Published on March 2025

Women and Thyroid Disease: Treatment

A must-read Guide for women Having Uncontrolled Thyroid Issue along with PCOD- 2025

Studies behaviour-

1) Women with normal Thyroid vs Thyroid due to PCOD
2) How to find a women have Thyroid due to PCOD
3) General Precautions and cure
4) What are the symptoms to identify the patient
5) Why These women are always dependent on men

This Thesis is written for Doctors and Females with these issues.

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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2025

Abstract

Women and Thyroid Disease:

Treatment Experiences and the Doctor-Patient Relationship

by

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MSEd, Youngstown State University, 2003

BS, Westminster College, 1998

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

August 2025

SCOPE OF STUDY

There are several studies on Thyroid and the ways to cure it. In medical field there are several studies and medical procedure available for curing of Thyroid the two widely used processes are

1) Medication: The standard treatment is daily oral medication with synthetic thyroxine (T4), known as levothyroxine.
2) Radioactive iodine (RAI) therapy: The most common treatment in the U.S. is a capsule or liquid containing radioactive iodine (I-131).

In medication it's a lifelong process and one needs to take medicine till his lifetime. Even though one can't ignore the side effects of medicine, and its dose increases as time increases. In radioactive iodine therapy its very complicated and have much side effects and not full proof solution. On the other hand, all researchers work on normal thyroid problems but about 5% of women suffer with a problem Thyroid due to PCOD and the normal medical process don't seem to be effective on it because other than medication it also needs hormonal balancing from inside the body. Otherwise the woman suffering from it gets severe medical and hormonal imbalance issue in 40s that become impossible to cure.

Here are few reasons why every women must know whether she is suffering from normal thyroid or thyroid occurred due to PCOD are following-

a) If she knows she has thyroid due to PCOD she can maintain her lifestyle accordingly because it's a lifestyle problem and only medication will not help.
b) She will not get frustrated because it takes time to get cured in this case.
c) She can know she has risk of vaginal or anal cancer, and she can transfer to its partner also she can go for HPV vaccines on time.

d) Women whose assessment score is more than 70 has chance she will get excessive fat and will get beard or hair on her face after age of 45 due to lack to Estrogen. So, precaution is needed earlier.

e) The women whose score is above 75 has a chance of getting early wrinkles on their face and skin. So, she can take extra precaution, take hormone therapy before its too late.

f) Other than that if she knows she can reduce the effect of problems that is caused by thyroid which starts getting visible after 45 years of age even you take medicine.

In simple words you can say they put on heavy weight, dull skin and wrinkles, digestion problems, weak bones, early menopause, vaginal cancer and many such issues come across them and they cant understand how to handle it. And doctors cant help because its problem from inside and can be solved with daily life changes and building strong determination. In this we will se many women has done it and left medication so its not impossible but fist you need to find your stage of severity of thyroid. This research paper written for Doctor point of view(full document) and patient point of view(in different colour). Read accordingly.

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Dearest Pat, my husband—I could not have completed this study without your constant support and encouragement. From the bottom of my heart, thank you.

Dr. Ruth Crocker—Thank you so much for sharing your wisdom with me during this long journey. Your guidance and patience have been invaluable.

My study participants—Thank you for trusting me with your experiences. Together, we will acquire the treatments that we need and deserve.

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Chapter 1: Introduction to the Study

Introduction

Approximately 200 million people worldwide have been diagnosed with thyroid disease, a chronic illness (Rajoria et al., 2010). According to the American Association of Clinical Endocrinologists (AACE, 2013), approximately 30 million Americans are affected by thyroid disease, although more than half remain undiagnosed. Across cultures, the prevalence of thyroid disease is much higher among women than among men (Canaris, Manowitz, Mayor, & Ridgway, 2000; Cassidy, Ahearn, & Carroll, 2002). In fact, women have an estimated 1 in 7 chance of developing thyroid disease (Godfrey, 2007).

A number of factors make proper diagnosis and treatment of thyroid disease challenging. For example, according to Adams (2008) and Dayan (2001), the most commonly used blood test (thyroid stimulating hormone [TSH]) for diagnosing thyroid disease can produce misleading results. More specifically, although use of all three main thyroid function tests (TSH, free T3, free T4) produces the most thorough analysis of thyroid function, the TSH test tends to be used alone (Dayan, 2001). Because of this, clinically important diagnoses (e.g., hyperthyroidism, hypothyroidism) are sometimes missed. In addition, as thyroid dysfunction produces symptoms similar to those of other disorders (e.g., depression, menopause), thyroid disease is often misdiagnosed and left untreated (Canaris et al., 2000; Godfrey, 2007; Simmons, 2010). Likewise, as the TSH test tends to be used alone to determine treatment effectiveness, many women with thyroid disease continue to experience symptoms even when they are receiving treatment (Bunevicius & Prange, 2006). In the face of such challenges, a doctor-patient relationship

based on mutual trust and collaboration helps to ensure positive treatment outcomes (Houle, Harwood, Watkins, & Baum, 2007; Munch, 2004). In addition, effective communication between doctors and patients is critical in both the diagnosis and management of thyroid disease (Shimabukuro, 2008; Simmons, 2010). However, the culture of the medical profession, diagnostic bias, and gender differences in communication may interfere with doctor-patient discourse (Cheney & Ashcraft, 2007; Hamberg, Risberg, & Johansson, 2004; Hoffmann & Tarzian, 2001; Kaiser, 2002; Munch, 2004). An exploration of women's experiences in the treatment of thyroid disease, especially relative to these three points, may contribute to better understanding on the part of doctors and thus more effective doctor-patient communication and relationships.

Despite the pervasiveness of thyroid disease in women and the importance of the doctor-patient relationship in positive treatment outcomes, there is a gap in the literature regarding the treatment experiences of women diagnosed with thyroid disease, particularly regarding the doctor-patient relationship. Therefore, the purpose of this phenomenological study was to explore female thyroid patients' experiences of treatment and the doctor-patient relationship.

The phenomenological research approach was used, as it is designed to examine the meaning of experiences about a particular phenomenon (e.g., thyroid disease) across several individuals who have experienced it (Creswell, 2007). The theoretical perspectives used to guide data interpretation included feminism and social constructivism. More specifically, the following issues were addressed in regard to their relationship with women's treatment experiences: (a) the culture of the medical profession (see Kaiser, 2002; Thomas, 2001), (b) diagnostic bias (see Hamberg et al.,

2004; Hoffmann & Tarzian, 2001; Munch, 2004), and (c) gender differences in communication (see Cheney & Ashcraft, 2007; Tannen, 2007).

The following paragraphs provide a review of the literature relevant to the study, followed by the problem statement, the purpose and nature of the study, research questions, conceptual framework, definition of terms, assumptions and limitations, and the significance of the study.

Background of the Study

The incidence of thyroid disease is higher than previously thought (Canaris et al., 2000), affecting an estimated 30 million Americans (AACE, 2013) and 200 million people worldwide (Rajoria et al., 2010). Of the 30 million Americans with thyroid disease, more than 15 million remain undiagnosed (AACE, 2013). Across cultures, the prevalence of thyroid disease is much higher in women than men (Canaris et al., 2000; Cassidy et al., 2002). Approximately 1 out of every 7 women develops thyroid disease, and its prevalence increases with age (about 20% in women over age 60; Godfrey, 2007). The two predominant conditions resulting from thyroid disease are hyperthyroidism and hypothyroidism, with Grave's disease and Hashimoto's disease, respectively, as the most common causes (Zeitlin et al., 2008). Both conditions cause a wide range of somatic and psychiatric symptoms.

Hyperthyroidism

Hyperthyroidism is the result of excessive thyroid hormone production (AACE, 2002) and is frequently associated with anxiety, panic, and phobias (Aslan et al., 2005). In the United States, the most common cause of hyperthyroidism is Grave's disease, an autoimmune form of thyroid disease (Bunevicius & Prange, 2006). Individuals with

hyperthyroidism experience heat intolerance, hot flashes, absent menses, insomnia, decreased libido (Godfrey, 2007), rapid heartbeat, sweating, and tremors (Aslan et al., 2005) and may present with diffuse goiter and ophthalmological abnormalities (Ginsberg, 2003).

Hypothyroidism

Hypothyroidism results from the undersecretion of thyroid hormones from the thyroid gland (AACE, 2002) and is frequently associated with depressive disorders (Aslan et al., 2005). In the United States, the most common cause of hypothyroidism is Hashimoto's disease, an autoimmune form of thyroid disease (Erdal et al., 2008). Individuals with hypothyroidism experience fatigue (Bono, Fancellu, Blandini, Santoro, & Mauri, 2004), lethargy, apathy, difficulty concentrating (Aslan et al., 2005), weight gain, dry skin, and decreased libido (Godfrey, 2007). In extreme cases, the individual may experience slowing of thought processes, progressive cognitive impairment, hallucinations, and delusions (Bono et al., 2004).

How to identify normal thyroid vs PCOD thyroid by body symptoms for better cure

There is a huge difference between normal and PCOD thyroid body. Though in both medical and medication process are same but the body behaviour and response towards the medicine is different. So it is important that women must know that she has Thyroid due to PCOD so that she can take extra home remedies other than medicines to get better results. For PCOD women it not possible to eradicate Thyroid without maintaining hormonal level in blood. Normal thyroid responds fast to medicine and in

few cases it has been seen that they automatically get cured and no medication is needed. In some cases even their TSH value shows high but no symptoms is shown by body and no medication is required. On other hand the woman with PCOD caused thyroid show body symptoms even slight up and down in TSH and it becomes hard for the women to ignore the medicine. The response of meditation on this type of thyroid is very slow. The women can't depend only on medicine but they have to cater the hormonal issues those are responsible for the thyroid. Without catering hormonal imbalance it's become hard to control thyroid. It has been seen many women has left medication after following diet proper medication and hormone therapy. It's hard but not impossible.

