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Lived Experiences of Individuals with Alopecia Areata in Social Relationships: A Qualitative Study

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Masoumeh Zakipour[1], Zahra Fadai Moghadam[2] , Somayeh Ashrafifard[3], Forud Gholami[4*], Mohammadreza Mahjourian[5], Amin Allah Gholami[6]

1 PhD in Health Psychology, Department of Psychology, Karaj Branch, Islamic Azad University, Karaj, Iran
2 Master of Science in General Psychology, Department of Psychology, Qom Branch, Islamic Azad University, Qom, Iran
3 PhD Student in Educational Psychology, Department of Psychology, Vajid Bojnourd, Islamic Azad University, Bojnourd, Iran
4 M.A. in Women Studies, Department of Social Sciences, Faculty of Literature and Humanities, University of Isfahan, Isfahan, Iran
5 Master of Social Sciences, Shiraz University, Shiraz, Iran
6 Master of Criminal Law and Criminology, Ahvaz Branch, Islamic Azad University, Ahvaz, Iran

*Correspondence: forud.gholami@ltr.iu.ac.ir

ABSTRACT

This study was conducted to explore and clarify the lived experiences of individuals with alopecia areata in the context of their social relationships. This research adopted a phenomenological approach. Participants were selected through purposive sampling from individuals diagnosed with alopecia areata who were either referred to a specialized dermatology hospital or were members of the Iranian Alopecia Areata Association. The number of participants was determined based on the principle of data saturation. In-depth, semi-structured interviews were conducted with 14 participants to gather rich and detailed data. Data were analyzed using the content analysis method proposed by Strauss and Corbin (Strauss & Corbin, 1998), which allows for the systematic identification of patterns and themes within qualitative data. The analysis of data concerning the experiences of individuals with alopecia areata in their social relationships led to the emergence of five core themes, each containing multiple subthemes. These included the psychological and social pressures experienced by individuals, the various forms of social support they received, the role of social comparison in shaping their perceptions, the coping skills they employed to manage psychosocial stressors, and the outcomes of their effective social interactions. These themes reflect the complex interplay of internal and external factors that influence how individuals navigate their social worlds while living with alopecia areata. The findings of this study indicate that individuals with alopecia areata encounter a range of psychosocial difficulties as they attempt to maintain their social engagement. Nevertheless, these individuals demonstrate resilience through the utilization of social support, the application of effective interpersonal skills, and a reliance on their personal strengths in communicating and connecting with others. As a result, negative experiences may be restructured into positive ones, fostering growth, increased success, and ultimately leading to experiential well-being and an improved social position. Enhancing awareness among patients and society at large regarding the importance of supporting individuals with alopecia areata is a critical necessity.

Keywords: Alopecia areata, social relationships, psychosocial dimensions, hair loss, qualitative research.

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Introduction

Health and illness are not merely biological or psychological phenomena; rather, they simultaneously possess social dimensions and essences as well (Cuthrell & Jiménez, 2024). Social factors, just as they play an essential role in creating, maintaining, and promoting health, also have a fundamental impact on the emergence, prevalence, and continuation of illness (Raymond, 1997). As experiential well-being—which necessitates being free from discomfort and isolation and possessing the capacity for growth—is defined through social relationships (1), illness, too, must be understood as a social entity no less than a biological one (2).

Typically, illness is considered a temporary abnormal condition that must be overcome for a person to return to normal life. However, in chronic illnesses, this goal is not easily attainable, requiring attention to the transformed personal and social world of the patient (3). Alopecia areata is a chronic dermatological condition characterized by sudden hair loss on the scalp and other parts of the body (Selçukoğlu Kilimci et al., 2024). It is classified as an autoimmune disorder in which the immune system becomes dysregulated and attacks hair follicles, leading to hair loss from the scalp, face, and body (4).

Alopecia areata manifests in three clinical forms: patchy hair loss (alopecia areata), total hair loss of the scalp (alopecia totalis), and complete loss of scalp, eyebrow, eyelash, and body hair (alopecia universalis) (5). Although many patients experience no physical pain or lesions, the unusual and sudden pattern of hair loss causes emotional and psychosocial distress (6). Previous research has acknowledged that while patients are physically healthy and not impaired in physical functioning, alopecia areata is fundamentally an appearance-altering illness. The loss of hair—especially eyelashes and eyebrows, which help define one's facial identity—can cause individuals to appear drastically different (Piraccini et al., 2024).

