British Journal of Dermatology 2004; **150:** 750–752. DOI: 10.1046/j.0007-0963.2003.05809.x

CONCISE COMMUNICATION

Women who present with female pattern hair loss tend to underestimate the severity of their hair loss

S.BIONDO, D.GOBLE AND R.SINCLAIR*

Department of Psychology, Monash University, Victoria, Australia
**University of Melbourne Department of Dermatology and the Skin and Cancer Foundation, Victoria, Australia*

Accepted for publication 30 April 2003

Summary

Background Female pattern hair loss (FPHL) is the preferred term for androgenetic alopecia in women. FPHL can be a source of considerable distress for affected women. Our hypothesis was that women with FPHL who seek treatment would rate their condition as more severe than would their treating doctors.
Objectives To identify discrepancies between the severity ratings of the women and their clinicians.
Methods Participants were 30 women receiving treatment for biopsy-proven FPHL and 44 women on a waiting list to receive treatment for FPHL. Each woman completed a self-report photographic measure of severity of hair loss, specifically developed for the current study.
Results Although no difference was found between the severity ratings of women receiving treatment and their clinicians, it was found that women in the waiting list group underestimated the severity of their hair loss compared with their clinicians' ratings.
Conclusion The results indicate that FPHL-affected women who seek treatment for FPHL do not overestimate the severity of the hair loss; in fact, they tend to underestimate. The present findings have implications for the treatment of FPHL.

Key words: androgenetic alopecia, psychological impact, self-assessment scale, self-perceptions

Hair is a physical expression of personality and social role. For many, hair is central to feelings of attractiveness and self-esteem.[1] *Ipso facto*, hair loss is commonly distressing. Female pattern hair loss (FPHL) is the most common type of hair loss in women. FPHL typically develops as diffuse thinning over the crown. The frontal hairline is usually retained.[2] A number of studies have identified psychosocial difficulties experienced by women as a result of FPHL. These correlate more closely with the woman's self-perception of the severity of her hair loss than the clinician's assessment.[3] This suggests that women's perceptions of hair loss severity may be more related to some other factor, possibly the psychological impact of FPHL rather than just the physical aspects of hair loss.[1,4] Also, clinicians may encounter patients whose concerns and distress about hair thinning are very intense and on occasion seem out of proportion to the degree of hair loss.[1] These patients' symptoms and perceptions of the severity of their hair loss may appear exaggerated.[1,5]

There is very little known about female patient perceptions of their hair loss. In order to investigate this further we used a self-report photographic measure of severity of hair loss, the Women's Alopecia Severity Scale (WASS) (Fig. 1) to investigate whether there is a discrepancy between the severity ratings by women with FPHL and their clinicians.

Methods

Participants

Participants comprised two groups: treatment and waiting list. The treatment group were women who had biopsy-proven FPHL and were undergoing medical

Correspondence: Dr Rodney Sinclair, Department of Dermatology, St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria 3065, Australia.
E-mail: sinclair@svhm.org.au

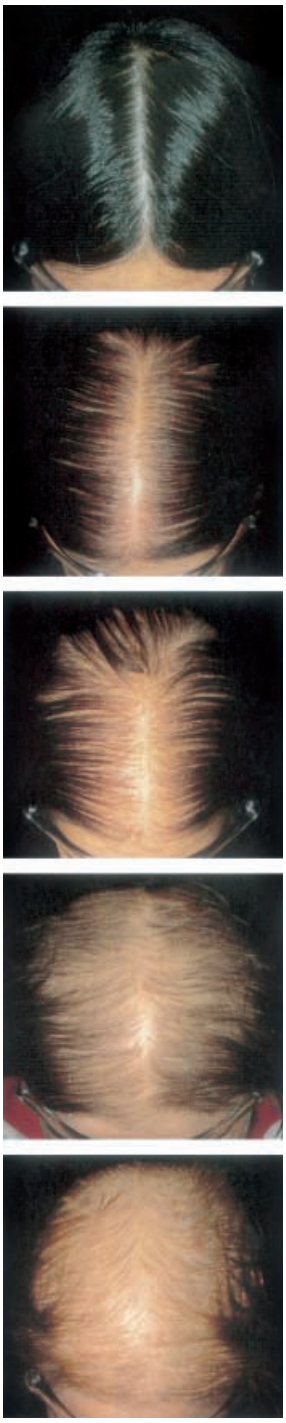

Figure 1. The Women's Alopecia Severity Scale (WASS).

treatment for that condition. These women had previously seen photographs of their own scalp taken in the same way as used in the WASS.

The waiting list group had an appointment in a hair loss clinic. At the time of the initial survey their diagnosis was not known. All patients were seen within 4 weeks of the survey. A clinical examination was undertaken along with scalp biopsy. Participants in the waiting list group were excluded if they did not have clinical and histological evidence of FPHL.

Participation

Participants were 74 women with FPHL, 30 of whom were receiving treatment and 44 of whom were on the waiting list for treatment. The mean age was 42·3 years (SD = 12·3 in the treatment group), and 44·9 years (SD = 15·8) in the waiting list group.

Patient rating

An explanatory statement was mailed to the participants, with a consent form and a questionnaire that included the WASS. Participants returned their completed questionnaire to one of the investigators (S.B.).

