

Reactions to Behaviors: The Role of Education on People's Perceptions of Body-Focused Repetitive Behaviors

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Abstract

Reactions to body-focused repetitive behaviors (BFRBs) (trichotillomania, excoriation disorder, onychophagia, and trichophagia) were measured by evaluating people's reactions on a Likert scale. A total of 221 participants completed the survey. It was predicted that educating people about those conditions would produce more positive ratings. However there was no difference between the experimental and control group that received no information. It was found that trichophagia was viewed most negatively followed by trichotillomania, excoriation disorder, and then onychophagia which was viewed most positively. These findings suggest that information presented in a quick and limited format did not impact the views of participants. However, it is seen that attention needs to be directed toward promoting a greater understanding of these disorders in order to minimize the negative perceptions of people with these conditions.

Keywords: BFRBs, trichotillomania, onychophagia, excoriation

1.Introduction

1.1 Overview of BFRBs

One person's atypical behaviors can often incite a reaction in others. Behaviors such as trichotillomania (hair-pulling disorder), excoriation disorder (skin-picking disorder), onychophagia (nail-biting disorder), and trichophagia (hair-eating disorder) may elicit emotional responses from others. These disorders are called body-focused repetitive behaviors (BFRBs). These disorders are classified under Obsessive Compulsive and Related Disorders in the Diagnostic and Statistical Manual 5 (American Psychiatric Association, 2013). Imagine looking around a room and knowing at least two out the fifty people shared the same disorder¹. That is true for these conditions, however onychophagia is even higher in prevalence. These disorders are thought to affect at least twenty percent of the population. These conditions affect individuals of all ages and all genders. These disorders often lead to negative social, economic, physical, and emotional outcomes for individuals with BFRBs. It is anticipated that trichophagia would be rated most negatively, followed by trichotillomania, excoriation disorder and onychophagia, and that the informational component will result in more positive view of the disorders.

1.2 How Those With BFRBs Perceive Their Own Conditions

To get an idea of how these disorders cause others to react, it is important to understand how people with BFRBs perceive their own conditions. Casati, Toner, and Yu completed interviews with women with trichotillomania². They found that women in the study commonly felt embarrassed, isolated, and had poor body images. If individuals with BFRBs withdraw from

social interactions, it could be startling to other people who are witnessing these behaviors for the first time. The study was conducted by speculating that the feelings of shame often lead people to continue the cycle of pulling. However, some of the women felt disclosure of their condition meant they could educate others. The study ultimately found that while there is a significant psychosocial impact on women with trichotillomania, through psycho-education the women's negative perceptions of themselves could be alleviated. While this study described how women with trichotillomania felt about their appearance, it is important to evaluate how others view their appearance as well because gaining insight into their reactions can help to determine the type of interventions that would best inform others.

They conducted two-hour interviews and asked patients about their history with the disorder, other co-morbid conditions, treatment history, and the social implications the disorder has had on patients. It was found that shame and depression were common emotions expressed by patients. Additionally, for social situations, individuals with trichotillomania avoided going in a swimming pool or going to a hairdresser for a haircut. This point is relevant for the current study because if individuals with BFRBs avoid social situations, it means that those who witness BFRBs may have been less exposed to these differences in appearance. If individuals with BFRBs are staying hidden in society, it could be startling to those witnessing these behaviors for the first time. The study concluded by speculating that the feelings of shame often lead people to continue the cycle of pulling. Some individuals with BFRBs will attempt to hide the hair loss in social settings. However, it becomes a constant burden for individuals with BFRBs to carry that secret. While the study suggests that not all non-sufferers understand the hardships of individuals with these disorders, it brings value for individuals with BFRBs to know others with the same disorder share common feelings. While the point of the current study was to call

attention to reactions of those witnessing these behaviors, the insight from those with these disorders is important to see if their feelings of social rejection match the reactions of others.