As such, the disease carries serious psychological consequences and leads to emotional, personal, social, and occupational difficulties for patients (7). In a systematic review of 19 studies, Tucker (2009) reported that individuals with alopecia experience psychological challenges, particularly in areas such as self-confidence, body image, and self-esteem (8). Research has shown that the prevalence of anxiety, depression, and phobias is higher in these patients than in the general population, which is also related to their coping skills and personality traits (9).

Hunt also investigated how individuals respond to alopecia areata and concluded that responses differ depending on perceived body image, self-esteem, coping strategies, personality traits, and the support of social networks (7). In another study, Hunt (2015) examined the coping methods used by adolescents in Pakistan, identifying negative emotions and thoughts, physical and future-related concerns, both adaptive and maladaptive coping strategies, and the emotional and social losses associated with the disease (10).

Recent studies have examined patients' quality of life, highlighting restricted activity, concealment behaviors, and various coping strategies. Socially, these studies suggest that patients' engagement in activities becomes limited (11).

Other similar investigations have also demonstrated that alopecia affects quality of life, with social functioning being one of the most significantly impacted dimensions compared to control groups (7, 12-14).

Cuthrell and colleagues have shown that individuals with alopecia areata may be at increased risk for major depression, anxiety disorders, and social phobia (15-18). Picardi and colleagues (2003) examined psychosomatic factors at the onset of alopecia areata and found that compared to patients with other dermatological conditions, individuals with alopecia exhibited greater avoidant attachment, higher levels of alexithymia, and lower levels of perceived social support (19, 20).

By reviewing the literature on psychological issues and the effects of alopecia areata on patients' quality of life, it becomes evident that social factors and patients' social concerns play a substantial role (21). This highlights the social dimension of the illness—how it disrupts the natural and transparent manner in which individuals enter social interactions—and reveals new social challenges that arise directly from the illness itself (Habif, 2005).

Although some previous studies have addressed social factors, the majority have utilized quantitative methods, and none have specifically examined the patient's own perspective and lived experience regarding social relationships and the psychosocial aspects of the illness. Since gaining a deeper understanding of a phenomenon's emotional, cognitive, and subjective dimensions is best achieved through qualitative methods (Strauss & Corbin, 1998), and because individuals' experiences of receiving and offering support are shaped by the culture and societal conditions in which they live, this study was conducted using a qualitative approach to explore the lived social experiences of individuals with alopecia areata.

Methods and Materials

The present study is a qualitative investigation employing the grounded theory approach. Qualitative research is utilized to examine ongoing processes in human interaction and to attain deep understanding of individual experiences with the aim of acquiring the most comprehensive data possible. This study, using a phenomenological perspective, aims to explore the lived experiences of individuals with alopecia areata in the context of social relationships. Data were analyzed using Strauss and Corbin's grounded theory methodology. According to the literature, this method has been widely used in nursing studies; therefore, adherence to the ontological and epistemological assumptions of this version is crucial for maintaining macro-level quality in grounded theory research. Grounded theory is a general research method aimed at generating theory. Grounded theory refers to theory that is derived from data systematically collected and analyzed during the research process.

Participants were selected through purposive sampling from individuals diagnosed with alopecia areata who were referred to a specialized dermatology hospital, as well as members of the Iranian Alopecia Areata Association. The number of participants was determined based on data saturation. A total of 14 individuals (5 men and 9 women) aged between 15 and 40 years participated in the study. The inclusion criteria for inviting individuals to participate in the interviews were mental health stability, age, disease duration, and differential diagnosis. Since the first two years following the onset of alopecia areata are typically marked by emotional crisis and grief, a disease duration of more than two years was considered a necessary inclusion criterion. Differential diagnoses of alopecia areata include trichotillomania, syphilis, telogen effluvium, particularly tinea capitis, androgenic alopecia (male and female pattern baldness), and chemotherapy-induced alopecia, which were all considered during participant selection.

In terms of disease severity, participants had the universal form of alopecia areata (alopecia universalis), characterized by complete loss of hair on the scalp, eyebrows, eyelashes, and body, resulting in the most dramatic changes in appearance. Some participants had experienced other forms or severities of the disease during different periods.

