participants. However, the amount of time that the individuals spent in a particular stage differed from one participant to another.

Reasons for Engaging in the Behaviour

Following the data analysis I became aware that the most common reason for engaging in the behaviour is related to stress and anxiety. Participants described different situations that contribute to the feelings of anxiety which may in turn trigger the hair pulling behaviour. Most participants mentioned exam periods, while Emily added that her anxiety is usually due to the thought of people criticising her. Emily feels that such situations tend to create a “vicious cycle” – when she thinks that people may be criticising her, she tends to engage in the behaviour which may result in bald patches. Consequently, she feels that these bald patches may increase the chance of people talking about her and thus increasing her anxiety. This may be related to negative self appraisal as a result of low self-esteem.

The participants mentioned other reasons for engaging in the behaviour and these differed from one individual to another. Kate and Erica relate Trichotillomania to boredom and the need to be active, while Susan explained that the behaviour tends to follow a persistent urge. A number of participants expressed that the behaviour tends to be automatic and therefore difficult to stop. “While I’m thinking and doing it somehow I can’t stop”. Additionally, Erica described the hair pulling behaviour and the process that follows it as
“entertaining”. On the other hand, Erica and Susan specified that they do not feel that the behaviour is done out of self-harm.

Need for Control

All the participants felt that the behaviour needed to be controlled or stopped in one way or another. Tom expressed this need by saying “hopefully it won’t happen again”. On the other hand, Kate and Susan try to control it but are worried that if they stop, the anxiety may be expressed in another way. The reasons for controlling the Trichotillomania and the different methods that can be used to control the behaviour were the two main themes related to control that emerged from the interviews.

Reasons for controlling the behaviour. I noticed that the main reason for controlling the behaviour was related to the effect that Trichotillomania has on the image of the individual. All the participants expressed their awareness of the damage that the behaviour is causing to the hair and the subsequent effect that this has on their appearance. Tom added that this may have had an effect on how people perceived him when he was growing up. Another reason for controlling the behaviour is the fact that the behaviour tends to waste time as it distracts the individual. Additionally, Kate stated that she is trying to abstain from engaging in the behaviour in front of her children as she is worried that they might try to imitate the behaviour.

Reluctance to stop. On the other hand, I noticed that some of the participants were reluctant to stop the hair-pulling and tried to justify the behaviour. In fact, Kate said “but at that very moment it’s hard to replace the damage and the idea that it’s doing harm with what I’m getting out of it...the relief I’m getting out of it”.
**Ways of controlling the behaviour.** Different participants talked about different ways of controlling the behaviour. From the interviews I noticed that throughout the years the participants made various attempts to end the “habit”. The most common method used amongst the participants was the substitution of the behaviour with something similar such as “dolls with wigs” or “rubber toys” even though, the participants admitted that “it’s not the same thing” or “not as satisfying”. Erica described this method as being rather successful. Susan tried to control the behaviour by wearing a hat or sitting on her hands but this was not always successful. Additionally, some of the participants chose to analyse themselves and the possible triggers of the behaviour. It was interesting that Emily was the only participant who felt the need to seek professional help.

**Personal Beliefs and Attitudes Related to the Behaviour**

It was interesting that when asked about their thoughts regarding the behaviour one participant had contrasting views when compared to the views of the other participants. Four of the participants compared the hair-pulling behaviour to a “habit”. “I accept it as a habit in the same way that people accept smoking as a habit”. As a result, these participants do not relate Trichotillomania to severe problems even though they are aware of the damage that they may be causing. Additionally, I noticed that these four participants did not feel comfortable with the fact that the behaviour is labelled as a mental disorder. In fact, it was frequently compared to nail-biting. I also noticed that Tom associated the behaviour with a childhood habit. “...when I did it now...I thought it passed in fact I was laughing and I was like I’m not 4 anymore”. Moreover, Erica specified “It’s not a part of me...it’s just something that I do”.

On the other hand, Emily feels that the behaviour is a problem and has tried different ways to control and stop the behaviour. Additionally she feels that she identifies with the behaviour and said “This is part of me, the same way as hormonal changes are a part of life, the same way as so many things are a part of life. This is who I am”

**Relationships**

It seems that the relationships that the participants had with significant people had a particular role in their overall experience. The main relationships mentioned during the interviews were the ones with family members and friends.

