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HAŞİMOTO TANISI ALMIŞ KADIN HASTALARDA TRAVMATİK YAŞANTILARIN VE KOŞULSUZ KENDİNİ KABULÜN DEĞERLENDİRİLMESİ: KANTİTATİF VE KALİTATİF BİR ÇALIŞMA

A CLOSER LOOK AT THE PAST TRAUMATIC EXPERIENCES AND CURRENT UNCONDITIONAL SELF-ACCEPTANCE OF WOMEN WITH HASHIMOTO'S DISEASE: A QUANTITATIVE AND QUALITATIVE ANALYSIS

Doktora Öğrencisi, Uzm. Psk. Kadriye SLOCUM

Fatih Sultan Mehmet Vakıf Üniversitesi, Sosyal Bilimler Enstitüsü, Psikoloji Anabilim Dalı, Klinik Psikoloji Doktora Programı, İstanbul / TÜRKİYE, ORCID: 0000-0001-7109-2756

Dr. Öğretim Üyesi Elif YAVUZ SEVER

İstanbul Üniversitesi, Edebiyat Fakültesi, Psikoloji Bölümü, İstanbul / TÜRKİYE, ORCID: 0000-0002-9751-9487

ÖZET

Çalışmanın ana hedefi, Türkiye'de üzerine çok az çalışılan Haşimoto hastalığını psikolojik açılardan incelemek olmuştur. Bu rahatsızlık kadınlarda üç kat daha yaygın olduğundan, bu çalışma kadınları ele almış ve çalışmaya Haşimoto tanısı almış ve tedavi görmekte olan ve başka psikiyatrik ve nörolojik bir rahatsızlığı olmayan, 18-45 yaş aralığında 25 kadın katılmıştır. Çalışmada bu kadınların geçmiş travmatik yaşantıları ve şimdiki koşulsuz kendilerini kabul düzeyleri, hem Travmatik Yaşantılar Ölçeği (TYÖ) ve Koşulsuz Kendini Kabul Ölçeği (KKKÖ), hem de kalitatif araştırmalar için yarı yapılandırılmış görüşme tekniği ile araştırılmış, niteliksel veriler tümevarım yöntemi ile değerlendirilir iken, niceliksel veriler istatistiksel yöntemler ile analiz edilmiştir. Bulgulara göre, travmatik yaşantılar açısından cinsel travma yaşamış olmanın Haşimoto hastalığı ile anlamlı bir ilişkisinin olmadığı; katılımcılarının çoğunluğunun da koşulsuz kendilerini kabullerinin düşük olduğu saptanmıştır. Tümevarım yöntemi ile incelenen görüşmelerden saptanan sekiz ortak tema arasında, Haşimoto hastalığı olan kadınlarda erken dönem anne-kız ilişkisinde ve bunun iletim kalitesinde yetersizliklerin olduğu dikkat çekmiştir. Haşimoto hastalığına yönelik yapılabilecek ileriki çalışmalar ve bu hasta grubunda dikkate alınabilecek terapötik unsurlar bu sonuçlar kapsamında tartışılmıştır.

Anahtar Kelimeler: Haşimoto hastalığı, infertilite, cinsel istismar, travmatik yaşantılar, Türk kadınları, koşulsuz kendini kabul

ABSTRACT

Little is known about the experiences of women with Hashimoto's disease in the Turkish population, from a psychological perspective. As this condition is three times more frequent among women, women were recruited for this study and twenty-five Turkish women, living in the city of Istanbul, Turkey, volunteered to participate. Participants were between 18 and 45 years of age, diagnosed Hashimoto's patients with no other serious medical illness and/or psychiatric or neurological disorder. Their past traumatic experiences and current level of unconditional self-acceptance were evaluated in the scope of the qualitative research interview and two self-report scales: the Traumatic Experiences Questionnaire (TEC) and the Unconditional Self-Acceptance Questionnaire (USAQ). An inductive analysis of interviews identified eight main themes, the most important indicating that these women had a poor mother-daughter bond since their youth. Analysis of the TEC demonstrated that a history of sexual trauma does not have a significant relationship with having been diagnosed with Hashimoto's while the majority of the participants scored low on the USAQ. Suggestions for future studies and the treatment of those with Hashimoto's disease are discussed.