Body type and body behaviour of PCOD type Thyroid women

Only 5 to10 percent women fall in this category but they can identify their body type with body type and symptoms. Here are few body type behaviour which defines these types of women. Its self-assessment process for a women because the medication process for both Thyroid are same as a doctor point of view but some women responds to the medicine and some women doesn’t respond. The who doesn’t respond quickly and have more visible problems due to thyroid fall in this category. They need to self-access herself and know the only medication will not work and the need to have patience for the results to be visible. For this please take assessment test and rank your self and see in chich category do you fall.

1) They are generally short height and slim in early age because of excessive mensuration bleeding and cramps but they gain weight after marriage. (Points- 10)

2) They have less or no hair all over the body because of deficiency of hormones but in later age this backfires and they suffer dry skin and excessively weight gain in mid 40s. The reason is lack of male hormones which helps tone of muscles. (Points- 13)

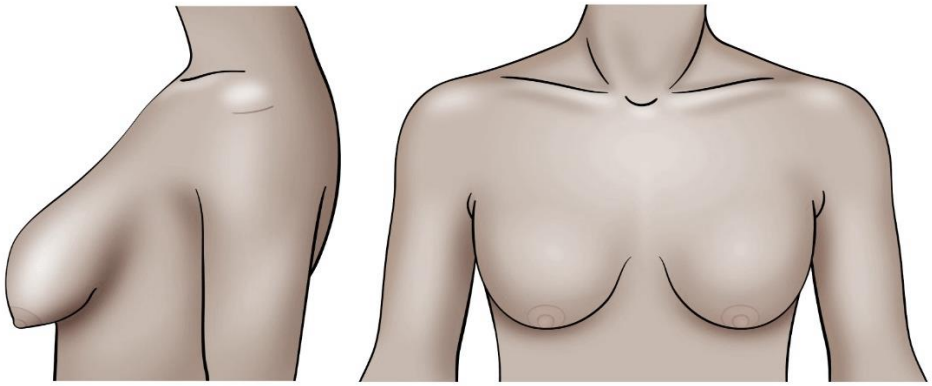
3) This type of woman has more bleeding and clotting in initial stage of life, so their vagina becomes stiff and a bit hard. Due to this reason their vaginal elasticity is less, and it always regains it shape if not having sex for few days. Males love to have sex with this type of women because they always find a harder vagina while intercourse. But this equally works as curse for women because as the walls are stiff male get highly exited due to high friction and ejaculate fast and women remains unsatisfied. They need more intercourse time but men get easily discharged. So this type of women wishes two to three men for intercourse and satisfaction. In our study men reported they love having sex with this type of women than normal women. As the vaginal absorption is low in this type of woman at least three consecutive ejaculation is needed for hormonal balance of women. Men love this type of women because they can handle three two four men at once because of stiff vagina

and they give equally enjoyment of each men. In adult porn industry this type of models are selected for group sex because they can with stand two to three men easily and also female get ready because it give her ultimate satisfaction and hormonal balance. One ejaculation is not enough for these type of women that will not improve their hormone deficiency. The curse with these type of women is that more and more men want to have sex with these type of women but these women need more and more orals. In USA and many European countries, it is seen that women with this type of problem indulge in group sex with few vaginal and few orals at a time. It is the best treatment for these types of women till now. (Points- 18)

4) These women has problem of low blood pressure in morning and evening and feels low in energy. They are generally active in afternoons. (Points- 5)

5) This type of women gets easily infection in vagina due to lack of sufficient lubrication. (Points- 5)

6) The next Symptom is the shape of breasts. The shape of breasts of these type of women is little sagged towards downward. (Points- 8)

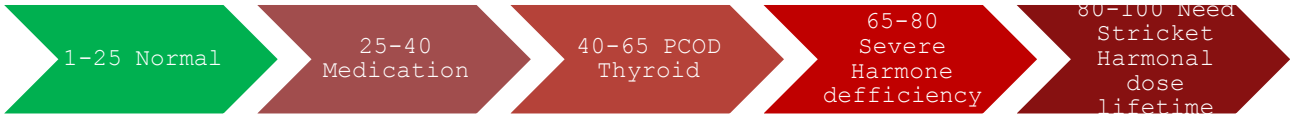


7) These women have heavy and tuff fat deposit at lower side of belly and it doesn't go even doing exercise. This is because of low testosterone in body. (Points- 8)

8) They have decolourisation in legs this is also due to hormonal imbalance. (Points- 5)

9) These types of women generally get mot sexually active one the mensuration cycle is over. Theie mood remains active for only 5-6 days and then gown down, and libido decreases. (Points- 8)
10) The Other main symptoms of these types of women will get more exited or libido increases once they have sex with partner. If they don't have sex for few days their sex desire becomes very less or almost nil. This is because once they get hormonal boost from the male partner they get sexually exited and as the hormonal level goes down the libido ends. (Points- 10)
11) Other than that constipation is also a symptom that is predominantly present in these types of women. (Points- 10)

Now get your rating



If you rate yourself in above scale you can easily understand what type of medication you need. Once again its important to note your same medicine is prescribed to all type of patients but your approach should be according to the scale you are falling. If you have PCOD type thyroid and you want to leave thyroid medicine, then either medication will not work or work very slowly. So you have to first find the root cause of the problem that is the hormone deficiency and the throat stiffness occurred due to Thyroid. If your score is above 65 then you should regularly go for oral hormones from your male partner, then only quick recovery is possible. And the last case is if your score is above 80 means you need to take serious action after age of 35 because your body is producing very less hormone and your body is crying for help. Your vagina is stiff and not easily sucking the hormones form male ejaculation. What you should do now?? There are only 5% or less women who fall in this category. In our sample there were 175 such women and out of those 115 left medication, 35 were in controlled medication with no effect of thyroid and 25 show no action and got severely affected by thyroid symptoms.

What are are main issues with the females who falls in category score above 75?

The main issue with these females are they struggle to maintain their Thyroid doses and must go for frequent dose change in a month or two whereas

doctors suggest at least three months for next blood test for TSH. These women face so many issues that they start doing TSH test in every one or two months. The main reason for this is they encounter so many hormonal issues related to that like constipation, fatigue. Tiredness, weakness, double chin etc. They have always issue of late periods and period cramps in back. They have high risk of anal and vaginal cancer. Thay can also transfer their disease to their partner. So it is advised if your score is above 60 do go for HPV vaccination to be safe and keep your partner safe. For better results you can go for semcocen process for better results.

What is semcocen process? Who should try this?

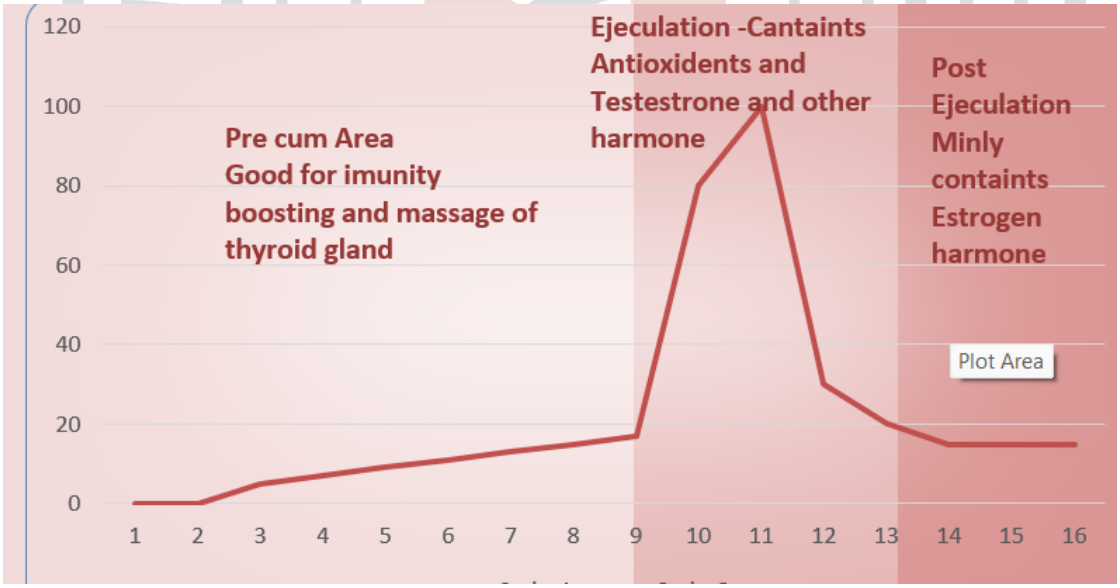
Semcocen is a process by which you can get better concentration of semen from your partner. This process is must if your score is above 75. If your score in 60 to 80 at one semcocen is needed in week. And if your score is above 80 then go for at least two semcocen in a week. This process need time of 10 o 12 hours so must be done accordingly. Now lets discuss the process for this-

1) Try to sleep nude with your partner so that male could get full exited.
2) Female needs to full arouse the man by kissing his nipples and any fantasy he likes to have.
3) Always keep your one hand on his scrotum (penis balls) and give gentle massage.
4) You can talk anything but keep massaging his scrotum gently. Properly talk sexy to excite him.

5) Try to keep your hand on his scrotum by covering the whole part with hand to give warmth to the scrotum as warmth help produce more semen.
6) Put your hands on scrotum while you fell asleep and whenever you wake up in night give a gentle massage and give warmth to it.
7) As you wake up in morning try to try to get the semen as oral as soon as possible because the hormones level are best before 10 am in the morning.

What is best licking process for hormonal licking?

For this first you must understand how at what time what fluid come out of the penis this will give clear indication how to do that.