**Family.** All of the participants mentioned the role of at least one family member as part of their lived experiences. Most of the participants said that the parents or close family members were the first to notice that they were engaging in the behaviour. Additionally, these family members made great efforts to control and prevent the behaviour. Tom’s mother shaved his hair and used gifts as reinforcers to help him control the behaviour. Emily talked about her mother and said “She was the first person to notice, she was the person to seek, to read, to take me places to meet different people and she’s still concerned”. However, Emily believes that her family members were unable to understand what she was going through and feels that this had an effect on the way she evaluated herself while growing up. “Every time my parents were seeing me they were correcting me about this [behaviour] so it hit my self-esteem big time.” On the other hand, Susan felt that the fact that her sister Kate engaged in a similar behaviour had a positive effect on her outlook regarding Trichotillomania – “it made it more normal”. Kate expressed a similar view.
Friends. Not all the participants felt the need to talk about Trichotillomania with their friends. In fact, Susan believes that people “tend to be covert” about such things. However, she added that it felt good to know that a close friend was aware of what she was going through. Emily was of the same opinion and felt that her friends were better at understanding the behaviour than her family members. Emily and Susan both explained that not all their friends were able to react to it in the same way but most of their friends “were loving and accepted it”. Additionally, both Emily and Susan said that it was comforting to meet other people that engage in the same behaviour.

Public Perception and Awareness

All the participants feel that there is a lack of local awareness regarding Trichotillomania. However, not all the participants were of the same opinion regarding the need for such awareness. Erica believes that public awareness may result in an increase in the prevalence of Trichotillomania while Susan thinks that “it does not need to be blown up”. Additionally, all participants agree that the lack of awareness regarding Trichotillomania makes it easier to conceal it. Moreover, Kate thinks that the public perception needs to change before increasing the awareness. “It is seen as such a severe disorder which I personally don’t connect with that if the awareness increases people who do it might start thinking that something is really wrong with them”. On the other hand, Emily believes that if there were better public awareness she would have found more support from family and friends. Furthermore, all the participants are of the opinion that hairdressers need to be fully aware of Trichotillomania and capable of dealing with such clients.
Professional Services

As mentioned above, Emily was the only participant that felt the need to seek professional help. The other participants did not feel “that it merited that much”. However, Emily feels that there should be better awareness regarding Trichotillomania amongst professionals. Moreover, all the participants felt that professionals should be well aware of Trichotillomania and able to help people seeking professional help.
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<th>Example of illustrative quote</th>
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<td>v. Maintenance and relapse</td>
<td>“it happened to me again”</td>
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<td></td>
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<td>“when I found that people I knew had the same problem...I actually told them how to stop...”</td>
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<td>Reasons for engaging in the behaviour</td>
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<td></td>
<td>Negative self appraisal</td>
<td>“the possibility of someone thinking negatively of me, i think that’s when I pull”</td>
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<td>Distraction</td>
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<td>“Boredom”</td>
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<td>Urge</td>
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<td>Difficult to control and stop</td>
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<td>Entertaining</td>
<td>“It’s quite entertaining you know when you pull out the hair and you look at it...”</td>
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<td>Not done to harm self</td>
<td>“I love my hair...I have no problem with my hair”</td>
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<td>Need for control</td>
<td>Reasons for controlling behaviour</td>
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<td>“That’s how I stopped...I just carried it [the rubber toy] around with me”</td>
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<td>Attitudes and personal beliefs</td>
<td>Compared to habit</td>
<td>“it’s no big deal, it [the hair] grows back” “The label bothers me”</td>
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<td>Problem</td>
<td>“This is part of who I am now”</td>
</tr>
<tr>
<td>Relationships</td>
<td>Family</td>
<td>“my mother from the very beginning, she tried to stop it”</td>
</tr>
</tbody>
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Friends

“it’s something that is intimate so not everyone is able to react in the best way possible...”

Public awareness and perception

Lack of public awareness

“No one knows about it”

Professional Services

Lack of awareness amongst professionals

“it’s been almost 15 years that I’ve been pulling and I’ve been looking for help for a good ten years and still I’m rather stuck”
Chapter 5: Discussion

Introduction

This section aims to discuss some of the themes that have emerged from the study and link these themes to the way that the individual participants perceive the hair-pulling behaviour. The discussion of these themes will be related to the literature presented in chapter 2. The limitations of my study will then be presented, followed by possible implications and recommendations of future studies.