Keywords: Hashimoto's disease, infertility, sexual abuse, traumatic experiences, Turkish women, unconditional self-acceptance

1. INTRODUCTION

Hashimoto's disease is an autoimmune disorder of the thyroid gland, characterized by the destruction of the thyroid gland, by autoantibodies namely thyroperoxidase autoantibodies (TPOAb) and thyroglobulin autoantibodies (TgAb). In addition to being the most common disease among all other thyroid disorders, it is also the most common cause of hypothyroidism in the United States and the incidence is estimated to be 3.5 per 1000 per year in women and 0.8 per 1000 per year in men [1].The annual incidence of Hashimoto thyroiditis worldwide is estimated to be 0.3-1.5 cases per 1000 persons [2,3,4].

According to various epidemiological studies it is three times more frequent among women [5,6,7]. Similarly, according to the Turkish Endocrinology and Metabolism Society (TEMD), Hashimoto's disease is 15-20 times more common among women than men in Turkey, with approximately 95% of those diagnosed with Hashimoto's being women and approximately 10% of these women being between the ages of 18 and 50 [8]. Genetics also plays a role in Hashimoto's, with approximately 60% of the first degree relatives of Hashimoto's cases having a high number of thyroid antibodies, and in such cases it is most commonly passed on from mothers to daughters [9,10,11].

The thyroid gland is responsible for the production of two specific hormones, namely Thyroxine (T4) and Triiodothyronine (T3), both of which are critical for normal metabolic regulation. The destruction of the thyroid gland in Hashimoto's disease prevents the normal production of these hormones and in turn has drastic impacts on normal bodily functions. Exhaustion, forgetfulness, weight gain, hair loss, irregular menstrual cycles, dry skin, recurrent miscarriages and infertility are among the most common symptoms [12,13,14].

Despite being a disorder evoking a complex set of psychological and physical symptoms [15], most studies conducted on Hashimoto's have been medical in orientation, with fewer studies on its psychological reflections. While studies outside of Turkey have looked into the lived experiences [15], associated psychological disorders [16,17,18], and traumatic experiences [19,20] of people with Hashimoto's, such aspects of Hashimoto's have been poorly studied in Turkey [21].

It is known that a history of psychological trauma increases the likelihood of developing a physical illness with physical and sexual abuse having been associated with numerous physical illnesses in adulthood [22,23,24]. From among the studies conducted outside of Turkey, a study using the data of 2,142 individuals, found distinct interactions between childhood maltreatment and thyroid disorders in modifying the association between depression and anxiety disorders [19]. Another study using the data of 680 individuals, of which 7.7% were diagnosed with a thyroid disorder, found a significant relationship ($p<.05$) between sexual trauma and thyroid disease, among women [20]. As of yet, however, there has been no study that has looked into the traumatic experiences of those with Hashimoto's in Turkey.

The questionnaires tapping into trauma are mostly quantitative in orientation. However, it is qualitative interviews that allow access to a wider scope of knowledge on the possible traumatic experiences of women with Hashimoto's. Qualitative interviews, as such, have been used abroad to understand the lived experiences of people with hypo- and hyperthyroidism [15,25]. As of yet, there has been no study that has evaluated the experiences of people with Hashimoto's in the scope of a qualitative research interview in Turkey.

In addition, unconditional self-acceptance "means that the individual fully and unconditionally accepts himself whether or not he behaves intelligently, correctly, or competently and whether or not others approve, respect or love him" [26]. Given the fact that Hashimoto's brings about symptoms that can potentially highly impact the female identity, the level of unconditional self-acceptance of women with Hashimoto's seems to be of significance. As of yet, however, there has been no study in Turkey or internationally that has looked into the unconditional self-acceptance of women with Hashimoto's. Increased self-acceptance has been associated with "successful therapy outcomes in diverse areas including alcohol dependence (Grant, 1929), postdivorce adjustment (Waller, 1930), and schizoid personality (Tidd, 1937)" [27].