1.3 How BFRBs Impact The Lives of Those With Them

Some researchers choose to focus on how these conditions impact different dimensions of individuals with BFRBs lives³. One study was done with adults who confirmed their diagnosis with an interview and the Massachusetts General Hospital Hair Pulling Scale. The participants of the study were then asked to complete a survey that assessed the participants' monetary losses related to trichotillomania such as makeup and wigs. The survey also assessed how participants were socially impacted. It was found that many of the participants avoided romantic relationships, haircuts, and social events. It was found that 44.6% of participants experienced a missed day of work due to hair pulling.⁴ A total of 70.3% of participants spent money on psychologist visits as well. These results meant that individuals with BFRBs were spending money for treatment and cosmetics as well as losing money for missed work and school. Both studies found that trichotillomania hinders social experiences and places an abundance of economical costs on those with the disorder. It shows how these behaviors may happen in any setting despite other people being around. However, it lacks insight into how others view the impact of these conditions.

While some studies focus solely on individuals with BFRBs feelings and reactions to their conditions, other studies focused on peers of individuals with BFRBs. One study asked middle school students to complete a Social Acceptance Scale (SAS) after watching a video of actors with behaviors including trichotillomania and tic-like movements⁵. They used two groups

to examine if tic movements or trichotillomania would result in lower scores on the SAS. It was found that the actors portraying trichotillomania were given statistically significantly lower scores on the SAS than the actors not displaying trichotillomania. These results are important because it demonstrates the social judgments that individuals with trichotillomania face.

1.4 How Others Perceive Those With BFRBs

Another study that aimed to measure the effects that trichotillomania has on peers of those with the disorder was done by Marcks, Woods, and Ridosko⁶. It was conducted by having anecdotal conditions where characters with the disorder are described as identifying his or her condition or hiding it. Undergraduate students answered the surveys after reading these anecdotal stories. They then answered a 24-question survey regarding their feelings about the character in the anecdotes. The researchers found that in the anecdotes where the character admitted to having trichotillomania, that character was given significantly lower ratings. In situations in which the character had hair loss but did not disclose his or her diagnosis, the characters were rated as neutral and sometimes positive. The study explains that overall this outcome can be attributed with the stigma surrounding mental health conditions. Marcks, Woods, and Ridosko thought that if education was provided, it may have influenced the participants' ratings⁷. Marcks, Woods, and the Ridosko's study used photographs and the Boudjouk, Woods, Miltenberger, and Long's study looked at peer perceptions, however both had the limited lenses of participants who were middle school students or college students.^{8,9} The current study hopes to gain a broader picture of reactions of adolescents and adults. These studies were also done over ten years ago. While stigma for mental illness still exists it is important to note that the

social dynamic surrounding mental health has changed which could possibly impact the reactions to these conditions.

A more recent study examined how participants view individuals with trichotillomania before and after treatment¹⁰. It was found that after viewing before and after pictures of individuals, participants rated pictures of people with trichotillomania lower on attractiveness than the controls without a BFRB. Like previous studies, researchers attributed these lower scores to mental health stigma. However, if participants are unaware of these conditions and the implications, they may use their judgment based solely on appearance. While they were informed that participants had trichotillomania, they were not provided with information about the disorder. The current study aims to compare a group without information and one with information to see if education improves reactions. However, this study that involves rating photographs gives insight into the current study. It does this by providing possible reactions from participants. The reactions to the photographs were overall negative providing a general expectation of negative reactions from participants in the current study when reading the anecdotes about trichotillomania.

1.5 The Current Study

While there have been studies where researchers tested individual's reactions to these disorders, there is little that has been done to see if any interventions would change participants reactions. Studies have mentioned that education would be a variable that may influence participant's reactions¹¹ The current study will compare a group who receives educational information on these disorders and one that will not get information. This manipulation is to see if this

intervention yields different reactions to BFRBs. The current study will focus on a broader age group of people who are ages eighteen and older. In addition, this study is taking place over ten years after these earlier studies and there is potential that shifting societal values regarding mental illness may yield different results. While BFRB is a relatively new term, few studies tend to address these behaviors together and tend to discuss them separately. Aside from research done on the perceptions of BFRBs, there are very limited resources regarding BFRBs aside from how they impact individuals psychologically¹². This study will bridge this gap by addressing four BFRBs: trichotillomania, excoriation disorder, onychophagia, and trichophagia. Trichophagia is presently ignored in the research in terms of social implications. Most studies concentrate on the medical complications that result from bezoars (balls of hair that form in the intestines)¹³. This study includes trichophagia to address this absence in existing research.

