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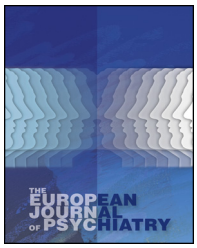

ORIGINAL ARTICLE

The relationship between depression, anxiety, personality traits and coping strategies of patients with euthyroid Hashimoto's Thyroiditis

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KEYWORDS
Hashimoto Thyroiditis;
Personality;
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Abstract
Background and objectives: We aimed to investigate the depression and anxiety levels and to explore the coping strategies and personality traits of patients with euthyroid Hashimoto Thyroiditis (HT).
Methods: The study population consisted of 108 outpatients with euthyroid HT. The participants completed the Hospital Anxiety and Depression Scale (HADS), the Big Five Personality Inventory (BFI), and the Coping With Problems Experienced Inventory (COPE).
Results: Depression scores were negatively correlated with emotion-focused and problem-focused coping style scores. Emotion-focused and problem-focused coping style scores were negatively correlated with neuroticism, and positively correlated with openness scores. Emotion-focused coping style scores were also positively correlated with agreeableness scores. Dysfunctional coping style scores were negatively correlated with conscientiousness scores. Higher agreeableness and anxiety scores as well as lower neuroticism scores were predictive of emotion-focused coping style scores. Problem-focused coping style scores were predicted by lower depression scores. Dysfunctional coping style scores were predicted by lower conscientiousness scores.
Conclusions: The present study points the importance of taking personality features and individual coping strategies into account when evaluating patients with HT. Determining the personality features and coping strategies might be useful for identifying patients in need of particular counseling and support.

Introduction

Hashimoto's Thyroiditis (HT), which is a chronic inflammation of the thyroid gland, is considered the most common autoimmune disorder, and the most common endocrine

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disorder.[1] HT is the most common cause of hypothyroidism, and it is more likely to occur in women.[2] Many studies have shown a connection between stress and autoimmune thyroid disorders.[3] Clinical and epidemiological studies investigating the relationship between autoimmune thyroid disorders and psychiatric disorders have reported inconsistent results.[4] Some studies demonstrated that psychiatric disorders were more prevalent among patients with autoimmune thyroid disorders.[4–6] On the other hand, certain studies showed that thyroid autoimmunity did not cause an increase in psychiatric morbidity.[7–8] HT is associated with lower levels of quality of life as well as with physical and psychological problems.[9]

People utilize a variety of strategies in responding to stress. Coping is defined as the use of cognitive and behavioral strategies for dealing with the perceived pressures, demands, and emotions involved in stressful situations.[10] Although there is no formal classification of coping strategies, Wong et al. suggested categorizing coping strategies into three groups: problem-focused coping strategies, emotion-focused coping strategies, and dysfunctional coping strategies.[11] Coping strategies are also important in dealing with physical illness and autoimmune disorders.[12] They enable the patient to adapt to problems and stressors arising from the disorder, such as pain, fatigue, limitations in mobility, and difficulties in daily life activities.[13] It is well known that personality traits may impact the evaluation of stress, and affect the particular utilization of coping strategies.[14]

There is no research examining coping strategies and personality traits in patients with euthyroid HT. In the present study, we aimed to investigate the depression and anxiety levels of patients with euthyroid HT. We also intended to explore the coping strategies and personality traits in the same group. If the person's coping styles are determined, it may help the clinician to better identify the treatment goals and therapeutic efficacy of the treatments.

Therefore, it will be of value to have a better understanding of the coping strategies and personality traits of these patients to manage them in routine clinical practice.

Methods

Participants

The study population consisted of 108 outpatients (99 women, 91.7%) aged 18 and older (mean (*M*) age = 37.96 years, standard deviation (*SD*) = 10.06, range: 18–68 years) presenting to the internal medicine clinics of a university hospital. Patients in the study population suffered from HT. Participants were excluded from the study if they had a current diagnosis of any psychotic disorder, mental retardation, organic brain disorder, head trauma, degenerative neurological disorder, substance dependence, or medically uncontrolled chronic illness.

Measures

The interviewers completed a demographic and clinical data form, onto which they recorded the age, sex, marital status, level of education, place of residence, employment status, socioeconomic status, and substance use.

The participants completed the Hospital Anxiety and Depression Scale (HADS),[15] the Big Five Personality Inventory (BFI),[16] and the Coping With Problems Experienced Inventory (COPE).[17] The HADS is used to measure the severity of depression, and it consists of two separate 7-item subscales. The BFI is a 44-item inventory that measures an individual on the big five dimensions of personality, i.e. extraversion vs. introversion, agreeableness vs. antagonism, conscientiousness vs. lack of direction, neuroticism vs. emotional stability, and openness vs. closedness to experience. The COPE is a 60-item, 4-point self-report scale consisting of 15 subscales. The COPE consists of three main groupings with five scales per group and four items per scale: (a) problem-focused coping: active coping, planning, restraint coping, seeking social support for instrumental reasons, and suppression of competing activities; (b) emotion-focused coping: positive reinterpretation and growth, religion, humor, acceptance, and seeking social support for emotional reasons; and (c) dysfunctional coping: focus on and venting of emotions, denial, behavioral disengagement, mental disengagement, and alcohol/drug use. Scores of all of the subscales may be used individually, or a composite score for emotion-focused, problem-focused, and dysfunctional coping styles may be computed. The Turkish versions of all of these scales were used in this study.[18,19] In the Turkish version of HADS, the cut-off score for the depression and anxiety subscales were 7 and 10, respectively.

Procedure

All participants were interviewed face-to-face by the internal diseases specialist, and the measures were completed after the interviews at the outpatient clinic. The intake period lasted from July 2015 to December 2015. No compensation was offered to the participants.

Statistical analyses

All analyses were performed using *IBM SPSS for Windows, Version 22.0* (IBM Corp., 2013). Demographic and clinical data of the participants were analyzed by descriptive statistics. Bivariate Pearson product moment correlations between the psychometric scales were computed. To examine the unique associations between the demographic and clinical variables, i.e. age, sex, marital status (married vs. other), level of education (≥8 years vs. other), personality characteristics (BFI subscale scores), and the HADS subscale scores, a stepwise linear regression analysis using the backward method was performed. At each step any variable with a probability of $F \leq 0.05$ was retained in, and any variable with a probability of $F \geq 0.10$ was removed from the analysis. This stepwise selection continued until all of the variables were either included or excluded. The outcome variables were the composite subscale scores of the COPE. Statistical significance was set at a p value of <0.05.

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