In an attempt to close some of these gaps in the literature, a qualitative and quantitative study was conducted to take a closer look at the past traumatic experiences and current unconditional self-acceptance of women with Hashimoto's in Turkey.

2. METHOD

2.1. Patients

The study having been conducted as the first author's thesis for her Master's degree in Applied Psychology, at Istanbul University in Turkey, the materials and methods were chosen in lieu with the rules and regulations and time limitations set by the ethical committee of Istanbul University Department of Psychology. This included having three months for data collection and analysis. Consequently, convenience sampling was used in which all study participants were recruited from an accessible private clinic connected to the local health authority of Istanbul, Turkey. All participants were previously diagnosed Hashimoto's patients who were referred to the first author of this study by an internal medicine specialist, each participant having freely chosen to be a part of this study. Written informed consent was obtained from all participants, according to the protocol approved by the committee.

Given that Hashimoto's is three times more frequent among women than men, only women were included in the study, and within the time frame of three months, twenty-five women accepted to participate in the study. Participants in menopause or with any serious medical illness or psychiatric or neurological disorder were excluded from the study to decrease confounding variables. This led for the participants' age range to be between 18 and 45 years.

The number of valid and reliable scales in the Turkish language in the area of traumatic experiences and unconditional self-acceptance being few, scales and measures were chosen based on availability and higher rates of validity and reliability in the Turkish population. All scales and measures were conducted in a private room of the clinic, in one sitting, with no recording devices or third parties present, save the participant and the researcher, in lieu with the rules and regulations of the ethical committee. Interviews were manually recorded, transcribed verbatim and all identifying information was removed, and pseudonyms were assigned to each participant. Following the interview, all handwritten notes taken by the researcher were personally approved by the participants for research trustworthiness [28], credibility [29], and confirmability and transferability [30] of the analysis. Notes that were not approved by the participants as being a truthful expression of their replies were excluded from the study.

Since the participants' traumatic experiences were a focus of the study, each participant was informed to respond to all questions within the boundaries of their own comfort and was given the freedom to leave the study at any point desired. In addition, following the completion of the scales and measures, a review discussion was conducted with each participant, inquiring on whether any aspect of the study had caused disturbance or not. In the case that it was necessary, arrangements were made for the participants to be referred to a psychologist connected to the local health authority of Istanbul, Turkey.

2.2. Scales and Measures

2.2.1. Demographic Survey Questionnaire

Each participant completed a demographic survey questionnaire to identify their age, education, economic status, occupation, marital status and basic aspects of their diagnosis, as well as possible other medical or psychological diagnoses. Individuals with prior psychiatric therapy or continuing therapy were excluded from the study.

2.2.2. Qualitative Research Interview

The qualitative research interview aims to describe and understand the meanings of central themes in the world of the subjects, the main task being to understand "the meaning of what is being said" [31]. The standardized, open-ended interview was chosen for the purpose of this study with the same open-ended questions asked to all participants. Hashimoto's being a psychosomatic disease, with psychoanalysts having grappled with the phenomenon of psychosomatic illness from the very beginning, the psychoanalytic psychosomatic approach was incorporated into the construction of the questions [32]. Psychoanalytic theory is frequently used across a wide range of "mediums and disciplines to interpret

literature, film, cultural acts, behaviors, autobiography, interviews, psychological testing, and so forth (see, e.g. Kracke, 1981, 1988; Ottenberg, 1988; Mellard, 1991; Sekoff, 1994; Alasuutari, 1997; Schafer, 1976; Rosenwald and Wiener, 1993)" [33].