The current study created anecdotal situations representing trichotillomania, excoriation disorder, onychophagia, and trichophagia. One group was given information explaining how these disorders impact individuals and one did not receive the information. Participants were then asked to rate adjectives in order to measure reactions to people with these conditions. This manipulation was designed to test if education influences participants' reactions to the disorders. This study would be a meaningful addition to current research because by delineating different reactions based on the specific disorder, it is hoped that education about these disorders can be improve

2. Method

2.1 Participants

A total of 221 participants completed the survey; 58 filled out a paper copy and 163 took the online survey. Of the 221 participants, their ages ranged from 18 to 55 ($M=$

21.52; $SD=5.72$). A total of 74.8% ($N=166$) of participants were female, 20% ($N=44$) of participants were male, 1.4% ($N=3$) were transgender, 2.7% ($N=6$) were gender nonconforming, and 0.5% ($N=1$) preferred not to answer. A majority were college-aged students from a variety of majors.

3.Design

This study was a mixed (between and within subjects) design. The independent variables are the types of disorders and whether participants received information on the disorders before making their judgments. The dependent variable is how strongly the participants reacted to the behaviors based on how they rated the positive, negative, and neutral adjectives.

Group 1 was the control group because they did not have the information. Group 2 was the manipulation group. Prior to reading the anecdotes, Group 2 received an informational sheet that explained each disorder, the social and emotional implications of the disorders and statistics about the disorders.

4. Materials

The purpose of the questionnaire was to measure if participants who were given the information about the disorders (Group 2) had more positive reactions as compared to the group just given the anecdotes (Group 1). Prior to the survey there was an informed consent form and a sheet that asked participants to confirm that they were at least eighteen years old. The survey included an eight-question demographics portion which asked about gender, age, disability status, sexual orientation, religion and education. Some participants omitted some of these answers. The Qualtrics online version followed the same format as the paper version.

Then there were four pages each of which contained anecdote describing the following disorders: trichotillomania, excoriation disorder, onychophagia, and trichophagia. After each anecdote there were seven adjectives and two open-ended questions. The anecdotes were crafted based on research that described the behaviors, and were made gender neutral to avoid confounding variables. The adjectives on the Likert questions ranging from Strongly Disagree (1) to Strongly Agree (7). The following adjectives were used to assess people's responses to the anecdotes: confused, concerned, sympathetic, ambivalent, curious, annoyed, distressed, disgusted, and altruistic. Ambivalent, curious, and confused were considered neutral. Annoyed, distressed, and disgusted were considered negative. Altruistic, sympathetic, and concerned were considered positive. These were chosen to give a representative sample of words. For example, altruistic was chosen in order to gauge if a participant would want to help someone who was engaging in these behaviors. Annoyed was used to see if participants felt these behaviors were a nuisance. Following this there were two qualitative opened questions which were "Do you know what this scenario describes?, and Have you heard of or experienced this scenario before? If so, where?", Participants had no restriction on the length of their answers.

Study 2

4.1 Procedure

Participants were recruited from public areas surrounding New Paltz and public areas in New York City. Data was collected from participants in areas that included dining areas, class, and meeting spaces. The experimenter who approached participants was a female SUNY New Paltz undergraduate student who was randomly assigning participants to groups. Prior to and at the

completion of classes, meetings, etc., participants were invited to participate in a study about reactions to certain behaviors. Interested parties were given an informed consent form and then provided with a hard copy of the survey. The only criterion of inclusion/exclusion was based on age of consent, which is 18 years old. Participants were also recruited electronically through a campus-wide email system and Facebook pages. These participants took the survey through Qualtrics. Participation was voluntary and the surveys were collected from SUNY New Paltz students as well as people from the surrounding town area and the greater New York City area.