So, It is clear from graph pre cum, ejaculated cum and post cum all three are equally important for you but for the ladies with PCOD caused thyroid has has deficiency of Estrogen Harmon in them and that comes after 30 to 45 seconds of ejaculation. So the

best practice is after ejaculation suck the penis like a baby for at least 2 minutes and keep rubbing the balls so that you can get the Estrogen Harmon out. Penis keep producing Estrogen Harmon up to 3 to 5 minutes of ejaculation that keep coming out so more time you give more you can get.

Why is Estrogen Harmon important for women with PCOD?

This Harmon is also called beauty Harmon. Once a lady crosses 35 years of age this Harmon body start to lower its production. But for woman with PCOD it has been seen that their menopause starts at 40 and body stops its production at age of 45. One the hormone production is stopped they start development of beard type hair on face, wrinkles on skin, Loss in hair volume, uneven body weight, most important body stops producing new skin cells so face looks dull and old at age of 45. So for a women beauty this is referred as beauty Harmon.

What is best time for oral and Vaginal sex?

As we have discussed the vagina of these women are stiff so it is better to have sex just after periods is over to get better benefit . But as the day progresses go for more and more orals. If you diagnose yourself with thyroid dur to PCOD then do go for Semcocen process as described earlier before its too late. Because as age progresses the body stats to stop responding and you have to keep yourself on medicine. But medicines only keeps your TSH down at later age the side effect of thyroid will still be visible in mid 40s.

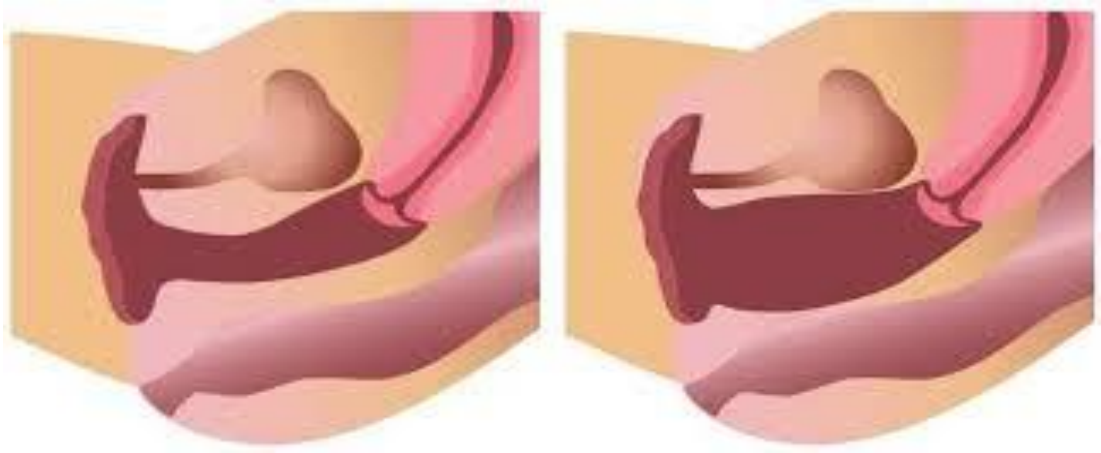
Why woman with thyroid with thyroid are in called sex dolls in USA?

For this in our sample of PCOD caused thyroid we have three women who later became porn star. Lets take their view on it first.

1) JILLIAN JANSON – She says she was tired of her life with PCOD and thyroid at age of 23. She decided to end her life but she thought why not enjoy before dying. So she decided to become a pornstar. And from there every thing changed. She saw more and more people wanted to have relation with her and she was able to sustain three to four people easily. She noticed she has drastic change in her body in five years and she was most demanding girl. She met the doctor and found the TSH to be normal and doctor explained the reason. Then she started enjoying group sex as she can do it better from others and it was good for the health. Now she has left the medicine and lives stress free life.
2) MIA MALKOVA- She says I was frustrated with my husband as he never satisfied me. She took divorce from him and started relation with her boss in office. Once she was caught by her three office staff and at first time she had sex with all three at once. And she could handle all three and got satisfaction for first time. This continued for few month and she noticed her TSH level getting normal. After meeting the doctor she knew olas can do better for her. So she went for four to five people for three vaginal and two orals the continued for two years and she got her reports normal. But her boss come know about this and he fired him from office and then she decided to become a porn star because the orals and sex satisfaction was necessary for his life so why not earn from it.
3) STELLA COX – She Has also the same story as two she was not satisfied by her husband. She wanted a baby so she met the doctor. Doctor diagnosed her as Thyroid due to PCOD and told to have more sex and orals. She talked about this to her husband. He agreed as the life of her wife was important. So he agreed to

arrange three to five men two times a month for her oral and vaginal needs. She also got her PCOD and thyroid normal. In few years she left the medicine and also got pregnant but due to some reason she got divorced and got in depression. She also lost baby when she was in first trimester. From there she decided to become a porn star as it will help him in thyroid and retain its beauty.

From above conditions we can understand that woman with PCOD and Thyroid are in much demand in boys for sex and their vagina remains hard and give full enjoyment. She can also give please to to three person at once and then get satisfaction but it is her necessity also. She has to take orals and multiple sex for healthy vagina and healthy body. She needs orals for hormonal balance. So its depends upon person to person how they take it. In first image its PCOD vagina it give good sexual experience to men but doesn't absorb semen fluid because of small size and stiff vaginal wall. Same is opposite for second image.



Diet for Thyroid control

Both type of Thyroids need same medication and diet chart. So prepare your diet chart from any dietitian. Many websites offer advice on what foods to eat or not eat with thyroid disease. However, there are no specific foods or dietary supplements that you can use to treat your thyroid disorder. It is important to eat the right variety of foods in the correct proportions. Having a balanced diet is the best way to ensure your body gets all the nutrients it needs.

The NHS Eatwell Guide recommends you should try to:

- eat at least five portions of a variety of fruit and vegetables every day
- base meals on higher fibre starchy foods like potatoes, bread, rice or pasta
- have some dairy or dairy alternatives
- eat some beans, pulses, fish, eggs, meat and other protein
- choose unsaturated oils and spreads, and eat them in small amounts
- drink plenty of fluids (at least 6 to 8 glasses a day)
- avoid processed foods and reduce sugar intake

There is also increasing evidence that having diverse gut bacteria is associated with better overall health. A diet containing fresh, whole foods, mainly from plant sources like fruits, vegetables, legumes (plants that have their seeds in a pod, such as chickpeas, lentils and edamame), beans, nuts and wholegrains and that avoids highly processed foods can promote a healthy microbiome. At this stage, there is not enough evidence about the role of gut bugs and how they affect thyroid function although some research has been undertaken.

As is often the case, results are clearer in mouse models, using mice that are genetically identical, all female, the same age and fed the same food and water, than in humans with the same condition, who display none of these characteristics. In our mouse model of Graves' disease (GD)/Graves Orbitopathy (GO) we found a clear connection between certain gut bacteria and disease symptoms; treatments to change the microbiome influenced the induced GD/GO. Antibiotics improved disease whilst faecal material from people with GD/GO made it worse. Although probiotics increased white blood cells with anti-inflammatory properties, some GO symptoms were aggravated.

The gut microbiome has also been shown to be less diverse and less 'healthy' in people with GD/GO but there is wide variation in the changes reported in different geographic regions [ii] (ref Biscarini), reflecting divergent diets and lifestyles. Consequently, it is too soon to recommend a particular antibiotic, prebiotic (fibre-rich foods) or probiotic to treat – or even help to prevent- GD/GO and other thyroid conditions.

The following foods, however, are known to affect thyroid function:

Brassicas

Brassicas (e.g. cabbage, cauliflower, kale) may contribute to the formation of a goitre (swelling or enlargement of the thyroid gland) in some cases, but consumption would need to be very high before this is a real concern. In the UK, under normal dietary conditions, this is not normally a problem, and the risk is very low.

Kelp

Avoid products such as kelp and sea moss as they may interfere with thyroid function and wellbeing. Kelp supplement is derived from seaweed and is naturally high in

iodine. Because of this, it is sometimes marketed as a 'thyroid booster' and can be purchased in dry preparations and tablets. As with iodine supplements, it is of no health benefit to people with a diagnosed thyroid condition.

Soya

Soya interferes with levothyroxine absorption, therefore if you are taking levothyroxine you should try to avoid soya. If you wish to take soya, you should leave as long as possible (at least four hours) between eating the soya and taking the levothyroxine.

Supplements

It is important to note that no vitamins and minerals (supplements) can provide the same nutritional benefits as a healthy balanced diet. However, it is not always easy to maintain a varied and healthy diet. For this reason, you may wish to take supplements. If you decide to do this, you should avoid taking them in excessive amounts. Not only can this be harmful, some can also interfere with your thyroid function or your thyroid blood test results. So, you should let the person taking your thyroid function tests know if you have been taking supplements.

Please also note that supplements should never be taken as an alternative to prescribed medication.

We recommend you take appropriate advice from your doctor or pharmacist before taking any supplements or vitamins.

Biotin (vitamin B7)

This is used in many cosmetic products, as well as supplements, to promote hair and nail growth. Although its benefits are anecdotal, it is understandably popular among

people living with hypothyroidism to address these issues but no clear evidence exists for a beneficial effect in thyroid conditions, even in people with additional autoimmune conditions. The daily recommended intake of biotin for an adult is 30mcg but many biotin supplements marketed for cosmetic reasons contain much higher doses, ranging from 5,000mcg to 10,000mcg. We recommend you be aware that these mega doses of biotin can sometimes result in incorrect TSH, FT4 and FT3 levels and may give a reading that suggests an overactive thyroid (hyperthyroidism). If you are taking biotin supplements the American Thyroid Association advises that you avoid taking them for two days before having thyroid blood tests to minimise the risk of a false reading.

Calcium

Some calcium-rich foods and supplements interfere with levothyroxine absorption. A gap of four hours between the two would be adequate to ensure there is no significant impact on blood thyroxine levels. If you use semi-skimmed or skimmed milk, this remains high in calcium despite being lower in fat.