Data collection was conducted through in-depth, semi-structured interviews aimed at acquiring detailed and focused knowledge from those who had experienced alopecia areata. Verbal informed consent was obtained from all participants prior to the interviews, and they were assured that their information would remain confidential. Anonymity, confidentiality, and the right to withdraw at any time were key ethical principles observed in the study. At the beginning of each interview, the researcher built rapport with the participant through a friendly introduction, and then guided the conversation with open-ended questions about social relationships. Example questions included: "At what age and stage of life did it occur—school, university, or employment?", "How did you feel?", "How did others react and how did you respond?", "How were you in public or social settings?" When needed, participants were encouraged to elaborate further by asking, “Can you explain that a bit more?” This approach encouraged participants to express their experiences more freely. Based on participants’ narratives, exploratory questions were also asked to deepen the exploration of their experiences. Interview durations ranged from 30 to 90 minutes. With participants’ permission, interviews were audio-recorded.

After each interview, a verbatim transcription was made to facilitate data analysis. In this strategy, data collection, data analysis, and the theory ultimately derived from the data are closely interrelated. Coding was conducted in three stages: open coding (identifying concepts in the data), axial coding, and selective coding. In grounded theory, data analysis for theory generation involves theoretical coding. Initially, appropriate codes are assigned to different segments of the data, and these codes are grouped into categories in a process known as open coding. Then, the researcher reflects on different dimensions of these categories and identifies connections between them through axial coding.

It is important to note that during this coding process, the researcher engaged in theoretical sampling based on emerging concepts from the data. This involved gathering additional data about individuals, events, and situations that could provide a richer understanding of the resulting categories and concepts. Finally, during selective coding, the categories were refined, and a theoretical framework emerged through this iterative process. Every effort was made to adhere to these stages and conditions throughout the research. Constant comparison was conducted between the codes to establish logical and coherent relationships among them. According to Strauss and Corbin (1998), credibility and quality assessment in grounded theory research involve considerations of fit, workability, relevance, and modifiability.

Findings and Results

Data analysis of the lived experiences of individuals with alopecia in their social relationships resulted in the identification of five main categories, each encompassing several subcategories. These main categories include: psychosocial pressures (social anxiety, unsuccessful social experiences, and illness-related social problems), social support (support from significant others, organizational support, and support resources), social comparison (positive self-evaluation, gratitude, and support groups), coping skills for psychosocial pressures (maladaptive coping, self-esteem and self-affirmation, intimate relationships, and contradictory experiences), and outcomes of effective social interactions (sense of self-efficacy, social status, social acceptance, and popularity).

Table 1. The Results of Qualitative Study

Sample Participant Quotes	Open Coding	Axial Coding	Selective Coding
"One of my coworkers stares at my eyes a lot; his gaze is full of questions.""Everyone looks at you.""They wouldn't accept me in groups.""Kids mocked me, called me bald, and even stole my hat.""Sometimes I don't go out due to extreme cold or heat."	Being observed and evaluated, Drawing attention, Rejection and exclusion, Being mocked, Physical and environmental discomfort	Social anxiety, Unsuccessful social experiences, Illness-related social problems	Psychosocial pressures
"My family, relatives, and friends are very supportive. They lift my spirits.""My teacher treated me the same as my classmate.""The gym manager's acceptance helped me feel more comfortable at the gym and with others.""Had I not gotten into sports and learned to deal with this, I would have never accepted my condition.""Reading the Quran gives me peace."	Emotional support from family and friends, Equal treatment by significant individuals, Support from staff, Religious practice, book reading, artistic and physical activities, travel, nature contact	Support from significant others, Organizational support, Support resources	Social support
"I compare myself to my peers and see how far I've come.""It could've been worse; we're lucky our disease isn't painful.""When I came to this hospital, I felt uplifted because I realized I'm not alone."	Self-assessment against peers, Comparing the illness to other conditions, Interaction with fellow patients	Positive self-evaluation, Gratitude, Support groups	Social comparison
"I quit school. It was too hard to face society—I just wanted to escape one hardship.""Sometimes I fight back and retaliate.""I'm confident. I go everywhere.""I don't care what others think; I love myself as I am.""My relationship with my husband is great. I always share my worries and pains with him. He always comforts me.""It's like my hardships and shortcomings are compensated by these achievements."	Avoidance, Aggression, Self-confidence, Self-respect and self-love, Supportive, intimate relationships, Achievements and progress	Maladaptive coping, Self-esteem and self-affirmation, Personal intimate relationships, Contradictory experiences	Coping skills for psychosocial pressures
"I always thought I couldn't handle official work because of my condition, but I managed.""Later, my boss gave me a big responsibility—I really wanted to succeed, and I did.""I always treat others respectfully, and they treat me with respect. Everyone in my family and workplace likes and accepts me."	Self-confidence and belief, Social responsibilities, Enacting social roles, Respectful and friendly interactions	Sense of self-efficacy, Social status, Social acceptance and popularity	Outcomes of effective social interactions