Another consideration in the designing of the interview questions involved the main areas of the study, namely Hashimoto's disease, trauma, and self-acceptance. Questions surrounding marriage and children were incorporated due to the symptoms of Hashimoto's, specifically the challenges that could be linked to the symptoms with potential effects on the female identity, i.e. infertility, frequent miscarriages, and menstrual irregularities. As such, the qualitative research interview included the following six questions: 1) Can you please briefly talk about yourself, the history of your diagnosis, and your family?, 2) Can you please describe a memory (any memory of your choice)?, 3) How was your childhood?, 4) If you are married, can you please talk about your marriage?, 5) Are you a parent?, 6) Can you please explain a dream you saw (any dream of your choice)? The qualitative research interview was conducted in the scope of Kvale's seven stages of conducting in-depth interviews [27] and lasted for approximately 1-hour for each participant.

2.2.3. Traumatic Experiences Questionnaire (TEC)

The TEC [34] is a self-report measure that taps upon six areas of trauma (emotional neglect, emotional abuse, physical abuse, sexual harassment, sexual abuse, and bodily threat from a person) through 29 potential traumatizing events. If the individual has experienced any one of the traumatic events, this equates a score of 1, while not experiencing the event is given a score of 0. As such, a TEC score can be between 0-29. In addition, developmental level composite scores can be calculated for each of the six areas of trauma, where the score for emotional neglect, emotional abuse, sexual harassment, and sexual abuse ranges between 0-12 each, and physical abuse ranges between 0-21 points. As such, one can get a total developmental level composite score that ranges between 0-69. The closer the individual's score is to 29 on the TEC score, the more umber of traumas he/she is said to have experienced, while the closer his/her total developmental level composite score is to 69 the more he/she is said to have been deeply effected by the experience.

Developmental level composite scores are calculated according to the answers that have been given to four questions: 1) having experienced the traumatic event or not (for which one gives the answer Yes or No), 2) how old the individual was when it happened (for which one lists all the ages it happened, if it happened more than once, and lists the age range if it happened for years), 3) how much of an impact the experience had (for which one indicates the impact by circling one of the numbers between 1 and 5 where 1=none, 2=a little bit, 3=a moderate amount, 4=quite a bit, 5=an extreme amount), and 4) the relationship of the people responsible for the mistreatment or abuse.

The Turkish version of the scale [35] was used for the purposes of this study, which demonstrated to be a reliable and valid instrument suitable for use in clinical practice and research in Turkey.

2.2.4. Unconditional Self-Acceptance Questionnaire (USAQ)

The USAQ [36] is a self-report questionnaire that measures unconditional self-acceptance. The Turkish version of the scale [37] was used for the purposes of this study, which was found to be a reliable and valid tool for clinical practice and research in Turkey. The English version consists of 20 statements. However, since the factor load of the 20th statement was lower than .30 in the reliability and validity studies for the Turkish translation, it was excluded. Hence, the Turkish version of the scale consists of 19 statements. Participants respond to each statement on a scale from 1 ("almost always untrue) to 7 ("almost always true"), and while eight items are worded such that higher scores represent greater unconditional self-acceptance (e.g. "I avoid comparing myself to others to decide if I am a worthwhile person"), 11 items are reverse scored such that higher scores reflect greater conditional self-acceptance (e.g. "I set goals for myself such that I hope will prove my worth"), such that a total USAQ score is calculated through the sum of the scores on all items and ranges between 19 and 133 points. As of yet there have been no systematic epidemiological studies using the USAQ, but "it seems that adult samples of either sex can be expected to average in about the mid-80s, with about two thirds of respondents scoring between 70-100" [36].

2.3. Statistical Analyses

Data analyses were performed for the demographic survey, TEC and USAQ using cross tabulations, while conventional content analysis and Charmaz's four stages of analysis were used for the qualitative research interview. In conventional content analysis, "researchers avoid using preconceived categories (Kondracki & Wellman, 2002), instead allowing the categories and names for categories to flow from the data" [38]. Charmaz has noted four stages of analysis of a prepared data source: open coding, focused coding, axial coding and finally theoretical coding [39].