Carnitine[iii]

Carnitine is found naturally in all tissues and body fluids. During the normal process of releasing energy from food, a type of activated oxygen is released which can damage our cells. Carnitine helps to reduce this effect. Our bodies make about one-quarter of the carnitine we need, the rest is provided by our diet and is found in red meat. A trial of carnitine in people with hyperthyroidism found that it improved many of the symptoms, particularly irregular heartbeat. There is no evidence to suggest it benefits people with hypothyroidism.

Ginger

A study found that supplementing ginger in 2 x 500mg doses per day helped alleviate some symptoms of hypothyroidism. However, there were some limitations to the research suggesting that further human studies are needed with larger sample sizes, longer durations, different ginger doses, and a follow-up period after discontinuing the supplement. There is no requirement for food supplements to be licensed or registered with the UK government. However, all foods must comply with the relevant food law. So, if you want to try ginger supplementation be mindful that the products will most likely vary in contents and cost between brands. If you see no improvement in symptoms, then discontinue. [iv]

Iodine[v]

If you have a properly functioning thyroid, iodine is essential as it is required to produce thyroxine. It is particularly important in women who are pregnant as it is needed to ensure the development of a baby's brain during pregnancy and early life.

If you are taking levothyroxine for hypothyroidism (underactive thyroid) or for a goitre (thyroid swelling) there is no need to take iodine supplements.

If you are being treated for hyperthyroidism (overactive thyroid) taking an iodine supplement is unnecessary and can worsen the condition. The extra iodine can counteract the benefits of the antithyroid drugs.

BTF information about iodine

Iron

The thyroid needs iron to generate T4 and T3 (selenium, discussed below, is essential in converting T4 into T3, which is the active form of thyroid hormone). A literature review found that iron deficiency is often associated with hypothyroidism,

especially in pregnant women. Some iron tablets (ferrous sulphate) can interfere with the absorption of thyroxine therefore doctors recommend a four-hour interval between taking thyroxine and the iron. Follow the advice of your doctor or pharmacist and be aware that some multivitamin tablets contain iron.

Lemon balm or Melissa Officinalis

This is an antioxidant like carnitine and resveratrol and it is claimed it can improve sleep, skin quality and circulation. A study from the 1980s suggested lemon balm may be beneficial in Graves' disease. The study showed that components of lemon balm could prevent the thyroid-stimulating antibodies that cause Graves' disease from binding to the thyroid on/off switch.[vi]

A more recent report described two individual women whose overactive thyroids were improved by lemon balm. Their stimulating antibody levels decreased but this could have happened spontaneously as the disease followed its natural course. These laboratory experiments and case reports suggest that lemon balm may help Graves' disease patients but controlled clinical trials are required before it can be recommended.

Magnesium

Magnesium can be found in legumes, nuts, seeds, and green leafy vegetables. Smaller amounts are found in meat and fish. It is reported to have several health benefits including improving bone health, mood, sleep quality and reducing anxiety. Some studies suggest that magnesium deficiency may be associated with hypothyroidism. Other studies show that increased magnesium levels can help with the control of Graves' disease. However, the data is inconclusive at this stage.[vii]

Resveratrol

This acts similarly to carnitine, and has antidiabetic, anti-inflammatory and antioxidant effects. It is found in red wine. Unfortunately, there are no proper trials of its usefulness in relation to thyroid disease [viii]

Selenium

This is found in Brazil nuts, tuna, sardines, eggs and legumes (e.g. beans, chickpeas, lentils). As mentioned above, it is vital in generating the more active T3 from T4. All of these foods are recommended as part of a healthy balanced diet.

The evidence around selenium's benefits is mainly in patients with mild thyroid eye disease so it is recommended as a treatment for people with this condition. A large European [ix]study has shown that six months of selenium supplements had a beneficial effect on thyroid eye disease and were associated with improvement in the quality of life of participants. These positive effects persisted at 12 months. There were no side effects.

Some trials show that selenium can bring thyroid antibody levels down in patients with Graves' disease. However, there does not appear to be any link between taking selenium and improvement in thyroid function.[x] [xi]

BTF information about selenium and mild thyroid eye disease

Vitamin B12

Vitamin B12 helps the body to make red blood cells and keep the nervous system healthy. It also helps the body to release energy from food and use folate.

There is an association between vitamin B12 deficiency in patients with autoimmune thyroid disease secondary* to pernicious anaemia. A recent meta-analysis found significantly lower levels of vitamin B12 in people with hypothyroidism (but not hyperthyroidism or subclinical hypothyroidism) than in healthy individuals. However,

there is no substantial evidence to suggest thyroid function may improve by supplementing with B12.[xii] [xiii]

Vitamin D

Vitamin D helps regulate calcium and phosphate absorption and is needed for healthy bones, teeth and muscles. A large number of studies[xiv] have investigated whether vitamin D is associated with thyroid disorders, with many, but not all, finding that low levels correlate with thyroid autoantibodies and maybe even features of thyroid cancer.

Since most people may be deficient in vitamin D (particularly in the autumn and winter months when the sunlight in the UK is not strong) the NHS advises that all adults and children over the age of five take a supplement of 10mcg each day. This applies during the autumn and winter for most people but you should consider taking this supplement throughout the year if you are concerned that you may not be getting enough sunlight even at other times of the year, e.g. you are not often outdoors or you tend to cover yourself up with clothes when you are outside.

If you have dark skin you are also at risk of not getting enough vitamin D from sunlight and should consider taking 10mcg supplements throughout the year.

BTF article on 'Vitamin D and thyroid disease'

Zinc

This is found in shellfish, beef, chicken and legumes and it is thought that it helps with thyroid function.[xv] A review of studies suggests that zinc [xvi], alone or combined with other supplements, may improve outcomes in people with

hypothyroidism. However, further large-scale trials are required to assess the role of zinc supplementation in people with thyroid problems and in the general population.

The TSH blood test is the most commonly used test in the initial screening for thyroid disease (Dayan, 2001) and is considered the "gold standard" for determining thyroid dysfunction (Adams, 2008, p. 1). However, as the use of all three main thyroid function tests (TSH, free T3, free T4) produces the most thorough analysis of thyroid function, the effectiveness of the TSH test alone has been debated by endocrinology experts (Adams, 2008; Beckett, & MacKenzie, 2007). Furthermore, abnormalities in thyroid function present with symptoms similar to those of other disorders and can be mistaken for other conditions (Canaris et al., 2000; Godfrey, 2007; Simmons, 2010). For example, hyperthyroidism and hypothyroidism are frequently misdiagnosed as anxiety and depressive disorders, respectively (Aslan et al., 2005; Godfrey, 2007). Postpartum thyroiditis, which affects more than 8% of women, is sometimes mistaken for depression (Fassier et al., 2011). In older patients, symptoms of hyperthyroidism and hypothyroidism often lead to inaccurate diagnoses of menopause or dementia (Godfrey, 2007; Shimabukuro, 2008). Thus, it is vital that physicians conduct a thorough assessment of their patients, including an ongoing discussion of symptoms, to ensure proper diagnosis and treatment.

Hyperthyroidism. Three types of treatments are currently available for hyperthyroidism: (a) surgical intervention, (b) antithyroid drugs, and (c) radioactive iodine (AACE, 2002). Thyroidectomy is usually performed only when thyroid cancer is

suspected. Although antithyroid drugs have been used for over 60 years, remission rates are variable, and relapses are frequent. Radioactive iodine (RAI) is the standard treatment for hyperthyroidism in the United States. Regardless of the treatment chosen, individuals treated for hyperthyroidism become euthyroid, then hypothyroid, and require lifelong thyroid hormone replacement therapy (AACE, 2002).

Hypothyroidism. An individual with hypothyroidism requires lifelong thyroid hormone replacement therapy (AACE, 2002). Levothyroxine (T4; brand name Synthroid) is the most commonly used and is recommended by the AACE. However, some experts recommend the addition of T3 (liothyronine; name brand Cytomel) due to its antidepressant effects (Dayan, 2001; Joffe, 2006).

As previously mentioned, proper treatment of thyroid disease is dependent upon accurate diagnosis. Misdiagnosis of thyroid disease delays treatment and can result in progressive psychological and physiological problems (Heinrich & Grahm, 2003; McDermott & Ridgway, 2001) including psychosis (Gaitonde, Rowley, & Sweeney, 2012; Heinrich & Grahm, 2003) and potential heart failure (Hak et al., 2000; Roberts & Ladenson, 2004). These risks highlight the importance of an effective doctor-patient relationship in ensuring proper diagnosis and positive treatment outcomes.

The treatment experiences of women with thyroid disease might be best examined from social constructionist and feminist viewpoints, as both worldviews emphasize individuals' experiences in social contexts (Docherty & McColl, 2003; Fernandes, Papaikonomou, & Nieuwoudt, 2006; Hearn, 2009). From a social constructionist viewpoint, patients' interpretations of their illness experience are important in understanding and treating illness. The feminist viewpoint suggests that female patients'

interpretations of their experiences are influenced by social constructs (e.g., health and illness; masculine and feminine) related to the body and gender issues (Docherty & McColl, 2003). Because social constructs come from patients, physicians, and social institutions (Hearn, 2009), women's experiences with thyroid disease diagnosis and management may be influenced by the culture of the medical profession, diagnostic bias, and gender differences in communication.