Discussion

From the interviews it was evident that Emily had contrasting views regarding Trichotillomania when compared to the rest of the participants. The other four participants seemed to share the idea that their hair-pulling behaviour should be accepted as a habit similar to nail biting. On the other hand, I noticed that Emily relates the behaviour to more severe problems and higher levels of distress. I think that this distinct difference amongst views is an important finding since I believe that it had a considerable effect on the other results. This contrast may be due to different severity levels of Trichotillomania. As mentioned in the literature review, previous research regarding Trichotillomania has shown that the severity of the behaviour may differ from one individual to another. Following my interviews, I believe that the severity of Trichotillomania may influence the way that the individual feels about the behaviour and the effect that it will have on the individual’s life. Additionally, this difference in outlook may also be related to certain personality factors that affect the way that the individual copes and reacts to challenging situations. During the process of my study I felt that I could relate more to the view of Emily than to the views of
the other participants. As a result, the data analysis and subsequent interpretation proved to be rather challenging since I had to bracket my knowledge and perception to fully understand the lived experiences of all the participants.

Another factor that seemed to influence the view that the participants had regarding the disorder was the lack of knowledge regarding the diagnosis of Trichotillomania. Before becoming aware of the diagnosis and label of Trichotillomania the participants, excluding Emily, did not associate the hair-pulling behaviour to a mental disorder and felt that it was comparable to other common habits such as nail-biting. This comparison may be justified by the fact that nail biting and hair-pulling tend to serve a similar function. Both behaviours may act as coping mechanisms in situations of heightened tension and anxiety. Additionally, both behaviours demonstrate a kind of compulsion that may cause a certain degree of damage. However, the current DSM classification of Trichotillomania is different than that of nail-biting (APA, 2000). The classification of nail-biting is still rather unclear but researchers are relating this disorder to obsessive-compulsive spectrum disorders (Pacan, Grzesiak, Reich, & Szepietowski, 2009). The relation of nail biting to the obsessive-compulsive spectrum, the similarities between nail biting and hair pulling and the fact that most participants expressed a significant link between the two behaviours may help to further sustain the need of re-classification of Trichotillomania from Impulse Control Disorders Not Elsewhere Classified to Anxiety and Obsessive-Compulsive Spectrum Disorder.

However, in spite of the various similarities between nail biting and hair pulling the participants themselves are aware that there seems to be a much wider public acceptance of the former behaviour. I believe that this may be partially related to the greater prevalence
of nail-biting. However, this may also be due to the lack of public awareness and knowledge of Trichotillomania. All the participants felt that there is a lack of awareness of Trichotillomania and expressed the need for a better understanding and perception of the behaviour, especially amongst professionals. This coincides with the need expressed by Parakh and Strivastava (2010). Some participants claimed that the public perception of Trichotillomania tends to associate hair pulling to severe mental disorders and this may have an effect on the way that the individuals suffering from the disorder are perceived by society. This makes the participants feel uncomfortable since they do not relate to this public perception. I myself share a similar opinion regarding the public perception of Trichotillomania and believe that there should be a subtle awareness aimed at improving this perception. Such an improvement may also make it easier for people suffering from the disorder to speak up and seek professional help if they feel that it is required.

Moreover, from the interviews I noticed that the age of onset may have an effect on the way that the disorder is experienced. In fact, as mentioned in chapter 2, previous literature has described different types of Trichotillomania based on the age of onset. Research has found that early onset is usually related to a more benign form of Trichotillomania while later onset increases the tendency of a more chronic and relapsing course (APA, 2000). In line with this theory, I observed that the participant with the earliest onset, Tom, may have found it easier to control and manage the behaviour once he started to grow older. This may be due to the fact that he was more inclined to associate the behaviour to childhood and therefore felt the need to stop the behaviour later on in life. Additionally, this difference may also be a result of Tom acquiring better coping strategies throughout the years or a change in his environment. Nevertheless, all participants are aware that the
behaviour tends to reappear during times of stress and anxiety even though some of the participants feel that they are controlling the behaviour successfully. In fact, most participants feel that it has become a part of their lives. This chronic quality of Trichotillomania may be compared to the chronic tendency of obsessive-compulsive spectrum disorders and thus continues to sustain the relation between the two disorders.