Prior to distribution an equal number of each condition of the survey was counted out. In addition to this to reduce experimenter bias, the experimenter placed a blank sheet of paper over all surveys. Consent forms were then handed out prior to survey. Participants were then given a survey with information or without information. The manipulation was if participants are given the information about the disorders. If not given the information in the beginning of the survey, participants were given the information as part of their debriefing. The instructions written on the surveys with information indicated that participants were to read the information prior to answering questions. For the surveys without the information, participants simply had the instruction of reading the anecdotes and then answering questions. Proceeding the Likert scales all survey indicated for participants to, "Please read the following passages and answer the questions that follow. When answering the questions think about how you would react in that moment." All participants in the in-person study were then given a debriefing form in a sealed envelope in their packets. If participants did not have information they were given the information on their debriefing form and were made aware of the differences between conditions. The envelopes indicated that they were not to be opened until the completion of the

survey. Their surveys were collected and participants were thanked for their time. The survey took participants approximately ten minutes to complete. The procedure was the same for online participants however, they were recruited through emails and social media and led to a Qualtrics survey link. To ensure results were consistent separate mixed ANOVAS were done to compare the paper edition, and electronic survey results. These results compared with the combined data which showed significance in how the disorders were viewed but not for the condition of information or not given information

5.Results

In order to determine if being informed about the disorders led to a difference in the ratings of the positive, negative and neutral adjectives between the four disorders, three mixed 2 (condition) x 4 (disorder) ANOVAs were done.

The adjectives were grouped together based on whether they were positive, negative, or neutral. Then positive, negative and neutral scales were created by averaging the Likert scale responses for each emotional reaction. These three groups served as the dependent variables to determine if the manipulation of knowledge about the disorder and the type of disorder affected people's reactions. It was found that the disorders differed from each other significantly within each adjective. Below the delineation of this according to adjectives is explored.

For the negative adjectives the ANOVA revealed that the ratings of negative adjectives were significantly different between disorders, $F(3,567) = 26.72, p < .005$. The Tukey post hoc test revealed trichophagia had the most negative scores, followed by trichotillomania, excoriation disorder, and onychophagia. These results showed that trichophagia disorder was viewed least favorably in comparison to the others which showed that participants reacted with more disgust,

annoyance and distress toward the situation that described an individual with trichophagia. All disorders differed from each other for the negative adjectives according to the subscripts indicated by the Tukey post hoc tests. For means, standard deviations and post hoc comparisons, see Table 1. There was no significant difference in ratings based on the manipulation, $F(1,189) = 2.85$, ns and no interactions, $F(1,189) = 1.10$, ns.

Table 1. Means and Standard Deviations for Negative Adjectives

<i>Disorder</i>	<i>Mean</i>	<i>Standard Deviation</i>
Trichotillomania	2.64 _a	1.34
Excoriation Disorder	2.56 _b	1.29
Onychophagia	2.25 _c	1.25
Trichophagia	3.06 _d	1.59

For the positive adjectives the ANOVA revealed that the ratings of positive adjectives were significantly different between all four disorders, $F(3,543) = 41.32$, $p < .001$. The Tukey post hoc test revealed that trichotillomania had the highest positive ratings overall followed by excoriation disorder, trichophagia, and then onychophagia. These were positive adjectives and higher scores indicate participants agreeing with feeling altruistic, concerned, and sympathetic for people with this disorder compared to the other disorders. Therefore, participants were most sympathetic, altruistic, and concerned toward the person with Trichotillomania. All disorders differed from each other for the positive adjectives according to the subscripts indicated by the Tukey post hoc tests. For means, standard deviations and specific contrasts between means, see Table 2. There

was no significant effect of the manipulation, $F(1,181) = 0.001$, ns and no interactions, $F(1,181) = 1.88$, ns.

Table 2. Means and Standard Deviations for Positive Adjectives

<i>Disorder</i>	<i>Mean</i>	<i>Standard Deviation</i>
Trichotillomania	4.71 _a	1.24
Excoriation Disorder	4.48 _b	1.35
Onychophagia	3.78 _c	1.41
Trichophagia	4.27 _d	1.29

For the neutral adjectives, the ANOVA revealed that the ratings of neutral adjectives were significantly different based on the type of disorder, $F(3, 531) = 78.06$, $p < .001$. The Tukey post hoc test revealed that trichophagia and trichotillomania had the highest scores for the neutral adjectives followed by excoriation; onychophagia had the lowest ratings. This means that participants felt most ambivalent towards these disorders. Trichotillomania and Trichophagia did not differ from each other however Excoriation Disorder and Onychophagia differed from each other. For means, standard deviations and specific contrasts between means, see Table 3. There was no significant effect of the manipulation, $F(1,177) = 0.04$, $p < 0.001$, ns and no interactions, $F(1,177) = 0.47$, ns.