3. RESULTS

3.1. Characteristics of Patients

The age of the participants ranged between the ages of 18 and 45 with the mean age being 33.1. The most common age group was between the ages of 41 and 45 (28%), with the second most common age range being between the ages of 18 and 25 (24%). For the place of birth; Istanbul (48%), education level; primary school (28%), working/not working; not working (71.4%), socioeconomic status; middle class (66.7%), marital status; married (72%), age of marriage; 21-25 years old (42.1%), mother/not a mother; mother (73.7% of the 72% married participants, as none of the participants were mothers out of wedlock) and number of kids; 3 kids (35.7%) were the most common results.

Regarding the history of Hashimoto's, being diagnosed between the ages of 21 and 30 was most frequent (48%) and genetics were observed to be significant, with 68% of the participants answering "Yes" to the question, "Is there anyone else with this diagnosis in your family?" Moreover, 70.6% of this 68%, answered it as being not only "In 1 member of the family", but "In more than 1 member of the family", and with the family member "mother" being the most frequent reply (37.9%). Hence, previous findings on the fact that Hashimoto's is usually passed on from mothers to daughters, was also supported in this study. 92% of the participants reported taking synthetic thyroid medication alone as treatment for Hashimoto's.

3.2. Findings from the Qualitative Research Interview

In the conventional content analysis of the qualitative research interview open and axial coding [40] of the data were conducted and following saturation of conceptual categories, the deidentified interview transcripts were read repeatedly. Out of this process, lists of themes and sub-themes were identified and related propositions were developed [41]. An ongoing iterative process of developing themes and refining propositions resulted in the identification of eight major themes [42] related to participants' accounts. These themes included self-descriptions, reasons for seeking help, statements on Hashimoto's, quality of the mother-daughter relationship, value of the father, choice of dream, pregnancy and infertility and childhood.

Self-Descriptions: Participants described themselves as being introverted, usually preferring to live out their difficulties inside of themselves, so as never to become a burden upon others. Also all participants were deeply sensitive and emotional, despite keeping a cool demeanor on the exterior.

Reasons for Seeking Help: Participants described that intolerance, "ill-placed" anger bursts, unexplainable severe fatigue, hair loss, weight gain, menstrual irregularities and infertility were among the main symptoms that led them to seek help.

Statements on Hashimoto's: Participants described that though they had never heard of Hashimoto's, and initially were taken aback from being told they had to "be on medications for their whole-life", the symptoms that they were experiencing had caused so much havoc in their life, that they had little concern for what they were diagnosed with and only wished for their symptoms to subside. All felt relieved to be on medications and were fearful of the return of their symptoms.

Quality of the Mother-Daughter Relationship: Participants made statements to the effect that their mother-daughter relationship had been one filled with "inadequacies", commonly explained as "basically no expression of love and affection through touch", "mother who was busy with the objects of the household instead of the people in it", and "mother who was busy with her own feelings, usually found in the midst of tears, rather than in the feelings of others."

Value of the Father: In contrast to the poor relationship described with their mothers, a vast majority of the participants described a relationship of great value with their fathers. Some expressed this bond through the experience of having lost their father, and having never been able "to get over it", with the constant urge of comparing the other men in their life, specifically their husbands, to their fathers only to find out that "no one is like [their] father." Others made statements of great passion towards their bond with their fathers, that summed up to describing themselves as their "father's daughter."

Choice of Dream: From among all the possible dreams to explain, almost all of the participants began their answer to the question on their dreams with the statement: "I would like to explain the dream that most effected me, the dream that I have never forgotten", upon which they then explained their "hallmark dream" with impeccable detail and emotion.

Pregnancy and Infertility: While a few of the participants described infertility, including having frequent miscarriages and the inability to fall pregnant for years, even with in-vitro fertilization prior to having been diagnosed, some others described "fear around ever being able to fall pregnant" once they were diagnosed. Most of the participants who were mothers, on the other hand, described the challenges of dose control while pregnant, and "living in the fear of having retarded children" due to possibly making errors in their use of their medication during their pregnancy. Overall, pregnancy was described as a "very sensitive" subject for a vast majority of the participants.