Culture of the Medical Profession

In the Western medical profession, health-care practitioners are taught via the medical model to base their diagnostic and treatment decisions on "objective evidence" of disease (e.g., blood tests) and to disregard patients' subjective experiences of illness (Hoffmann & Tarzian, 2001). Additionally, as argued by Annandale and Clark (2000), health has become "marketed as a result of lifestyle choice" (p. 58). In other words, the patient is totally responsible for his or her condition; if a person is overweight, then he or she must lack self-control. According to Vanderford, Stein, Sheeler, and Skochelak (2001), the traditional medical culture has encouraged physicians to behave in a paternalistic or authoritative manner when faced with differing treatment expectations from their patients. Traditional doctor-patient relationships are characterized by authoritarian and paternalistic approaches in which the physician controls the interview, makes a diagnosis, and chooses the treatment plan without the patient's input (Ehrenreich & English, 2005; Vanderford et al., 2001). Research indicates that these types of doctorpatient interactions are related to lowered patient satisfaction and negative treatment outcomes (Bradley, Sparks, & Nesdale, 2001; Chrisler & Parrett, 1995;

Copeland, Hudson Scholle, & Binko, 2003; Krupat, 1999; Stokes, Dixon-Woods, & Williams,

2006).

Diagnostic Bias

According to Hoffman and Tarzian (2001), women's complaints are often not taken seriously by medical professionals because women are viewed as overly emotional and likely to exaggerate their symptoms. Research indicates that physicians are more likely to interpret men's symptoms as biological and women's symptoms as psychosocial—that is, that women's symptoms are a result of a mental, rather than physical, illness (Chrisler, 2001; Hamberg et al., 2004; Hoffmann & Tarzian, 2001).

In their study on the treatment experiences of women with chronic pain, Werner and Malterud (2003) purported that the medical profession encourages a normative, gendered view of illness, which results in a perceived need for women to work harder in order to be perceived as credible patients. As a result, female patients can become wary of honestly communicating their symptoms and the psychosocial effects of those symptoms (Peters et al., 2008).

Gender Differences in Communication

It has been argued that gender differences in medical treatment can be partially explained by gender differences in communication. Whereas men tend to describe their symptoms in a frank and confident manner, women often give generalized descriptions of their symptoms (Hamberg et al., 2004). In addition, women tend to use contextual or more subjective information (e.g., impact on personal relationships) in their symptom reports, while men's reports tend to be objective descriptions of physical symptoms

(Hoffmann & Tarzian, 2001). Although these generalizations do not apply to all men and women, variations in communication patterns across genders have the potential to influence how physicians and patients interact (Hamberg et al., 2004; Platt, 2008; Sandhu, Adams, Singleton, Clark-Carter, & Kidd, 2009).

With regard to conversation during medical consultations, evidence suggests that there is a significant disparity between the communication styles preferred by patients and those preferred by physicians. Platt (2008) reported some of this evidence, noting that doctors commonly complain about verbose patients who tell long stories when doctors ask questions. Additionally, Platt noted that doctors use their authority to encourage patients to communicate in the doctors' preferred styles. Doctor-patient relationships are affected by communication, and gender differences in communication styles could amplify these effects.

In summary, an effective doctor-patient relationship helps to ensure proper diagnosis and positive treatment outcomes (Copeland et al., 2003; Houle et al., 2007; Munch, 2004). An ineffective doctor-patient relationship, on the other hand, has the potential to result in misdiagnosis, delayed or inappropriate medical treatment, and termination of the doctor-patient relationship (Chrisler & Parrett, 1995; Copeland et al., 2003; Houle et al., 2007; Stokes et al., 2006). The nature of the doctor-patient relationship, and hence women's treatment experiences related to thyroid disease, may be influenced by the culture of the medical profession, diagnostic bias, and gender differences in communication. Additional influential factors include sexism in healthcare, the medical education system, and economics, all of which are discussed in detail in

Chapter 2.

Normal Thyroid Vs Thyroid due to PCOD

Women thyroid can be divided into parts normal vs thyroid occurred due to PCOD. If you have normal thyroid it generally means you have thyroid but you don't have PCOD issue. It is generally due to Iodine deficiency and a bit stress that takes part in it. But in other case the case is completely different in this case your thyroid the due to hormonal blockage done by PCOD and in this case the thyroid problems appears four to five years after PCOD. In initial stage the female gets delay periods, excessive cramps and clots of bloods and delay in periods. And in few years the thyroid glands starts dysfunction. In this case the women suffers more hormonal issues. In this women's body use excessive hormones up to age of 40s and the menopause starts early. The main issue in this type of women is neck stiffness and lack of blood circulation in neck and thyroid area. These women gets excessive problems when season changes. They feel excessive hot in summer and cold in winter. They have excessive fat in belly area due to lack to testosterone hormone in them. Their skin starts gets dry in early 40s . In this type of women it is always advised to maintain certain hormones to overcome these issues because it has been seen in this type of women once the menopause occurs they get excessive weight gain which is hard to control as lack to testosterone hormone and their skin and face gets quick wrinkles at 45 years which is due to lack to Estrogen hormone. We will discuss the remedies in upcoming sections below.

This type of women's growth generally get hampered due to stress and excessive bleeding in teenage and are generally lean and thin and short heighted in teenager. This type of women are advised to get early marriage to get hormonal balance because their

body produce less hormones due to PCOD. The male partner can help to get their hormonal balance. But now a days it observed that due to excessive bleeding and clotting their vaginal lining becomes hard and it becomes unable to suck hormones through vagina after 35 years of age. Thus if a women with this issue is advised to get pregnant before 35 otherwise it is difficult for them to get pregnant. After 35 years it is advised to go for only orals for cater hormonal balance and thyroid issues.

to It disease affects approximately 1 out of every 7 women, and its prevalence increases with age (Godfrey, 2007). When properly diagnosed and treated, individuals with thyroid disease should return to normal endocrine function and experience a reduction in psychological and physiological symptoms (AACE, 2002; Bono et al., 2004; Constant et al., 2006). However, due to factors that can make proper diagnosis and treatment challenging (e.g., symptoms resemble other disorders, TSH blood test used alone), women with thyroid disease are often misdiagnosed and receive ineffective medical treatment (Canaris et al., 2000; Dayan, 2001; Godfrey, 2007), which can lead to chronic and worsening health problems (Cappola & Cooper, 2015; Gaitonde et al., 2012; Hak et al., 2000; Heinrich & Grahm, 2003; McDermott & Ridgway, 2001; Roberts & Ladenson, 2004).

The nature of the doctor-patient relationship has the potential to determine positive or negative treatment outcomes (Chrisler & Parrett, 1995; Copeland et al., 2003; Stokes et al., 2006). Numerous studies have been conducted about the influence of the doctor-patient relationship on the treatment outcomes of chronic illness (see Auerbach et al., 2002; Copeland et al., 2003; Docherty & McColl, 2003; Hamberg et al., 2004; Houle et al., 2007; Kralik, Koch, Price, & Howard, 2004; Kralik, Telford, Price, & Koch, 2005;

Krupat, Yeager, & Putnam, 2000; Roter, Hall, & Aoki, 2002; Street, Gordon, & Haidet, 2007; Werner & Malterud, 2005; Zandbelt, Smets, Oort, Godfried, & de Haes, 2006). However, there exist no studies in this area related to women with thyroid disease specifically, and even in studies that mention chronic illness generally, thyroid disease is rarely mentioned. Likewise, although studies have suggested that physician and patient gender influences diagnosis and treatment decisions (Di Caccavo & Reid, 1998; Hamberg et al., 2004; Platt, 2008; Sandhu et al., 2009), no such studies have been conducted with female thyroid patients. Despite the pervasiveness of thyroid disease in women and the importance of the doctor-patient relationship in positive treatment outcomes, there is a gap in the literature regarding the treatment experiences of women diagnosed with thyroid disease, particularly regarding the doctor-patient relationship. Exploring the treatment experiences of women with thyroid disease and how the doctor-patient relationship affects their treatment experiences is imperative for better determining the needs of female thyroid patients, and therefore for more accurately diagnosing and effectively treating this debilitating and potentially life-threatening disease.

Purpose of the Study

Exploration of the disease experience among people with thyroid disease is vital for understanding how individuals cope with their chronic illness, thus increasing the potential for the attainment of adequate treatment (Thomas, 2001). Understanding and constructing meaning for chronic illness may be particularly important for women because issues related to the body are instrumental in the formation of female selfidentity (Fernandes et al., 2006) and treatment experiences may differ by gender (Hamberg et al., 2004; Hoffmann & Tarzian, 2001; Miaskowski, 1999). In addition, the quality of care that

patients receive is directly related to the nature of the doctor-patient relationship (Chrisler & Parrett, 1995; Dugdale, Seigler, & Rubin, 2008; Houle et al., 2007). Therefore, the purpose of this phenomenological study was to explore female thyroid patients' experiences of treatment and the doctor-patient relationship.

Nature of the Study

This study used the phenomenological research approach because it examines the meaning of experiences about a particular phenomenon (e.g., thyroid disease) across several individuals who have experienced the phenomenon (Creswell, 2007). The research questions in this study were best addressed via qualitative methodology because the purpose of this study was to explore the treatment experiences of women with thyroid disease. According to Marshall and Rossman (2006), human behavior cannot be fully understood without knowledge of the framework within which people interpret their thoughts, feelings, and actions (p. 53). Thus, the use of open-ended questions in each interview was an appropriate method for capturing the experience of the phenomenon (Creswell, 2007).

Using an interview guide sheet (see Appendix A) I created, data were obtained from 16 female members (including myself) of The Thyroid Support Group, an international online support group for individuals with thyroid disorders, via interviews using X-IM, an encrypted online chat program (see http://www.x-im.net/). The recommended sample size of a minimum of 10 participants for phenomenological research corresponds to the traditional quantitative research designs based on statistical power analyses conducted by Onwuegbuzie and Johnson (2004). See Chapter 2 for a discussion of literature related to methodology, including an in-depth discussion of

literature related to data collection methods. The nature and methods of the study, including the reliability and validity of the interview guide sheet, are discussed in Chapter 3.