Table 3. Means and Standard Deviations for Neutral Adjectives

<i>Disorder</i>	<i>Mean</i>	<i>Standard Deviation</i>
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Trichotillomania	3.76 _a	1.23
Excoriation Disorder	3.14 _b	1.17
Onychophagia	2.51 _c	1.15
Trichophagia	3.76 _a	1.40

6. Discussion

Previous research has shown that the disorders tend to be viewed negatively by others and perceptions vary by disorder. It was predicted that trichophagia would be rated most negatively, followed by trichotillomania, excoriation disorder and onychophagia, which was supported by the results in this study. Onychophagia is most likely thought to be most accepted because it has a higher prevalence than all other BFRBs. The prevalence rate is between 12 and 14%¹⁴. Significance was not found for the interaction between the disorders and the informational condition of the study. This means that information did not prove to make a difference in participants' ratings of BFRBs.

Stemberger, Thomas, Mansueto, and Carter interviewed patients with trichotillomania who described the negative social implications of the disorder¹⁵. This finding matches the results of the current study. In general, the fact the disorders caused negative reactions of any kind is not surprising due to previous research which asked participants to rate actors with trichotillomania and those without it¹⁶. Those with any disorder were rated more harshly, which shows that these disorders are inherently seen in a negative light. For the neutral scores, onychophagia also had the lowest scores which can indicate how it is normalized. The finding that trichophagia was rated with the highest scores of the negative adjectives meant that participants were most

disgusted or distressed towards those with trichophagia. However, for the positive adjectives, trichotillomania was rated most positive, followed by trichophagia. This meant that more participants agreed with feeling altruistic or sympathy towards individuals with trichotillomania. This pattern could possibly be explained by the fact that participants did not fully understand the medical complications of trichophagia, which could possibly exemplify, why it was rated most negatively and not most positively. If participants just viewed it is a bad habit and as something gross, that is where the understanding of it being rated most negatively comes in. Onychophagia had the lowest ratings, for the neutral, positive, and negative adjectives. This means that because the negative adjectives were rated low that participants disagreed with the behavior being disgusting. The low scores on the positive adjectives mean participants did not agree towards feeling altruistic or sympathetic towards individuals who have onychophagia. This outcome could possibly be explained by the fact that nail biting is a commonly known as a “bad habit” thus participants may have experienced it more.

While the manipulation of information did not result in a significant difference in the ratings, it may be attributed to the limited nature of information provided. Participants only had a few paragraphs and possibly may not have had enough time to absorb or process the information. The presence of the manipulation could also have possibly contributed to more negative ratings because of the stigma associated with the word “disorders.”

The qualitative research portion of the study showed that participants were likely to disclose the status of their own personal experiences with these disorders or share information about others they knew with these conditions. Participants from both the experimental and control group explained that they recognized these disorders from television shows and YouTube

bloggers. This finding demonstrates the statistic that these disorders are relatively prevalent within the population, with an estimated two of every 50 individuals suffering from a disorder¹⁷.

7. Limitations

The time allotted was a limitation of this study. It may have been useful to perform this study under more controlled conditions. For the experimental condition, information could be given before the survey was administered and then participants would have to devote their attention to a physical presentation of information such as pictures and writing on a screen during a fixed amount of time. In the current study, the information was immediately followed by the survey, which did not provide much time for the participants to fully comprehend the information or guarantee their full attention. Also, the majority of participants came from college-aged students who may have a different perspective than those from other developmental periods in their lives.

8. Future Directions

Another way to conduct this experiment would be by adding photographs or videos which would more clearly represent what the different disorders entail. Having people in the experimental condition sit in a room and watch short clips that give information about these disorders and show someone struggling with the disorder could have strengthened the manipulation. Pictures could also show the variety of severity in the disorders, as well as provide information that would be clear and displayed long enough for participants to fully understand. These changes would help eliminate some ambiguity and personal interpretation that occurs with a written description.