One interesting finding was that most of the participants did not feel that Trichotillomania had such a significant impact on their lives. This goes against research put forward by Walther, Rickets, Conelea and Woods (2010) which states that adults suffering from Trichotillomania tend to have deficits in psychological, social, academic, and occupational areas of functioning. The participants did not feel that the disorder hindered any significant aspect of their lives and therefore did not relate it to such difficulties. Conversely, all the participants have a tertiary level of education and feel that they have established a career in their respective fields. Additionally, the participants did not mention feelings related to shame, guilt or low self-esteem as a result of the hair-pulling behaviour as mentioned by Bruce, Barwick and Wright (2006) even though they are conscious of the damage that the behaviour may be causing. The main discomfort expressed by the participants was largely related to the lack of understanding of the people around them such as family members, friends and hairdressers and not to the behaviour itself. I believe that these contrasting results may either suggest the presence of different types of Trichotillomania or a whole spectrum of severities.

Furthermore, I noticed a substantial similarity between the experiences of the participants engaging in hair-pulling and those engaging in hair-tearing. The current version of the DSM does not classify hair tearing as Trichotillomania since such a behaviour does not
result in noticeable hair loss (APA, 2000). However, one of the propositions presented by the DSM 5 work group is the removal of this criterion. I believe that the resemblance between the two behaviours substantiates this proposition and the possibility of a spectrum of Trichotillomania with hair tearing as a mild form of the disorder.

From the interviews, I became aware that the type of reaction and acceptance of relatives and friends of the participants had a significant effect on the experience. Most participants expressed considerable frustration when they felt that people around them could not empathise and understand what they were going through. This frustration was mainly due to the negative perception associated with the disorder. I believe that it is important that people going through such an experience find support and acceptance from family members or close friends. This support network may give the individuals a chance to share their concerns when they feel the need to do so while making them feel understood by the people that they love and care about. Not all participants felt the need for such a support network. However, I believe that the fact that all the participants talked about a family member or close friend who knows about their behaviour may suggest that people close to the individual need to have a clear understanding of Trichotillomania.

The participants talked about different reasons for engaging in the behaviour. However, the main reason was related to the function of the behaviour. Consistent with research by Stein and Christenson (1999), the participants felt that the behaviour acts as a coping mechanism during periods of heightened stress and anxiety. From the interviews, it seemed that the behaviour operates as a mechanism of self-soothing and emotional regulation. As a result, one underlying cause of the behaviour may be related to the lack of such mechanisms and strategies. By using a behavioural perspective it can be noticed that the gratification and
relaxation that the individuals gain from the behaviour acts as a mechanism of reinforcement and thus maintains the behaviour. This corresponds to the behavioural theory of Trichotillomania as presented by Keuthen, Aronowitz, Badenoch and Wilhelm (1999). Conversely, the cognitive-behavioural perspective gives equal importance to the cognitive processes of the individual and to the behaviour itself (Keuthen, Aronowitz, Badenoch, & Wilhelm, 1999). From the interviews I observed that some maladaptive thoughts of the participants contributed to the reinforcement of the hair pulling behaviour. One example of such maladaptive thoughts experienced by the participants was the belief that pulling is needed to reduce the anxiety.

Another interesting finding was the fact that Emily was the only participant who sought professional help. This may be due to her contrasting views regarding Trichotillomania. Emily felt that the behaviour was out of her control and required professional help to control it. On the other hand, the other participants either felt that they could control the behaviour on their own or that they can live with it. This may again suggest the possibility of a wide spectrum of severities of Trichotillomania.

**Limitations**

I believe that one of the main factors affecting my study was my preconceived perception regarding Trichotillomania as a result of my personal experience. I was aware of my prior knowledge regarding Trichotillomania throughout the process of the research and therefore attempted to keep an objective stance to make sure that I am truly understanding the unique experiences of the participants. However, I am aware that my experience may have caused me to pick out certain themes and literature that confirm my
beliefs rather than contradict them. Hence, I am conscious of the fact that my prior knowledge has had an effect on my interpretation of the results.

Moreover, I believe that my lack of interviewing experience may have limited my findings. During the interviews I felt anxious and was scared to probe as I did not want to make the participants feel uncomfortable. As a result, participants may have not delved in all the issues that pertain to the experience and thus limiting my results.