1. Psychosocial Pressures

Following the onset of diffuse hair loss, which alters their facial appearance, individuals face new challenges in continuing social participation and public engagement. In addition to the psychological stress caused by the illness and changes in appearance, they also endure significant psychosocial pressure in interactions with others and in social relationships. These pressures can be categorized as follows:

Social Anxiety: The intense and scrutinizing gaze of others, or the feeling of being watched and judged, generates anxiety. Most participants reported that the most distressing aspect of social gatherings—both private and public—was the probing stares of others. Whether individuals concealed their condition with wigs and makeup or chose to appear naturally, their presence attracted curiosity and questioning glances. One participant repeatedly said, "It was hard—very hard." When asked what was hard, she replied, "Just people's looks!" Another woman shared: "When my eyelashes started falling out, I'd draw eyeliner and go to work. A few lashes were still left. One colleague kept staring at me like he had a million questions. I told him about my condition and said these last few lashes would fall out too—don't be surprised. He was shocked and said he had never heard of this illness." A male participant noted: "I used to wear a wig for a while. I'd get stressed thinking someone would say, 'Hey, you're wearing a wig,' though they never did. Still, they whispered and stared. It didn't feel good."

Unsuccessful Social Experiences: All participants reported inappropriate interactions in social settings that caused distress and anxiety. Recalling these painful experiences was often emotionally difficult. Examples include being rejected by peers—"In school, I wasn't accepted in groups because we were all kids"—feeling different—"People look at you in a way that makes you feel you're very different from those around you"—being mocked—"When I played in the alley with friends, I'd catch neighbors staring or making snide remarks," and "Kids mocked me, called me bald, stole my hat, and I had to chase them." Others spoke of being labeled or socially avoided—"They thought I had cancer and avoided me," or "In school, I sat alone. Kids stayed away thinking it might be contagious or fungal." Some were denied accommodations—"School was really tough. They wouldn't let me wear a hat. I had to talk to each teacher individually to get permission. It was so hard." The fear of such encounters led some to withdraw—"I was only afraid people wouldn't like me or would reject me because of this disease."

Illness-Related Problems: Participants mentioned certain complications arising from the illness that caused them to withdraw from desired social activities. For instance, one woman stated: "I used to play on a basketball team. Everyone removed their scarves. I couldn't wear a wig—I was afraid it'd fall off. Wearing a scarf was uncomfortable too, so I quit basketball." Another participant shared: "Now I realize that hair really protects your head from cold and heat. Sometimes I avoid going out because of extreme temperatures."

2. Social Support

Social support includes emotional, practical, or informational assistance from family, friends, and others. It helps reduce stress, enhances one's sense of self-worth, and supports personal adaptation and coping strategies. Every participant, in various ways, reported receiving such support through interpersonal relationships.

Support from Significant Others: All participants emphasized the critical role of emotional support from family and close friends, especially in the early stages of illness, in helping them regain confidence and participate in social life. They stated: "My family and relatives were great. They supported me and lifted my spirits," or "My whole extended family knew, but no one made a big deal. That helped me feel comfortable in family gatherings." Another said: "My husband's family was very supportive. They'd say it's not an issue—we value who you are and your character. They gave me hope and positive energy."

An egalitarian view by important figures—treating individuals without regard to their illness or altered appearance—served as a powerful source of support. It gave individuals the confidence to participate socially and build meaningful relationships. As some noted: "My teachers treated me no differently from other students. That gave me motivation," or "My husband always says I haven't changed for him—he loves me the same," or "University was a great experience. Both male and female classmates accepted me exactly as I was. It was like the issue didn't even exist."

Organizational Support: Participants also highlighted the role of societal and institutional support. Positive interaction with school staff, medical personnel, administrative figures, and recreational and educational service providers helped reduce stress during social encounters. Support in services, finances, information, and employment can empower individuals to participate more actively in society. One participant shared: "I was anxious about joining a gym, worried something might happen. But the gym manager asked about my condition. I explained, and he said it wasn't a problem. His acceptance helped me feel at ease with others there." Another said: "It matters to me that there's an association that supports us. If they could ease bureaucratic burdens and offer more resources, the psychological load would be much lighter."