Additionally, potentially testing multiple methods of education and seeing which one produced the most positive reactions would garner information about how best to disseminate information. Potentially this could be done by introducing two forms of education to be compared. A video could be presented in which individuals with these disorders tell their story and factual information is provided in between their stories. Individuals would be asked if they had a BFRB and then in a separate item asked if they knew someone who did. This question would provide knowledge on if experiences with the disorder in some personal capacity influences participants' reactions to these disorders. Also questions that examine stigma would give more insight into how participants view these disorders. This could aid in pinpointing what parts of these disorder are explicitly not understood by participants. A method of looking at the findings for this future study would be to discern which form of education elicits more positive reactions from participants and then to see if knowing someone or having a BFRB made a difference in the results as well. It would be expected that individuals who have a BFRB would think more positively and have less or no stigma toward others, however other contexts such as own self-blame or shame may not lead to this predicted outcome. The same hypothesis can potentially be true for individuals who indicate they know someone with a BFRB. Just because they know someone with one of these disorders does not necessarily mean they understand or have less stigma towards individuals with these disorders. However, potentially this information could lead to a more thorough understanding of the motivations of people's reactions toward these disorders.

Finally, a stronger emphasis on how prevalent these disorders are could possibly provide context for these conditions. The researcher from this study would like to create educational materials potentially aimed at children to be used in schools using the results from the current

and proposed study. This educational material could use the results in targeting the aspects of these disorders that are most confusing and require more elaboration. Specifically, for children in school who are subject to speculation or potentially bullying, educational materials would hopefully be a deterrent for any of these implications. It is hoped this material could also be used by parents, caregiver, educators, or clinicians to explain the condition to those with the disorders as well.

9. Implications

By understanding the differences in reactions to these disorders, it is hoped that educational materials can be developed to give a clearer description of these conditions, emphasizing the commonality that exists. The reason that education is being suggested, despite there not being a significant difference between the conditions present is because it unclear as to if the word disorder in the education component promoted stigma. Perhaps, a follow-up study would include different wording and representations of explaining the disorder. Examples of educational programs would be slide shows that separate the disorders and explain them while emphasizing that they fall under the same classification of disorders. This approach is important because onychophagia for example is viewed most positively, therefore if people came to understand that onychophagia and trichophagia were similar, both disorder may be viewed less negatively. Other educational information could be distributed as pamphlets as they are easily accessible and easily produced. To incorporate findings from the current study, any education distributed would emphasize the commonality of disorders, which could help to alleviate feeling of distress, disgust, and annoyance. Education can inform people that sufferers cannot stop the behaviors and that many people live with these disorders. Giving more details about the disorders including the effects and severity of the symptoms and providing statistics about who

suffers from these disorders, the effects, as well as how these disorders are different for each individual can possibly diminish the false perceptions of these disorders. Based on the finding that trichophagia has the highest positive adjectives reactions, it can be inferred that there is inherent sympathy, altruistic reactions, and concern from others and these ideals can be used to appeal to the emotions of those learning about the other disorders. Finding negative reactions to all the disorders and a difference between all disorders shows the need for clarification. The results of this study could be used to aid in developing methods to promote a more positive understanding of these disorders in the future.