Another limitation in my study may have been the fact that most participants were recruited through snow-balling and therefore knew each other. As a result I noticed that the participants came from similar backgrounds and this may have biased my findings.

The imbalance in gender ratio of the participants may have also had an effect on my results. I would have liked to have a more balanced female to male ratio but I could not find more male participants. This may be due to the fact that research carried out so far has shown that Trichotillomania is much more common among females than among males (APA, 2000). However, it is still unspecified whether this finding is reflecting the factual prevalence of the condition or whether it is due to other cultural or gender-based attitudes (APA, 2000).

**Implications for Treatment**

From the interviews, I noticed that the hair-pulling behaviour tends to become ego-syntonic. In other words, Trichotillomania may become consistent with the individual’s sense of self. This may result in a state of ambivalence as the individual may have conflicting feelings towards the behaviour. While acknowledging the need to control and
stop the behaviour, the individual may simultaneously feel that the behaviour is serving a function and therefore feels the need to continue engaging in the behaviour. This ambivalence may lower the individual’s motivation to stop. As a result, motivational interviewing (MI) may be an effective treatment in such cases. This question-and-answer method is aimed at increasing the individual’s motivation to change by trying to shift the individual towards wanting to change the maladaptive behaviour (Alloy, Riskind, & Manos, 2005). Hence, MI may help individuals suffering from Trichotillomania by increasing their motivation to stop the hair-pulling behaviour while helping them to develop the confidence to change.

Moreover, I believe that the formation of a local support group regarding Trichotillomania would help individuals to share their feelings and concerns with people who are going through similar experiences. In fact, Emily and Susan said that it was comforting to meet other people that engage in the same behaviour.

**Recommendations for Future Research**

Following the interviews and my reading on the subject of Trichotillomania, I believe that there needs to be a clearer understanding of the hair-pulling disorder. This can be done by increasing the research regarding this subject and focusing on information such as prevalence, gender ratio, lived experiences of participants and knowledge of the disorder amongst healthcare professionals since I feel that research in these areas is rather limited. Additionally, I believe that there should be an increase in local research concerning Trichotillomania. In fact, I found that there is a considerable lack of information about the disorder in Malta. Such research may help to provide professionals with a clearer
understanding of this behaviour. This will make it easier for individuals who would like to seek help. Moreover, a subtle awareness regarding Trichotillomania in Malta may help to improve the current perception of the general public. Such an improvement in perception may help the individuals suffering from Trichotillomania to feel less uncomfortable talking about their behaviour. In fact, Kate stated “if the perception changes than probably I’ll speak”.

Conclusion

This study explores the lived experiences of Maltese sufferers of Trichotillomania. The key themes that emerged from interviews with individuals allowed me to explore the meaning of living with such a disorder from the individuals’ personal perspective. From these interviews I can conclude that the participants have their own way of perceiving and making sense of the experience. Additionally the study attempts to compare the different views of the participants. From this comparison it became evident that Trichotillomania is a complex and multifaceted disorder and that different individuals may have different views regarding the hair-pulling behaviour.
References


Appendix A: Letter sent to professionals

To whom it may concern,

I am a B. Psy (Hons) student and I am currently in my third and last year. For my dissertation, I would like to study the lived experience of Maltese sufferers of trichotillomania. This disorder and other Impulse Control Disorders have been extensively researched internationally using different research designs. However, to my knowledge there are still some gaps present with regards to local research concerning this area. As a result, I would like to carry out a qualitative study in order to understand the experiences of Maltese people suffering from trichotillomania.

For this study I will be interviewing 5 to 8 participants. The participants must be over the age of 18 and may be either males or females. Additionally, the participants must have suffered from trichotillomania at some point in their lives but have not been exhibiting any symptoms of this disorder for the last two years. Participation is completely voluntary and participants will be given an information sheet with the necessary details regarding the study. Additionally, before being interviewed, the participants will be asked to sign a consent form.

As specified in my research proposal, the participants should be approached by a psychologist who will act as an intermediary. As a result, my dissertation tutor, Dott. Darmanin Kissaun, suggested that I send an e-mail regarding my study to the Maltese Psychological Association since psychologists within the association may know of individuals who would like to consider participating in my study.
Attached please find a Maltese and English version of the information sheet intended for the potential participants which explains what the participation in this study involves.

Your co-operation would be greatly appreciated.