Supportive Resources: Whether they received the aforementioned types of support or not, many participants also turned to alternative supportive resources to restore emotional balance and accept their condition. These included religious practices, reading, artistic or athletic activities, travel, and contact with nature—either individually or in groups—which encouraged social activity. One participant stated: "My illness led me to search for answers. I studied facial analysis, philosophy, and read *Nahj al-Balagha*. I read books in three languages. I go to the gym and exercise, which boosts my mood and gives me a sense of pride. Without learning these things, I could never have accepted this reality.” Another said: “When I feel down because of my condition, I read the Quran—it calms me. I visit martyrs’ graves, confide in them, and draw strength. Sometimes I walk in the fresh air and listen to music.”

3. Social Comparison

Participants emphasized that evaluating themselves and comparing their condition with others was highly influential in adapting and improving their social lives. Social comparison is a central concept in social psychology, and it played a substantial role in participants’ experiences. It helped restore self-esteem, supported social skill development, and facilitated acceptance of the illness. This took three main forms:

Positive Self-Evaluation: Social comparison was closely tied to self-confidence and positive self-assessment. Participants said: “I’m more beautiful than many,” or “Even though this disease set me back, I’ve made great progress. When I compare myself to peers who had no health issues, I see that I’ve come so far while they haven’t.” Others noted: “I’ve done everything normal people have done—the best trips, best friendships, happiest moments... Of course, I’ve had bitter moments too, not just because of alopecia, but like everyone else.”

Gratitude: Participants reflected on how their condition compared to more severe or painful diseases and expressed gratitude. “It could have been worse—I could’ve had a painful illness. I’m thankful ours isn’t. That helped me accept it more easily and boosted my confidence,” said one. Another shared: “When I compare my situation to others with serious problems, I appreciate what I have more. Sometimes I even see this disease as a blessing.”

Support Groups (Shared Suffering): Most participants noted that meeting others with similar conditions at treatment centers or through the Iranian Alopecia Areata Association had a powerful impact. These support groups met individuals’ needs for affiliation, reducing anxiety, and information-sharing. One said: “When I came to the hospital and saw others with the same issue, I felt so much better. There are many of us. We talk, and we understand each other. In other places, people don’t understand.” Another added: “Since joining the association, I’ve felt more energized. I’ve found myself again and feel more comfortable in group settings. I learn from others’ experiences and gain awareness of treatments and side effects. We share and support one another.”

4. Coping Skills for Psychosocial Pressures

Maladaptive Coping: In response to social anxiety and unsuccessful social experiences, participants demonstrated two primary behaviors: avoidance and aggression. Since these behaviors often result from a lack of effective coping skills and are typically situational and temporary, they are considered as forms of defensive and maladaptive responses in this study. Some participants preferred to avoid anxiety-inducing situations: *Avoidant behavior:* “When you notice people acting like you’re different, you pull away yourself,” “I don’t attend parties or weddings. It’s not worth the stress. If I don’t go, I won’t be anxious,” “Since I lost my hair and lashes, I haven’t gone to work. I’m always afraid my wig might fall off or someone will sit next to me and ask, ‘What happened to your lashes?’” “I became isolated. Even though I was doing well academically, I stopped going to school. It was just too difficult to re-enter society, so I thought I’d at least escape one hardship.”

Aggressive behavior: “I lose my temper quickly. I’m kind with my family, but in public, even small things make me angry or confrontational,” “When kids mocked me or distanced themselves, I mocked everyone back. It became a grudge. I’d retaliate at the slightest provocation (said angrily),” “Over the years, just a few people have behaved badly and tried to remind me that I’m bald. Sometimes I retaliate—not out of malice, just so they realize their words are hurtful.”

Self-Esteem and Self-Affirmation: Participants considered confidence and self-esteem the most crucial and sensitive aspects of coping with their illness. All stated that the first thing impacted by the onset of alopecia, and also the most useful personal resource, was their self-confidence. Maintaining a positive self-image and regaining confidence are personal, social, and psychological competencies. These skills support individuals in forming and sustaining interpersonal relationships, engaging in social activities, and coping effectively with illness-induced stress. One male participant said, “The most important part of this issue (alopecia) is self-confidence. At first, I wore a wig, and it helped me feel confident. But later, I stopped wearing it—even hats. Back then, I didn’t have the confidence I do now,” Another added, “I’m very confident. I go everywhere and don’t hold back. I attend parties, gyms, and university comfortably and interact with everyone.”