Childhood: From among all the possible childhood memories, only two of the participants explained memories that could be described as "joyful", while the remaining twenty-three described memories in the form of traumatic childhood experiences. These traumatic experiences also corresponded to their replies on the TEC.

3.3. Findings from the TEC

Having to look after parents and/or brothers and sisters as a child (0%), loss of a family member as an adult (0%), serious bodily injury (e.g., loss of a limb, mutilation or burns) (12%), threat to life from illness, an operation or an accident (8%), divorce of parents (0%), own divorce (4%), threat to life from another person (e.g., during a crime) (4%), war-time experiences (e.g., imprisonment, loss of relatives, deprivation, injury) (0%), and second generation war- victim (war-time experiences of parents or close relatives) (0%), were not frequent among the participants, while family problems (e.g., parent with alcohol or psychiatric problems, poverty) (66.7%, of which only 7.8% was noted as poverty, alcoholism, while 58.9% was noted as mother-father conflict), loss of a family member (brother, sister, parent) when you were a child (28.6%; all of which were noted as loss of the father), and witnessing others undergo trauma (42.9%) were found as being frequent.

Emotional Neglect: From among all traumatic experiences emotional neglect was the most frequent (68%, with 88.2% of this 68% being from the mom), most commonly lasting for the duration of 12 years, with the developmental level composite score of 5-8 points being the most common answer (52.9%). Emotional neglect from siblings (11.8%) or more distant members of the family (11.8%) were found as not being significant. (Table 1)

Emotional Abuse: Emotional abuse was noted by 40% of the participants, most commonly from more distant members of the family (40%) and non-family members (50%). Once again, it was noted to last most frequently for 12 years, with the developmental level composite score of 5-8 points being the most common answer (70%). (Table 2)

Physical Abuse: Physical abuse was noted by 36% of the participants, most commonly from the father (44.4%) and non-family members (66.7%, of which were female teachers). As for the duration, 6 years was the most frequent answer (55.6%). (Table 3)

Sexual Abuse and Sexual Harassment: None of the participants reported sexual abuse or harassment by their parents. Moreover, only one participant out of the 25 (4%) noted sexual harassment by a non-family member, while three out of the 25 (12%) noted sexual abuse by non-family members. (Table 4)

3.4. Findings from the USAQ

The highest and lowest scores of the participants on the USAQ were 110 and 42 respectively, with the mean score being 70.9. Based on the fact that that adult samples of either sex are expected to average in

about the mid-80s, three levels of distribution were made for the purposes of this study, where scores between 19 and 80 were classified as having low, scores between 81 and 90 were classified as having average, and scores between 90 and 133 were classified as having high unconditional self-acceptance [24]. Based on this distribution, a low-level unconditional self-acceptance was most common (64%) among the participants, with only 8% having a high level of unconditional self-acceptance. (Table 5)

4. DISCUSSION

Compared to previous qualitative and trauma related studies conducted abroad, where a significant relationship ($p<.05$) was found between sexual trauma and thyroid disease among women, sexual trauma was not found as being significant among the participants of this study [20]. It must be noted that though sexual matters are extremely private in the Turkish cultural context, to the extent that they are rarely even discussed among family members [43], participants did not hesitate to specify the individuals responsible for their sexual trauma, even if, for example, in one case it involved their older brother. Consequently, despite the few number of the participants being involved in this study, and the purpose of the study being research oriented, rather than therapeutic, we believe that these results are representative of the actual circumstances of the participants of this study. The degree of openness by the participants may have been facilitated by the qualitative research interview, as participants demonstrated that they were comfortable with this method of data collection. For example, many thanked the researcher for having taken a genuine interest in them, not only after they completed the scales and measures, but also by phoning the researcher, in gratitude, the following day.