Julia Ann Camilleri
Appendix B: Information Sheet

Information Sheet

I am a University Student reading for a degree in Psychology. For my dissertation, I would like to study the lived experience of Maltese sufferers of trichotillomania. This information sheet explains why this research is being carried out and what it involves. Please read the following information carefully and feel free to ask me about anything that you have read or about anything else that you would like to be explained.

The Study

In the DSM-IV Trichotillomania is characterised as an Impulse Control Disorder which involves the recurrent pulling out of one’s own hair for pleasure, gratification or release of tension, resulting in noticeable hair loss. Trichotillomania and Impulse Control Disorders in general have been extensively researched internationally using various research designs. However, to my knowledge there are still gaps present with regards to local research concerning this area. As a result, I would like to carry out a qualitative study in order to understand the lived experience of Maltese people suffering from trichotillomania.

Participation

Participants must be over the age of 18 and may be either males or females. Additionally, the participants must have suffered from trichotillomania at some point in their lives but should have not shown any symptoms of the disorder for the last two years.
Involvement

If you decide to take part in this study, you will first be asked to sign a consent form. Once the consent form is signed, you will be interviewed. The interview will take place in an agreed location which is easily accessible to you and at a time that is convenient for you. You will be interviewed once and the interview will not take longer than an hour. The session will be tape-recorded and once the interview is completed and transcribed, you will be offered the option to read through the interview transcript. The findings of the study will also be provided once these are available.

Participation is completely voluntary. If you decide not to take part or if you choose to withdraw at any stage, you will not be required to give a reason. During the interview, you can choose not to answer any of the questions. You may also end the interview at any point without giving a reason.

Confidentiality

The study is completely confidential. Your name will not be used or attached to any information you give and a false name will be used in any write-up of the findings. The recording will be destroyed at the end of the study.

No one will know that you have participated in the study apart from me and anyone else you choose to inform. All identifying markers will be removed from the interview transcript and your signed consent form will be held in a secure place.
If you would like to find out more information about this study, the contact details are the following:

Mobile Number: 79291671

E-mail address: jcam0019@um.edu.mt

Julia Ann Camilleri
**Karta ta’ Informazzjoni**


Ir-Riċerka


Parteċipazzjoni

Il-partecipanti ghandhom ikollhom mill-inqas tmintax il-sena u jistaw ikunu kemm nisa kif ukoll irgiel. Barra minn hekk, il partecipanti jridu ikunu soffrew mit-Trichotillomnia xi darba f’hajjithom, pero ma jridux ikunu urew sintomi tal-kundizzjoni ghal dawn l-ahħar sentejn.
Involviment


Kunfidenzjalita

Din ir-ričerka hija komplettament kunfidenzjali. Ismek mhux se jintuza fl-ebda post u fit-teżi se jintuża isem falz jiprotegi l-identita tieghek. Ir-recording se jigi mħassar wara li tkun lesta ir-ričerka.

Ħadd m’hu ser ikun jaf li inti ħadt sehem f’din ir-ričerka, minn barra jien u xi nies li tiddeċiedi li tghidilhom inti. Kull marka li jista jkun hemm fuq it-transcript li tista twassal ghal identifikazzjoni tieghek se titnexeħa u il-formula ta kunsens se tinżamm f post sikur.

Jekk tixtieq tikkuntatjani għal iktar informazzjoni rigward din ir-ričerka tista tagħmel dan fuq:

Mobile Number: 79291671

E-mail address: jcam0019@um.edu.mt

Julia Ann Camilleri
Appendix C: Interview Schedule

Interview Guide/ L-Intervista

- Can you tell me a little about yourself?
  Tista tghidli ftit fuqk innifsek?

- Can you tell me something about your experience regarding Trichotillomania?
  Tista tghidli ftit dwar l-esperjenza tieghek ta’ Trichotillomania?

- What can you say about the role of your family regarding Trichotillomania?
  X’tista tghidli dwar ir-rwol tal-familja tieghek rigward it-Trichotillomania?

- What do you think about the current awareness about Trichotillomania in Malta?
  X’tahseb dwar l-gharfien li hawn bhalissa f’Malta rigward it-Trichotillomania?

- Can you say something about the help that you received for this condition?
  Tista tghidli xi haga dwar l-ghajnuna li rċivejt ghal din il-kundizzjoni?
Appendix D: Consent Form

FACULTY OF EDUCATION
ETHICS COMMITTEE
CONSENT FORM

Name of researcher: Julia Ann Camilleri

Address: 

Phone No.: 

Statement of purpose of the study: The study will focus on the lives experiences of Maltese sufferers of Trichotillomania.