Research Questions

Based upon social constructivism and feminist theory, this study answered the following research questions: "What are the treatment experiences of women with thyroid disease?"; "How does the doctor-patient relationship affect their experiences?"; and "Do their experiences differ based on the doctor's gender?" These research questions are coded as RQ1, RQ2, and RQ3, respectively, and are listed next to their corresponding interview questions in the interview guide (see Appendix A). The research questions are discussed in further detail in Chapter 3.

Conceptual Framework

In this study, data interpretation was guided by social constructionism and feminist theory. Social constructionism and feminism are worldviews that are compatible with qualitative research approaches because both emphasize individuals' experiences in social contexts (Docherty & McColl, 2003; Fernandes et al., 2006; Hearn, 2009). Whereas social constructionism assigns a general significance to social and cultural constructs in understanding the illness experience (Findlay, 1993; Docherty & McColl, 2003; Hearn, 2009; Martin & Peterson, 2009), feminist writers make specific arguments about women's perceptions of their bodies in light of socio-historical facts (Bohan, 2002; Cosgrove, 2003; Fernandes et al., 2006; Shields, 2007). The conceptual framework for the study is discussed in further detail in Chapter 2.

Definition of Terms

The following terms are used throughout the paper and are defined below for ease of reading.

Euthyroid: Normal serum TSH (0.4–4.0 mIU/L) regardless of free thyroxine (fT4) concentration (Walsh et al., 2006). In this state, the individual is considered to have normal thyroid function (AACE, 2002).

Free thyroxine (fT4): The amount of T4 hormone that is not bound to protein and is therefore able to enter cells (normal range is 4.5–11.2 mcg/dL; AACE, 2002). Generally, if the fT4 level is high, the individual is hyperthyroid. In contrast, if the fT4 level is low, the individual is most likely hypothyroid (Aslan et al., 2005).

Free triiodothyronine (fT3): The amount of T3 hormone that is not bound to protein and is therefore able to enter cells (normal range is 100–200 ng/dL; AACE, 2002). Generally, if the fT3 level is high, the individual is hyperthyroid. In contrast, if the fT3 level is low, the individual is most likely hypothyroid (Aslan et al., 2005).

Thyroid stimulating hormone (TSH): TSH, also known as thyrotropin, is secreted from cells in the anterior pituitary and stimulates the thyroid to synthesize and release the thyroid hormones T3 and T4 (Aslan et al., 2005). The normal range for TSH is 0.4–4.0 mIU/L (AACE, 2002).

Thyroglobulin antibodies (TgAb): Antibodies to thyroglobulin, the precursor in the synthesis of thyroid hormones. Detection of TgAb indicates Hashimoto's disease (Thyrasyvoulides & Lymberi, 2004).

Thyroperoxidase antibodies (TPOAb): Antibodies to thyroperoxidase, the enzyme that catalyzes thyroid hormone formation. Detection of TPOAb indicates Hashimoto's disease (Thyrasyvoulides & Lymberi, 2004).

Thyroxine: Also known as T4. One of the two main thyroid hormones secreted by the thyroid gland (Hall, 2010). When used as a medication, T4 is called *levothyroxine* (name brand Synthroid™).

Tri-iodothyronine: Also known as T3. One of the two main thyroid hormones secreted by the thyroid gland (Hall, 2010). When used as a medication, T3 is called *liothyronine* (name brand Cytomel™).

TSH receptor antibodies (TRAb): Antibodies to the TSH receptor on the thyroid follicular cell membrane. Detection of TRAb indicates Grave's disease (Takamura et al., 2003).

Assumptions

The assumptions that exist in the study have been made in reference to participant criteria. The criteria for inclusion in the study were as follows: (a) female, (b) aged 18 years and older, (c) with a diagnosis of thyroid disease, and d) a member of The Thyroid Support Group. As the study was conducted via the Internet and I did not meet with the participants face to face, the participants' ages and gender could not be verified. Likewise, the participants' thyroid disease diagnoses were self-reported. These assumptions allowed for the use of a purposeful (criterion) sample appropriate to a qualitative study rather than a representative, generalizable sample of the larger population (Creswell, 2007).

In addition, a number of participants considered vulnerable may have been included, but were not targeted, in this study. Vulnerable populations include (a) pregnant women; (b) residents of a mental health facility; (c) mentally/emotionally disabled individuals; (d) individuals who might be less than fluent in English; (e) traumatized individuals; and (f) economically disadvantaged individuals. Determining whether or not an individual fits into any of the aforementioned categories would have required asking invasive questions unrelated to the study. Furthermore, verification was impossible due to the nature of the Internet. Participants were informed that they had the right to leave the study at any time for any reason, without explanation.

As discussed in detail in Chapter 3, measures were taken in the study to protect participants, including the use of consent forms, confidentiality, and secure storage of data.

Delimitations

This study was delimited as follows: Participants were females aged 18 years and older who had a thyroid disease diagnosis. Although thyroid disease is most common in women ages 35 and older (Godfrey, 2007), thyroid disease can occur at any age and is influenced by genetic and environmental (e.g., smoking) factors (Manji et al., 2006). Excluding participants under age 35 would have likely precluded individuals who experienced thyroid disease early in life due to genetic and environmental factors (Godfrey, 2007; Manji et al., 2006), which would have eliminated an important subset of experiencers. Eliminating participants over age 35 would have precluded those individuals who experienced thyroid disease late in life due to an age-related decline in the thyroid hormones T3 and T4 (Begin, Langlois, Lorrain, & Cunnane, 2008; Morganti

et al., 2005). This would have eliminated another important subset of experiencers. Thus, the wide age range is a form of maximum variation for the phenomenon that was studied—thyroid disease in women (Creswell, 2007).

The participants were members of an online support group who chose to participate in the study and who were able to access and install X-IM software on their computers. Although participants could be from anywhere in the world, the sample was delimited to individuals who were able to write in the English language.

Limitations

A limitation of the study is the potential for personal bias, as I have a thyroid disease diagnosis and have been a member of The Thyroid Support Group since 2004. In order to control for this limitation, reflexive journaling was used during data collection and analysis. According to Moustakas (1994), when conducting phenomenological research, it is important for the researcher to identify his or her opinions or bias on the subject being studied. Therefore, I maintained a journal about personal feelings and opinions so they could be separated from the data. Moreover, Chapter 3 of this study contains a discussion of the role of the researcher in which my background and history as a thyroid patient are disclosed.

While research indicates that online support groups are desirable among adults with chronic illnesses, Internet users tend to be young, Caucasian, and have convenient access to a computer (Fox & Jones, 2009; Kraut, Olson, Banaji, Bruckman, & Couper, 2004). As such, the results of the study may not be generalizable to older, non-Caucasian individuals who do not have convenient computer access. Another limitation is that the

sample was self-selected, which means that the sample may vary systematically and therefore may not be representative of most female thyroid patients.

Significance of the Study

Thyroid disease causes a wide range of somatic and psychiatric symptoms that can be difficult to distinguish from those of other disorders. As such, many individuals with thyroid disease are misdiagnosed and experience progressive psychological and physiological problems (Canaris et al., 2000; Godfrey, 2007; Heinrich & Grahm, 2003; McDermott & Ridgway, 2001; Simmons, 2010). Within the prevalent culture of the medical profession, these problems are particularly troublesome for female patients, who may be met with sexism and marginalization in traditional doctor-patient relationships (Hoffman & Tarzian 2001; Platt, 2008; Werner & Malterud, 2003).

Numerous studies on chronic illness have indicated that diagnosis, treatment decisions, and treatment outcomes are related to physician and patient gender (Di Caccavo & Reid, 1998; Hamberg et al., 2004; Platt, 2008; Sandhu et al., 2009) and the nature of the doctor-patient relationship (Copeland et al., 2003; Houle et al., 2007; Munch, 2004). Expanding upon this research to explore the treatment experiences of women diagnosed with thyroid disease could contribute to positive social change by enhancing our understanding of how women experience the phenomenon of treatment of thyroid disease and the doctor-patient relationship, and ultimately help to determine the factors related to positive treatment outcomes. Proper diagnosis and effective management of thyroid disease can benefit female patients by preventing misdiagnosis or delayed diagnosis, thus minimizing the potential for progressive health problems

(Godfrey, 2007).

Considering that there are an estimated 158,288,693 women living in the United States (U.S. Census Bureau, 2012) and that approximately 1 in every 7 women develops thyroid disease (Godfrey, 2007), approximately 22,612,670 women in the United States may be expected to have thyroid disease. If the findings of the study are used in crafting follow-up studies of a quantitative nature, the results of such studies may benefit the approximate 22,612,670 women dealing with thyroid disease, as well as secondarily benefit the families and communities who support them. The results of such follow-up studies may, in turn, indirectly reduce healthcare costs (Darer, Hwang, Pham, Bass, & Anderson, 2004; Keck, Kessler, & Ross, 2008; Leifer, 2003; McKee & Peyerl, 2012; Rothman & Wagner, 2003) along with the incidence of complaints and litigation resulting from dissatisfied patients (Firth-Cozens, 2008a, 2008b). In light of the widespread nature of thyroid disease, the potential for a decrease in misdiagnosis and a reduction in complaints, litigation, and healthcare costs constitutes a substantial contribution to positive social change.

I intend to publish a condensed version of this study in a scholarly journal so that healthcare professionals can use the information in practice and future research. According to Creswell (2007) and Schensul and LeCompte (1999), researchers must shape the language of research results with their audience(s) in mind. As such, the findings of this research will be presented in a scholarly manner, but with minimal use of technical jargon. Some of the participants' quotes will be used in order to personalize the results. Recommendations for further research will be provided, in addition to

suggestions for how patients and doctors might be able to work collaboratively and communicate more effectively with each other.

Summary and Transition

Approximately 1 out of every 7 women develops thyroid disease, and its prevalence increases with age, yet the most commonly used blood test for diagnosing thyroid disease and for determining treatment effectiveness can produce misleading results. Because of this, clinically important diagnoses are missed, and many women with thyroid disease continue to experience symptoms even when they are receiving treatment. In addition, even once diagnosed with thyroid disease, female patients have reported that their physicians are not responsive to their complaints.