Clinician ratings

All participants had received a clinician's rating of the severity of their hair loss by R.S. The clinician did not discuss his rating with the patient and the results were mailed to S.B. and collated at a separate site from the clinic.

Women's Alopecia Severity Scale

The WASS was developed for the present study and is a self-report photographic measure of patients' perceptions of the severity of their hair loss. The scale comprises five colour photographs of women's scalps with the hair parted centrally. The photos were taken using a Canfield stereotactic device designed for photographic documentation of hair growth in FPHL.[6] The midline part view was used as it best demonstrates FPHL.[7] Actual patient photographs are preferred to digitally recreated images as used in the Savin scale because these fail to show the progressive frontal hair loss that is the hallmark of FPHL.[8] The first photograph is of a normal scalp and the photographs 2–5 are of scalps of women with increasingly severe hair loss. The photographs are numbered from 1 to 5 and respondents are required to circle the number of the photograph that they feel most closely resembles the appearance of their own hair when parted in the centre (Fig. 1).

Results

The means and standard deviations for patients' and clinicians' ratings for the FPHL groups are presented in Table 1. The results in Table 1 indicate that for both the treatment and waiting list groups, the clinicians' ratings, on average, were slightly higher than the patients' self-ratings. There was no significant difference between self- and clinicians' ratings in the treatment group (t [29] = − 1·36, P = 0·18, two-tailed). There was, however, a significant difference between self- and clinicians' ratings for the waiting list group.

Discussion

This study examined the relationship between affected women's perceptions of the severity of their hair loss and the clinical assessments by their doctor. The hypothesis that FPHL-affected women's self-perceptions of the severity of their hair loss would be significantly higher than their clinician's ratings was not supported.

Across all FPHL-affected women (combined treatment and waiting list groups), clinicians' ratings of severity of hair loss were, on average, higher than patients' self-ratings. When considered separately, there was no significant difference between self- and clinician's ratings for the treatment group. As most women in the treatment group had previously had scalp photography as part of their assessment, and thereby been made aware of the severity of their hair loss, this is not surprising. There was, however, a significant difference between self- and clinician's ratings in the waiting list group, where patients' ratings of the severity of their condition were lower than clinicians' ratings.

These finding are inconsistent with previous reports in the literature that suggest patients' perceptions of the severity of their FPHL are frequently at odds with their clinicians' ratings.[4] The reports in the literature, however, are, for the most part, anecdotal; no empirical research has examined this phenomenon.

The findings regarding differences between self- and clinician's perceptions of severity of hair loss may have been influenced by the type of self-report scale used. The WASS consisted of a 5-point scale with each point accompanied by a scalp photograph, increasing in severity from point 1 to 5. The statistical problem associated with the use of such simple scales is well known. For example, the difference between points 1 and 2 is not necessarily perceived by the respondent as equal to the difference between points 2 and 3, and so on, and there is a tendency for respondents to avoid endorsing the extremes of the scale (i.e. points 1 and 5), as was the case in the present study. In addition, five levels of severity of hair loss may not be enough to survey adequately the range of severity perceived by respondents. Further work is needed to establish the validity and usefulness of the scale used in this study.

The present findings have implications for the treatment of FPHL. FPHL sufferers have reported that medical and other professionals often fail to address the psychological impact of their hair loss. Furthermore, some patients report that their doctors are often dismissive of their concerns about their hair loss, implying that they are worrying about nothing. The present findings indicate that women affected by FPHL do not overestimate the severity of the hair loss—in fact, they tend to underestimate. As such, self reports of hair loss by women attending general practitioners should be taken seriously and managed accordingly.

Table 1. Means and standard deviations for patients' and clinicians' ratings for the female pattern hair loss groups

	Treatment group (n = 30)		Waiting list group (n = 44)	
	Mean	SD	Mean	SD
Self-ratings	1·98	0·69	2·44	0·71
Clinician's ratings	2·17	0·83	2·73	1·06

(t (43) = − 2·23, P = 0·03, two-tailed).

References

1 Cash TF. The psychology of hair loss and its implications for patient care. *Clin Dermatol* 2001; **19**: 161–6.

2 Ludwig E. Classification of the types of androgenic alopecia (common baldness) arising in the female sex. *Br J Dermatol* 1977; **97**: 249–56.

3 Cash TF, Price VH, Savin RC. Psychological effects of androgenetic alopecia on women: comparisons with balding men with female control subjects. *J Am Acad Dermatol* 1993; **29**: 568–75.

4 Girman CJ, Rhodes T, Lilly FRW *et al.* Effects of self-perceived hair loss in a community sample of men. *Dermatol* 1998; **197**: 223–9.

5 Hoffman R, Happle R. Current understanding of androgenetic alopecia. Part II. Clinical aspects and treatment. *Eur J Dermatol* 2000; **10**: 410–17.

6 Canfield D. Photographic documentation of hair growth in androgenetic alopecia. *Dermatol Clinics* 1996; **14**: 713–21.

7 Olsen EA. The midline part: an important physical clue to the clinical diagnosis of androgenetic alopecia in women. *J Am Acad Dermatol* 1999; **40**: 106–9.

8 Savin RC. A method for visually describing and quantitating hair loss in male pattern baldness. *J Invest Dermatol* 1992; **98**: 604 (Abstract).