Methods of data collection: Data will be collected through semi-structured interviews of approximately one hour in length.

Use made of the information: The interview will be tape-recorded and later transcribed for analysis.

Guarantees:

I will abide by the following conditions:

(i) Your real name will not be used in the study.
(ii) Only the supervisors and examiners will have access to the data
(iii) You will remain free to quit the study at any point and for whatever reason. In the case that you withdraw, all the records and information collected will be destroyed.
(iv) Deception in the data collection will not be used.
(v) Conclusions from the research will be communicated to you either verbally or in writing.

I agree to the conditions.

Name of Participant: Signature: Date:

Name of Researcher: Signature: Date:
Fakulta ta’ l-Edukazzjoni
Kumitat ghar-Riċerka Etika
Formula ta’ Kunsens

Isem tar-riċerkatur: Julia Ann Camilleri
Mobile: 
Indirizz: 

Dikjarazzjoni tar-raġuni ghalix ser isir dan l-istudju: Din ir-riċerka ser tiffoka fuq l-esperjenzi ta’ individwi Maltin li jbatu mit-Trichotillomania.

Metodu kif ser tingabar l-informazzjoni: L-informazzjoni ser tingabar minn intervisi li mhux ser jkunu itwal minn siegha.

Użu li sejjjer isir mill-informazzjoni: L-intervista ser irrekordjata biex l-informazzjoni tkun tista tigi analizzata.

Garanzija:
Jien ser nimxi ma’ dawn ir-regolamenti:
i. l-isem veru tieghek ma jiġix użat fl-istudju.
ii. is-supervizur u l-eżaminaturi biss ser ikollhom aċċess ghall-informazzjoni.
iii. inti fil-liberta’ li tieqaf mir-riċerka x’hin trid u ghal kull raġuni. F’kaz li tieqaf, kull oġġett rekordjat u informazzjoni migbura tingered mill-ewwel.
iv. bl-ebda mod m’int ser tiġi mqarraq fil-proċess ta’ ġbir ta’ informazzjoni.
v. int ser tkun avżat fuq l-konklużjonijiet tar-riċerka bil-kliem jew bil-miktub.

Naqbel ma’ dawn il-kundizzjonijiet imsemmija hawn fuq.

Isem il-partecipant: 

Firma: ____________________________ Data: ____________________

Firma tar-riċerkatur: ____________________________
Appendix E: Sample of Data Analysis

**Researcher**: And what effect do you think this experience had on your life?

**Emily**: How it has affected me... when I was in secondary school I was just about becoming aware of it and by then my mother was always panicking because I have this problem. Many of my extended family knew about it and they were always like I have a problem, you have a problem and you have to solve it. But when I was at this live in and everyone, like we were a group of I think 3, 3 or 4 people who experienced it in some way or another. It made it ok, I mean this is part of me. The same way as hormonal changes are a part of life, the same way as so many other things are a part of life. This is part of who I am. Now I do, I would like to stop. So I don’t hide it anymore because im past that, what use do I get by hiding it. I pull anywhere even in front of strangers. Before I never used to, I used to pull just at home and then it progressed that I do pull in front of strangers now.

| **Awareness of behaviour as a problem. (Stages)** |
| **Feels that family members were unable to understand her. (Relationships)** |
| **Comforting to meet other people with similar problem. (Relationships)** |
| **“This is part of who I am” (Attitudes)** |
| **Need for control** |
| **Progression. (Stages)** |
**Researcher:** And do you feel that the behaviour is triggered by anything?

**Emily:** I don’t know exactly what triggers it but I’ve tried for a number of years to try and see what my thought is exactly when I’m pulling and the main thought is usually related to how will people think of me. So for example if I’ve done something that I have doubts about will my performance be criticised, if I am going to do something new with a new group of people or do a presentation what will they think of me. Although im confident that I’m able to do and to fulfil all the roles I have, it’s in those moments of weakness when i think: what are they thinking of me now? Especially if they’re thinking negatively, the possibility of someone thinking negatively of me, i think that’s when I pull. Which makes it worse really because if I end up with bald patches you know its going to be more visible and its a vicious cycle.