Despite the pervasiveness of thyroid disease in women, there is a gap in the literature regarding the treatment experiences of women diagnosed with thyroid disease, particularly regarding the doctor-patient relationship. Therefore, the purpose of this phenomenological study was to explore female thyroid patients' experiences of treatment and the doctor-patient relationship.

Data were collected from 16 female members (including myself) of The Thyroid Support Group via individual online chat interviews. Using ATLAS.ti software and the analytic method recommended by Moustakas (1994), data interpretation was guided by social constructionism and feminist theory. Themes related to the culture of the medical profession, diagnostic bias, and gender differences in communication were identified.

Chapter 2 presents the literature search strategy, the conceptual framework for the study, and a review of the literature related to the chosen methodology. A thorough review of the literature on the doctor-patient relationship, the culture of the medical profession,

diagnostic bias, and gender differences in communication is given. Finally, a summary of the chapter is provided.

Chapter 3 contains a description of the research design and approach of the study, including a detailed discussion of the benefits of using a qualitative design over a quantitative design for the population that was studied. In addition, the suitability of phenomenology as opposed to other qualitative methods is explained. The context of the study is provided, along with a description of the participants and the role of the researcher. The procedures and instrumentation used for data collection are detailed, as are the steps taken to ensure the protection of participants. Finally, data analysis, trustworthiness, interpretation, and dissemination are discussed.

Chapter 4 presents the themes derived from the data analysis and is supplemented with direct quotations from the participants' responses to interview questions. Evidence of data quality is also discussed.

Chapter 5 provides an interpretation of the findings based on the relationship among the themes, research questions, and theories presented in Chapter 2. The chapter concludes with a discussion about limitations of the study, recommendations for future research, the dissemination of findings, implications for social change, and conclusions.

Chapter 2: Literature Review

Introduction

This chapter contains a review of the literature on the treatment experiences of women with thyroid disease. It is argued that women with thyroid disease experience the doctor-patient relationship as fraught with difficulty owing to the culture of the medical

profession, diagnostic bias, and gender differences in communication. As the nature of the doctor-patient relationship is related to patient satisfaction and treatment outcomes, an understanding of the treatment experiences of women with thyroid disease may help to enhance the potential for proper diagnosis and effective treatment in female thyroid patients' interactions with medical professionals.

The following section provides a description of the literature search strategy used, followed by an overview of thyroid disease. The conceptual framework for the study is described, and a review of the literature related to the chosen methodology is given. A thorough review of the literature on the doctor-patient relationship, the culture of the medical profession, diagnostic bias, and gender differences in communication is given. Finally, a summary of the chapter is provided.

Literature Search Strategy

The effort to develop this literature review began in March 2009 with searches in the EBSCOhost and ProQuest databases. Subsequent narrowing of the search included the use of the following databases: Academic Search Premier, Alt HealthWatch, CINAHL Plus with Full Text, ProQuest Dissertations & Theses Full Text, ERIC, Health Source: Nursing/Academic Edition, MEDLINE with Full Text, ProQuest Nursing & Allied Health Source, ProQuest Central, ProQuest Health and Medical Complete, ProQuest Psychology Journals, Psychology and Behavioral Sciences Collection, PsycARTICLES, PsycBOOKS, PsycINFO, SocINDEX with Full Text, and Sociological Collection.

The initial search included the use of the terms *women* and *thyroid disease* and was expanded to include the terms *diagnosis*, *treatment*, *gender*, and *doctor-patient*

relationship. Upon collection of relevant articles, the following search terms were added in June 2009: *diagnostic bias*, *culture* and *medical profession*, *doctor education*, *gender differences* and *communication*, *attitudes*, *perceptions*, *power*, *empathy*, *patient autonomy*, *patient competence*, and *patient credibility.* Between September 2009 and October 2010, a review of the reference lists in each article resulted in the collection of additional journal articles and books. Between November 2010 and February 2012, the aforementioned databases were searched for articles related to conducting research on the Internet. The following search terms were used: *online research*, *Internet research*, *online interviews*, *synchronous*, *asynchronous*, *chat*, and *ethical considerations*. In September 2012, an additional search of the aforementioned databases was conducted to gather articles regarding economic issues associated with chronic illness. The following search terms were used: *chronic illness* and *economic issues*, *misdiagnosis* and *delayed diagnosis*, and *healthcare costs*. In December 2012 and January 2013, the aforementioned databases were searched in order to gather literature about the steps that various research, educational, and medical institutions have taken to enhance awareness of gender issues in medicine. The following search terms were used: *women* and *medical profession*, *women* and *inclusion* and *research, doctor-patient relationship* and *gender*, and *doctor-patient relationship* and *women*.

After conducting the study and writing Chapter 4, I searched the aforementioned databases one more time in order to ensure that Chapter 5 would be written with consideration of the most recent literature available. From March 2015 through June 2015, the following search terms were used, and the resulting literature was incorporated into Chapters 1, 2, and 5: *women* and *thyroid disease, diagnosis* and *treatment, natural*

thyroid medication, doctor-patient relationship, gender, shared decision making, patient self-advocacy behaviors, switching doctors, self-medicating, health information-seeking, and *patient education level*. Thus, searching of the literature took place from March 2009 through January 2013 and then again from March 2015 through June 2015.

Overview of Thyroid Disease

Thyroid disease affects an estimated 30 million Americans (AACE, 2013) and 200 million people worldwide (Rajoria et al., 2010). It is estimated that of the 30 million Americans with thyroid disease, more than half are undiagnosed (AACE, 2013). Thyroid disease is more prevalent in women than men, regardless of culture, and occurs in approximately 1 out of every 7 women (Canaris et al., 2000; Cassidy et al., 2002; Godfrey, 2007). Women's risk for developing thyroid disease increases with age (about 20% in women over age 60; Godfrey, 2007). Hyperthyroidism and hypothyroidism are the two predominant conditions that result from thyroid disease, with Grave's disease and Hashimoto's disease, respectively, as the most common causes (Zeitlin et al., 2008). Both conditions cause a wide range of somatic and psychiatric symptoms.

Hyperthyroidism

Hyperthyroidism results from the overproduction of thyroid hormone by the thyroid gland (AACE, 2002), and tends to be accompanied by symptoms of anxiety and panic disorders (Aslan et al., 2005). Other symptoms associated with hyperthyroidism include heat intolerance, hot flashes, absent menses, insomnia, decreased libido (Godfrey, 2007), rapid heartbeat, sweating, and tremors (Aslan et al., 2005), diffuse goiter, and ophthalmological abnormalities (Ginsberg, 2003). Grave's disease, an autoimmune form of thyroid disease, is the most common cause of hyperthyroidism in the United States

(Bunevicius & Prange, 2006; Goolsby & Blackwell, 2004).

Hypothyroidism

Hypothyroidism is caused by the undersecretion of thyroid hormones by the thyroid gland (AACE, 2002), and often presents with symptoms of major depression and bipolar depression (Aslan et al., 2005). Other symptoms that tend to occur with hypothyroidism include fatigue (Bono et al., 2004), lethargy, apathy, difficulty concentrating and slowing of thought processes (Aslan et al., 2005; Bono et al., 2004), weight gain, dry skin, and decreased libido (Godfrey, 2007). In extreme cases, the individual may experience slowing of thought processes, progressive cognitive impairment, hallucinations, and delusions (Bono et al., 2004). Hashimoto's disease, an autoimmune form of thyroid disease, is the most common cause of hypothyroidism in the United States (Erdal et al., 2008; Goolsby & Blackwell, 2004).

It is important to note that the most common causes of thyroid disease are autoimmune in nature, as autoimmune diseases tend to co-occur. In fact, approximately 25% of women who have an autoimmune disorder will develop thyroid disease (Godfrey, 2007). A definitive diagnosis of thyroid disease requires a physical examination and thorough history of the patient (Goolsby & Blackwell, 2004).

Diagnosis

Making a definitive diagnosis of thyroid disease has shown to be challenging due to a number of factors. Namely, the "gold standard" thyroid-stimulating hormone (TSH) blood test for diagnosing thyroid disease tends to be used alone (Adams, 2008, p. 1), despite evidence that the use of all three main thyroid function tests (TSH, free T3, free

T4) produces the most thorough analysis of thyroid function (Beckett & MacKenzie, 2007; Dayan, 2001; Rivera, Sampson, & Sola, 2015). As an example of how TSH testing alone can produce misleading results, TSH values can be within the normal range while free T3 and/or free T4 values indicate thyroid dysfunction (Dayan, 2001). Thus, when the TSH blood test is used alone for initial screening of thyroid disease, clinically important diagnoses (e.g., hyperthyroidism and hypothyroidism) may be missed. In addition, although approximately 13 million Americans with thyroid disease remain undiagnosed (Goolsby & Blackwell, 2004), the U.S. Preventive Services Task Force indicated a lack of evidence for recommending for or against routine screening for thyroid disease in adults, thus leaving the use of this potentially beneficial diagnostic measure to the discretion of individual practitioners (Helfand, 2004). Even further, thyroid disease is often mistaken for other conditions due to the similarity in its symptoms to other disorders such as major depression, bipolar depression (Aslan et al., 2005; Pearce, 2015), postpartum depression, psychosis (Fassier et al., 2011), anxiety and panic disorders, phobias (Aslan et al., 2005), menopause, and dementia (Godfrey, 2007; Shimabukuro, 2008). Thus, a thorough assessment, including a physical examination and complete history of the patient, is vital for ensuring proper diagnosis and treatment of an individual with thyroid disease (Goolsby & Blackwell, 2004).