Some participants indicated that self-affirmation, rather than seeking approval from others, helped them to recognize their strengths and adjust their social functioning. Studies show that those who affirm themselves have lower social anxiety. “I avoided parties and friend gatherings for a while because I knew their looks and curiosity would bother me. But that didn’t last long. Eventually, I regained my spirit. I told myself people’s opinions don’t matter. What matters is that God sees me as beautiful this way. I love myself like this. That helped me cope and accept this condition (alopecia) more easily.”

Intimate Personal Relationships: Strengthening interpersonal bonds and having close personal relationships provided participants with safe spaces to express their anxieties and find comfort. The sense of personal worth and respect that emerges from intimate relationships helped individuals withstand the most intense psychological pressures. Participants highlighted the importance of their relationships with their mother, spouse, or a close friend and how these connections provided emotional peace and satisfaction. “My mom used to say, ‘You’re prettier this way.’ I often confide in her,” “My relationship with my husband is great—I always share my worries and pain with him. He always comforts me and says, ‘I love you just the way you are,’” “My friends are amazing—they’re always there for me. One friend gives me hope and boosts my morale and confidence whenever we talk. She doesn’t let me dwell on sorrow.”

Contrasting Experiences with Stress: Some participants spoke with pride and satisfaction about their achievements and personal growth. These successes, and the positive feedback they received, provided motivation and a sense of purpose. The joy of accomplishment served as a driving force for self-discovery, overcoming social fears and limitations, and accepting the illness and current circumstances. One participant shared, “Despite all the hardships, I’ve had successes and progress that make me feel proud. Sometimes I even forget my problems. It’s like these achievements compensate for my difficulties and shortcomings. They give me energy to keep striving.”

5. Outcomes of Effective Social Interactions

Given the visible nature of alopecia, patients inevitably experience stress and anxiety in social situations. Nevertheless, to fulfill their material and emotional needs, they must engage with society and build social relationships. All participants' social experiences—from how they interact with others to how they interpret those interactions—reflect the complex relationship between the individual and their social context. One of the major findings of this study is the identification of positive and desirable outcomes from these complex social interactions.

Sense of Self-Efficacy and Social Status: A sense of self-efficacy—gained through effective social interaction—refers to confidence in one’s abilities and expectations of success in tasks. Higher self-efficacy can be a motivational force that boosts performance and confidence. By engaging in socially functional roles, individuals can achieve recognition and a social position within the community.

One participant described their work and social experiences: “I had to go to work, but I couldn’t face strangers. Thankfully, my acquaintances supported me, and I performed well. That got me back into society. Interacting with colleagues helped improve my social skills. I always thought I couldn’t handle office tasks because of my condition, but I did. Later, my boss gave me a big responsibility. It was important and challenging, but it gave me purpose. I was determined to succeed—and I did. I gave it my all to prove myself. That opportunity helped me move forward and grow. With encouragement from coworkers, I even resumed my studies.” Another participant added, “Even without hair, I was always one step ahead of my friends. That gave me a lot of energy. I learned shooting—with all kinds of guns.”

Social Acceptance and Popularity: Most participants expressed that they had developed good social relationships. Their ability to connect with others, maintain respectful and friendly behavior, and observe social etiquette helped them to sustain those relationships and gain social acceptance and popularity. Though their interactions were sometimes limited or interrupted in certain settings, their interpersonal skills enabled them to reengage with society. As one participant put it, “I’m very sociable—I get along with everyone and have never had problems,” or “I have strong social relationships and enjoy visiting people,” or “Since childhood, I’ve been a good communicator. Though I faced setbacks because of this, I still have that potential. I always treat others respectfully, and they do the same. I have so many close friends—they’re more comfortable with me than with anyone else. If I don’t attend an event, they keep calling and say, ‘If you don’t come, we’re not going either.’”

Discussion and Conclusion

The findings of this study revealed that individuals with alopecia areata face numerous challenges within the social context, and their social relationships and participation undergo significant changes following the onset of the disease. The results showed that psychosocial pressures arising from being observed and experiencing social failures increase individuals' anxiety, and illness-related complications make active participation in social life more difficult. Several studies have likewise reported the psychological distress and social difficulties faced by individuals with alopecia areata. Hunt, for example, examined the psychological effects of the condition on social functioning and reported that 40% of women with alopecia areata experienced marital problems, and 63% encountered professional difficulties (10). Sellami et al. also reported a high prevalence of anxiety and psychological complications among patients (22).