10. References

1. Josee Casati, Brenda B. Toner, and Betty Yu. "Psychosocial issues for women with trichotillomania." *Comprehensive Psychiatry* 41, no. 5 (2000): 344-351.
doi:10.1053/comp.2000.9012.
2. Ibid., Casati, Toner, & Yu
- 3 Stemberger, Ruth M., Amanda M. Thomas, Charles S. Mansueto, and Jenna G. Carter. "Personal Toll of Trichotillomania." *Journal of Anxiety Disorders* 14, no. 1 (2000): 97-104.
doi:10.1016/s0887-6185(99)00028-6.
- 4 Chad T. Douglas W. Woods, Melissa M. Norberg, and Andrea M. Begotka. "The social and economic impact of trichotillomania: results from two nonreferred samples." *Behavioral Interventions* 21, no. 2 (2006): 97-109. doi:10.1002/bin.211.
- 5 Peter J. Boudjouk, Peter J., Douglas W. Woods, Raymond G. Miltenberger, and Ethan S. Long. "Negative Peer Evaluation in Adolescents: Effects of Tic Disorders and Trichotillomania." *Child & Family Behavior Therapy* 22, no. 1 (2000):17-28. doi:10.1300/j019v22n01_02.
- 6 Book A Marcks,, Douglas W. Woods, and Jaime L. Ridosko. "The effects of trichotillomania disclosure on peer perceptions and social acceptability." *Body Image* 2, no. 3 (2005): 299-306.
doi:10.1016/j.bodyim.2005.05.003.
- 7 Ibid., Marcks, Woods & Ridosko
- 8 Ibid., Marcks, Woods & Ridosko
- 9 Ibid., Boudjouk, Woods,& Mitlenberger
- 10 David C. Houghton, Colleen S. McFarland, Martin E. Franklin, Michael P. Twohig, Scott N. Compton, Angela M. Neal-Barnett, Stephen M. Saunders, and Douglas W. Woods. "DSM-5

- Trichotillomania: Perception of Adults With Trichotillomania After Psychosocial Treatment." *Psychiatry* 79, no. 2 (2016): 164-169. doi:10.1080/00332747.2016.1144438.
- 11 Ibid., Marecks, Woods & Ridosko
- 12 Christopher A. Flessner, "An Examination of Executive Functioning in Young Adults Exhibiting Body-Focused Repetitive Behaviors." *The Journal of Nervous and Mental Disease* 203, no. 7 (2015): 555-558. doi:10.1097/nmd.0000000000000327.
- 13 Veena Gonuguntla,, and D.-D. Joshi. "Rapunzel Syndrome: A Comprehensive Review of an Unusual Case of Trichobezoar." *Clinical Medicine & Research* 7, no. 3 (2009): 99-102. doi:10.3121/cmr.2009.822.
14. TLC Foundation for BFRBs, "Nail-Biting (Onychophagia)",2017
<http://www.bfrb.org/learn-about-bfrbs/nail-biting>
- 14 Ibid., Stemberger, Townsley, McCombs, Mansueto, & Gardner
- 15 Ibid., Boudjouk, Woods, Milternsberger & Long
- 16 Ibid., Casati, Toner, & Yu

Dress Behavior and Implications for Those with BFRBS

As human beings we adorn our bodies with piercings, trinkets, tattoos, intricate hairstyles, and a variety of modalities of dress. Individuals with body-focused repetitive- behaviors can somewhat become robbed of this choice. Their compulsions may cause them to inflict bald patches, blemishes on to the skin or other forms of disfigurements. This may force them to use different body adornments to either cover this damage. Consequently, it also may bar these individuals from having the ability to wear their hair in certain ways for trichotillomania and trichophagia. This may create difficulty in individuals going to a hair salon or getting professional haircuts due to shame or embarrassment from the state of their hair. For onychophagia, individuals may not be able to show their nails or have nail polish on them. This creates psychosocial difficulties because perhaps someone uses their hands for work and they are on display it might cause a sense of embarrassment.

Similar to trichotillomania and hair salons, individuals with onychophagia may not go to get their nails professionally painted due to fear of infection or being embarrassed about the state of their nails. This also takes away the social experience of going to get nails done with others. For someone with excoriation disorder, they may have to cover scabs or other blemishes in the skin. This may force them to wear clothing that seems out of place according to the weather condition. For example they may need to wear long sleeves or pants when the season's weather doesn't call for it. They also may be limited in their choices of makeup due to fear of infection. This is an example of self-expression being stifled. Self-expression is one of many dress motivations. It is something that encourages humans to be motivated to adorn their bodies the way they do. These disorders tend to strip individuals of this choice, as they must put on a façade of self-expression to adhere to what their society deems to be normal or beautiful.