In contrast to prior studies conducted abroad, among traumatic experiences, what were found as being possibly significant were: emotional neglect by the mother, loss of the father, mother-father conflict, witnessing others undergo trauma and physical abuse by non-family members. The emotional neglect by the mothers of the participants could have to do with the fact that the mothers themselves were struggling with the symptoms of Hashimoto's, since the mothers of most of the participants were also Hashimoto's. Similarly, the special bond these very same women shared with their fathers, could be linked to the fact that the fathers reached out to their daughters for emotional support, while their wives struggled with the symptoms of Hashimoto's. One alarming proof of this can be seen in the following quote shared by one of the participants in this study. The following was stated to her by her exasperated spouse: "You have your period fifteen days of the month, and you are an emotional wreck on the other fifteen. Plus, you are also not able to fall pregnant. What is this?" As we can see the effects of Hashimoto's on the emotional body not only effects the person who is diagnosed with it, but spouses especially and so the family as a whole. In addition to this, all traumatic experiences of the participants had occurred before 18 years of age, which supports the growing research on a history of psychological trauma in childhood increasing the likelihood of developing a physical illness in adulthood [43].

On the other hand, the majority of the participants received a low score on USAQ. We believe this is of special significance as it demonstrates that Hashimoto's may not only linked to past traumatic experiences, but can also be traumatic experience in and of itself, especially due to it possibly bringing about infertility. For example, being asked the question: "So are you thinking to have kids?" which is a commonly asked question in the participants' social circles, was expressed as being "a dreadful question" by many in the qualitative research interview. However, it must be noted that the scores of the participants on the USAQ prior to having been diagnosed with Hashimoto's did not exist. Hence, a direct causal relationship between Hashimoto's and the level of unconditional self-acceptance needs further study.

Finally, despite the fact that the findings of this study are based on a very low number of convenience sample, results seem to support the fact that women with Hashimoto's may not only benefit from thyroid medications but also from psychotherapy. This became evident during the qualitative research interview as the participants switched from their initial "introverted" and "not liking to talk too much" demeanor, to the point that they wanted to explain not only a dream, but their most significant dream and also expressed gratitude for someone having taken interest in "them", rather than simply taking interest in "the results of their blood tests." This can also be supported from the growing research on the psychological disorders linked to having been diagnosed with Hashimoto's disease. For example, in 2018, the results of a meta-analysis of 9 studies that comprised 21 independent samples and 36,174

patients showed that participants with autoimmune thyroiditis, Hashimoto's thyroiditis or subclinical or overt hypothyroidism had significantly higher depression scores compared with controls [44]. Furthermore, participants with these same thyroid disorders also had higher anxiety scores than healthy controls [44].

5. CONCLUSION

While this study did not recruit women from all of the cities of Turkey or a large number of participants, the study findings are unique given the negligible scholarly literature on the psychological aspects of women with Hashimoto's disease in Turkey. This study was also the first ever qualitative analysis of women with this disorder in Turkey as well as the first study to evaluate the degree of unconditional self-acceptance of women with Hashimoto's disease. With the growing number of women receiving the diagnosis of Hashimoto's in Turkey and globally, we believe that the results and suggestions of this study are of significance.

Future studies may evaluate the concepts considered in this study with a larger sample, as well as look into the impacts of psychotherapy on the anti-TPO levels of women with Hashimoto's disease. It is believed that therapeutic work on the traumatic experiences and unconditional self-acceptance of women with this disease may actually cause alterations in the autoimmune reaction of those with Hashimoto's. Finally, there may be studies that compare such findings in those with Hashimoto's with a control group.