Participants in this study frequently mentioned the emotional support from family members and social support from others as key elements that helped them regain strength and resilience. The importance of perceived social support for both healthy and ill individuals has been highlighted in numerous studies. Some researchers have emphasized the necessity of supporting patients (23) and the moderating role of social support for individuals with alopecia areata (24). One particularly strong form of support is peer support groups, where individuals’ needs for connection are met, problems are expressed in a safe and friendly environment, anxiety is reduced, information about the disease and treatments is shared, and a form of social comparison takes place (25).

Furthermore, participants utilized social comparison strategies by positively evaluating themselves, reflecting on their achievements, and comparing their illness with more severe conditions, resulting in greater gratitude and increased self-confidence. Similar findings in other studies have emphasized the impact of contact with peers and the role of shared experiences (26, 27).

The findings also revealed that participants employed various coping strategies to manage the psychological stress resulting from changes in appearance and social obstacles. One of the initial but maladaptive responses, attributed to the lack of appropriate skills when encountering negative behaviors or unsuccessful experiences, was avoidance or aggression. Many studies on coping strategies in individuals with chronic illness have similarly reported social avoidance, social isolation and anger (28), and avoidance of social interactions due to anxiety and discomfort in public, all of which contribute to reduced social participation (13, 29) and decreased daily functioning (7).

In contrast, adaptive and positive coping strategies—viewed as effective social skills—enable individuals to manage psychosocial stress while also fostering interpersonal communication and meaningful relationships. The most significant skill reported was self-confidence and self-affirmation. Although previous research has indicated that alopecia areata, by altering body image, negatively impacts self-esteem (7, 10, 25), the present findings show that this reduction in confidence is temporary. Consistent with other research, the study suggests that regaining self-confidence facilitates adjustment, enhances the sense of control over the illness, and fosters the development of relationships.

A particularly novel contribution of this study, not extensively discussed in prior research, is the role of intimate relationships and success in professional and social activities as catalysts for better adjustment, improved social relationships, and increased achievements. When individuals perceive themselves—and are perceived by others—based on their capabilities rather than their illness, this leads to effective mutual relationships. Consequently, fulfilling assigned responsibilities and playing constructive social roles leads to a sense of self-efficacy and recognition in the community.

Bandura's social cognitive theory posits that a high level of self-efficacy can serve as motivation for social participation, enhance chances of success, and boost confidence (26). Hunt (2015) also identified self-efficacy as a strong mediating factor for stress and, in line with Bandura, suggested that self-efficacy may influence immune system regulation, potentially impacting the progression of alopecia areata (10).

An important consideration is that the age of onset, the life stage at which the illness occurs (childhood, adolescence, early adulthood, pre- or post-marriage), the duration of the illness, its severity, the time span of its progression, and the treatment phases all psychologically affect individuals in varied ways. These variables significantly shape individuals' social experiences and the intensity of the psychosocial pressures they endure, making the lived experiences of alopecia highly diverse and complex.

The results of this study contribute to a deeper understanding of the social relationships and psychosocial dimensions of life for individuals with alopecia areata. The findings show that after the onset of the disease—especially following the loss of scalp, eyebrow, and eyelash hair—due to noticeable changes in facial appearance, individuals face difficulties and negative experiences in continuing their social life and suffer considerable psychosocial stress. However, with adequate social support from significant others and diverse sources, and through the use of effective communication and social skills, they adapt to new conditions and cope with the illness. Over time, grounded in their abilities and well-being, individuals reestablish connections with society and participate in social activities.

Negative experiences transform into positive ones, and maladaptive responses evolve into adaptive strategies, leading individuals to attain experiential well-being and appropriate social standing. This study, with its focus on participants' social experiences and the mutually beneficial interaction between society and effective communication skills, emphasized the positive aspects of these experiences. Nonetheless, understanding the obstacles and challenges is essential for professionals—policymakers, counselors, healthcare providers, and support groups—to better assist in overcoming social and communication barriers.

The study ultimately emphasizes the importance of raising individual and public awareness and calls for targeted education and support to empower patients. Through such support, individuals can attain meaningful experiences, greater achievements, active social presence, and ultimately, experiential well-being.

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Authors’ Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants. Written consent was obtained from all participants in the study.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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