Grooming is apart of our outward appearance. It is apart of putting on a socially acceptance appearance to fit in with society. Some individuals may interpret these behaviors as an over extension of grooming behaviors. Grooming behaviors are also a representation of presentation of that person, things such as laziness or unattractiveness may be inferred from the way these individuals choose to present

themselves. Someone who decides not to draw on eyebrows or take the time to get extensions or use hairpieces may be judged for these social choices. When they become past what is presentable to societally acceptable boundaries this is when a discrepancy in physical presentation exists. Grooming behaviors in our society consist, of shaving, plucking, waxing, cleaning, and covering certain parts of the body. These are things that are done across cultures. While the standards and ideals of grooming may change the act of it does not. Cosmetics are something that are sometimes apart of a dress routine for individuals.

Cosmetics may be used by any individual to cover blemishes, or perfume to portray a sense of sweet fragrance. Cosmetics may also be used by younger individuals who portray a sense of abnormality in their physical features from these disorders. However, in western society it is dictated that adolescent girls and women are considered socially acceptable to utilize makeup and other forms. However, these disorders do not discriminate they affect individuals of all genders and all ages. Therefore, it leaves a place of discomfort for men who may need to utilize these products to cover up their disorder, if they so choose to.

Children, specifically girls may be considered as sexualized beings, due to their use of makeup. As a result, children may be looked at in an inappropriate manner that their parents or whoever is dressing them do not intend for them to be perceived. Their peers may also be keen on the makeup they wear, as makeup worn by this demographic is not usually a common part of beauty routines (with the exception of beauty pageants, etc.). Their peers may notice it as something that is being covered up or question why their peer is utilizing the makeup. Additionally, enhancements such as hair dye or hair piece it be used by someone aging to enhance their features. However, when it is placed in the context of a disorder it becomes shameful for these individuals to utilize these cosmetic resources that other individuals use for a variety of reasons from changing their look to making them happier to make a change yet in that context it is celebrated. Individuals who admit to these behaviors are instead chastised. Organizations such as the Trichotillomania Foundation for Body-Focused Repetitive Behaviors have implemented a guide for

cosmetologists therefor professionals can aide in this process of assimilating beauty standards for these individuals rather than contributing to the stigma. This is one example where education is such a prominent vehicle of change.

Individuals with these disorders may provoke another dress motivation in others. This would be arousing emotional reactions in them. The finding from the survey results suggests that all disorders were rated negatively in some capacity. There was not a full positive rating given to any of the conditions regardless of education or no education. This matches with the ideal of these disorders causing negative reactions in those who don't understand them. Dress behaviors may be used to cover up this damage would explain why there is minimal visibility. However, the emotion that could be aroused from others could be from individuals who do not tend to follow the norm. For example in terms of trichotillomania (hair pulling disorder), it is considered abnormal in a majority of western cultures to be lacking in hair on the head, eyelashes, or eyebrows. Individuals who do not conform to beauty ideals are often seemed as the anomaly and are ostracized for what they are lacking. They also may ostracize for the method of cosmetics they use to cover it up with.

The western beauty industry also does not value these discrepancies in appearance. It would be very rare to have a model who was missing any one of these features or who was covered in blemishes or scars. Trichophagia, which is hair eating disorder, had the highest positive adjective ratings, followed by trichotillomania. This shows that while individuals feel sympathy towards these individuals it is not something they are inclusive of as they also rated them as negative. The negative description of adjectives included words such as "disgusted". However, this is these individual's natural form. Dress starts out with the base of the person before they adorn themselves with things as well. This population will be seen as inherently less attractive based on these findings.

Dress, is the art form in which allows us to alter our bodies, whether it be deemed as acceptable or not these are person choices that get made. Individuals with these disorders have these choices made for them and then this influences the way they are viewed by others. Understanding how these disorders

impact individuals in this way allows them to make choices best suited to their dress needs and it calls attention to individuals working in related fields such as cosmetologists and hair stylists to be aware of these conditions. The way these disorders are impacted by dress identities the idea that these disorder impact these individuals in a global way. This truly shows how dress can be a powerful vehicle in ameliorating some of the impacts of these disorders through its limitless abilities to change someone's appearance.

References

1. Roach, Mary Ellen, and Joanne Bubolz Eicher. *Dress, Adornment, and The Social Order*. New York, NY: John Wiley & Sons, 1965.