6. TABLES WITH CAPTIONS

Table 1. Emotional Neglect

Did you experience it?	**Frequency**	**Percentage**
Yes	17	68%
No	8	32%
Developmental Level Composite Score	**Frequency**	**Percentage**
1-4 points	5	29.5%
5-8 points	9	52.9%
9-12 points	3	17.6%
By Whom?	**Frequency**	**Percentage**
Mom		
Yes	15	88.2%
No	2	11.8%
Dad		
Yes	7	%41.2
No	10	58.8%
Siblings		
Yes	2	11.8%
No	15	88.2%
More Distant Family Members		
Yes	2	11.8%
No	15	88.2%
Non-Family Members		
Yes	5	29.4%
No	12	70.6%

Table 2. Emotional Abuse

Did you experience it?	**Frequency**	**Percentage**
Yes	10	40%
No	15	60%
Developmental Level Composite Score	**Frequency**	**Percentage**
1-4 points	0	0
5-8 points	7	70%
9-12 points	3	30%
By Whom?	**Frequency**	**Percentage**
Mom		
Yes	3	30%
No	7	70%
Dad		
Yes	2	20%
No	8	80%
Siblings		
Yes	1	10%
No	9	90%
More Distant Family Members		
Yes	4	40%
No	6	60%
Non-Family Members		
Yes		
No	5	50%
	5	50%

Table 3. Physical Abuse

Did you experience it?	**Frequency**	**Percentage**
Yes	9	36%
No	16	64%
Developmental Level Composite Score	**Frequency**	**Percentage**
1-4 points	5	55.6%
5-8 points	2	22.2%
9-12 points	2	22.2%
13-16 points	0	0
17-21 points	0	0
By Whom?	**Frequency**	**Percentage**
Mom		
Yes	2	22.2%
No	7	77.8%
Dad		
Yes	4	44.4%
No	5	55.6%
Siblings		
Yes	1	11.1%
No	8	88.9%
More Distant Family Members		
Yes	1	11.1%
No	8	88.9%
Non-Family Members		
Yes		
No	6	66.7%
	3	33.3%

Table 4. Sexual Abuse and Sexual Harassment

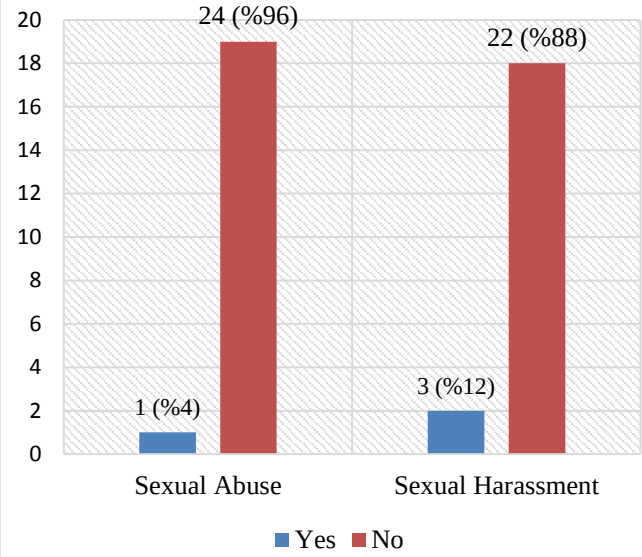
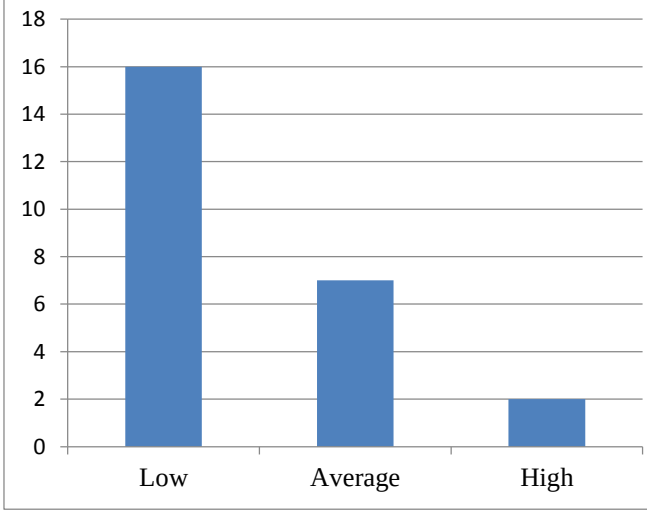


Table 5. Distribution of USAQ Scores



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