Treatment

Hyperthyroidism. Radioactive iodine (RAI), antithyroid drugs, and thyroidectomy are the three types of treatments available for hyperthyroidism in the United States (AACE, 2002). An ablative dose of RAI is considered the treatment of choice for hyperthyroidism. In cases of patients who are pregnant or nursing, antithyroid

drugs are considered safer than RAI. However, remission rates are variable and relapses are frequent when antithyroid drugs are used alone (Goolsby & Blackwell, 2004). Thyroidectomy tends to be performed only when cancer of the thyroid is suspected. Regardless of the treatment chosen, individuals treated for hyperthyroidism become euthyroid and then hypothyroid, and they require lifelong thyroid hormone replacement therapy (AACE, 2002; Goolsby & Blackwell, 2004).

Hypothyroidism. Lifelong thyroid hormone replacement therapy is the only treatment option available in the United States for individuals with hypothyroidism (AACE, 2002; Goolsby & Blackwell, 2004). The most commonly used medication is levothyroxine (T4; brand name Synthroid), which is recommended by the AACE. Some experts recommend the addition of T3 (liothyronine; name brand Cytomel) for its antidepressant effects (Dayan, 2001; Joffe, 2006). The dosage of these medications is determined by the results of the patients' blood work (the TSH blood test, and sometimes the free T3 and free T4 levels; AACE, 2002; Adams, 2008).

Effective treatment of thyroid disease depends upon an accurate diagnosis of hyperthyroidism or hypothyroidism (Cappola & Cooper, 2015; Goolsby & Blackwell, 2004; Heinrich & Grahm, 2003; McDermott & Ridgway, 2001). Regular monitoring of the thyroid patient's symptoms and interpreting blood work are necessary for determining treatment effectiveness. However, as previously mentioned, the TSH blood test, used alone, does not provide the most thorough analysis of thyroid function (Adams, 2008; Beckett & MacKenzie; Dayan, 2001; Rivera et al., 2015). Thus, in cases in which physicians do not use all three main thyroid function tests, thyroid patients often

experience chronic or worsening symptoms (Bunevicius & Prange, 2006; Heinrich & Grahm, 2003; McDermott & Ridgway, 2001).

Diagnostic and treatment challenges related to thyroid disease underscore the importance of an effective doctor-patient relationship (Copeland et al., 2003; Houle et al., 2007; Munch, 2004). Female thyroid patients' experiences of treatment and the doctorpatient relationship might be best understood through the lens of social constructivism and feminism, as both worldviews emphasize individuals' experiences in social contexts
(Hearn, 2009; Docherty & McColl, 2003).

Conceptual Framework

In this study, data interpretation was guided by social constructionism and feminist theory. Themes related to the culture of the medical profession, diagnostic bias, and gender differences in communication—all of which are discussed later in this chapter—were identified. Emergent themes were also identified. This study expands the research on women's health and adaptation to chronic illness by examining female thyroid patients' experiences of treatment and the doctor-patient relationship, which have not been studied from a social constructionist/feminist perspective.

Social Constructionism

Lupton (2003) and Martin and Peterson (2009) described the trajectory in medical thought by which social constructionism arose as a response to the biomedical model (p. 579). The biomedical model in health care arose in the 18th century. This model located disease in specific parts of the body and reduced medical concerns to mechanistic processes. In the 1950s, as a response to the biomedical model, Talcott Parsons developed

the functionalist perspective, in which the role of a sick individual is seen as a social response to the deviant place in society occupied by persons with poor health (Martin & Peterson, 2009). In the functionalist perspective, patients desire to be accepted by society and therefore seek verification from doctors that they are not malingering (Lupton, 2003). Although Parson's work is acclaimed for identifying the role of society in understanding illness, the functionalist perspective has been criticized for characterizing patients as passive and grateful, while doctors were portrayed as universally competent and altruistic. In addition, according to Lupton (2003), the functionalist viewpoint did not take into consideration the potential for conflict within the doctor-patient relationship. The social constructionist model emerged in the 1980s in response to these criticisms.

Within the social constructionist model, knowledge and "truth" are not understood as universal, but rather as dependent upon the individual's subjective interpretation of reality (Lupton, 2003; Patton, 2002). In this perspective, all medical issues, including health, chronic illnesses, and medical care, are socially constructed facts that are subject to varying degrees of consensus and interpretation due to cultural factors and social norms (Docherty & McColl, 2003; Fernandes et al., 2006; Hearn, 2009; Lupton, 2003). In other words, in the management of illness, both the patient and the doctor are influenced by their individual beliefs and experiences and the society in which they live. Thus, the social constructionist perspective is appropriate to the qualitative study of health and disease, which takes as its data the personal experiences, perceptions, observations, and narratives of individuals (Creswell, 2007; Hearn, 2009).

The logical positivist perspective, commonly used in quantitative research, involves an assumption that there are stable, social facts with a single reality, separated

from the feelings and beliefs of individuals (Creswell, 2007). In other words, regardless of how an individual perceives an event, only one interpretation of that event is considered to be appropriate or based on "truth" (Patton, 2002). For example, if an individual is diagnosed with a chronic illness and the medical profession contends that such a diagnosis should have a minimal emotional impact on the individual, for him or her to react in any other manner (e.g., fearful, depressed) would be considered abnormal. In contrast, social constructionism, commonly used in qualitative research, is based on the belief that multiple realities are socially constructed through individual (constructivism) and collective (constructionism) perceptions of the same situation (Patton, 2002). For example, on the individual (constructivist) level, one person might view a chronic illness diagnosis as manageable, while another person might view that same diagnosis as emotionally devastating. These individual perceptions are influenced by the collective (constructionist) framework (e.g., cultural values and norms) in which one lives. Within the social constructionist perspective, both of these interpretations would be considered valid.

Docherty and McColl (2003) noted that a social constructionist approach takes patients' interpretations of their illness experience into account. These interpretations are relevant because they influence the patients' feelings, reactions, and behaviors. Fernandes et al. (2006) noted that those adopting a social constructionist perspective view the body in light of the ways in which society assigns meaning to it (e.g., "healthy" and "unhealthy," "normal" and "abnormal," and "masculine" and "feminine"). Thus, the female body and bodily illnesses take on certain meanings in a social context, and these meanings influence patients' interpretations of the illness experience (Fernandes et al.,

2006). Using a qualitative approach, Fernandes et al. interviewed women living with breast cancer, eating disorders, and infertility and found that these women's illnesses manifested emotionally and socially as loss, anger, emptiness, loneliness, and isolation.

Findlay (1993) also argued that social construction is an important source of knowledge in the fields of science and medicine. However, according to Findlay, the technical nature of scientific and medical knowledge often results in perspectives that neglect the social contexts and construction of this knowledge. More specifically, diagnostic and treatment decisions tend to be based on "objective evidence" of disease (e.g., blood tests), and patients' subjective experiences of illness are largely ignored (Hoffmann & Tarzian, 2001). Furthermore, competing perspectives among pharmaceutical, medical, and insurance companies influence diagnostic and treatment decisions (Hearn, 2009). In order to underscore the social and political aspects of medical knowledge and practice, Findlay (1993) argued that biomedicine defines disease as a deviation from a particular standard viewed as biological normalcy. This standard, though often unquestioned, is socially and culturally determined. The implications of this can be seen, for example, in the way in which physicians treated female fertility issues in the 1950s, which often assumed a specific, socially constructed set of values (Findlay, 1993). Findlay cited descriptions of the hormonal systems of males and females from this period, noting that libido was emphasized in males and reproduction was emphasized in females, and argued that acknowledgment of hormones in females was restricted to those directly related to reproduction.

Feminists contend that women continue to be viewed by the medical profession as being at the mercy of their reproductive hormones (Fernandes et al., 2006; Munch, 2004;

Wright & Owen, 2001). This perception could have a significant impact on women with thyroid disease because of the psychological symptoms resulting from the hormone imbalances involved in thyroid dysfunction (Shimabukuro, 2008). According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (American Psychiatric Association, 2000), several of the most common cognitive, mood, anxiety, and psychotic disorders might be best explained by thyroid dysfunction. Yet, there are pervasive beliefs among physicians that women over-report pain and that vague symptoms are the results of mental, rather than physical, illness (Chrisler, 2001; Hoffmann & Tarzian, 2001). Viewed from a social constructionist perspective, these examples show how socio-cultural constructs, perspectives, and attitudes can influence the field of medicine.

Feminism

Despite efforts to incorporate gender-sensitive practices into the field of medicine, historically-based knowledge and beliefs about women persist (Chrisler, 2001; Hoffmann & Tarzian, 2001; Sherwin, 1999). Thus, the relevance of feminism to the current treatment of women in the medical field might be best understood from a historical review of oppressive practices. In the 19th and early 20th centuries, women's bodies were viewed as unstable and their minds were viewed as fragile (Fernandes et al., 2006). These beliefs resulted from the subordinate position that society assigned to women, who were assumed to be more at the mercy of biological forces than were men (Fernandes et al., 2006). Based upon theories of reproductive physiology, women were expected to maintain specific behaviors and social roles (Bohan, 2002; Cosgrove, 2003; Shields, 2007). For example, women were thought to be naturally passive and nurturing and were

advised to remain in the home as wives and mothers, as it was believed that too much social interaction would cause physical and emotional distress (Bohan, 2002). In addition, psychologists asserted that obtaining a higher education would damage a woman's ability to reproduce (Bohan, 2002; Schultz & Schultz, 2004).

In psychology as well as in biomedicine, women were historically viewed as fundamentally different from and inferior to men. In psychological practice, the presence of "feminine" emotion (e.g., fear, anxiety) was deemed problematic for women and abnormal in men (Shields, 2007). Although assertions regarding women's physical and intellectual inferiority to men appeared to be supported by scientific evidence (e.g., men's brains are larger than women's), the attributes assigned to each sex were based on biased research practices (Cosgrove, 2003). More specifically, as women were thought to be emotionally fragile and of "mediocre" intelligence compared to men, they were excluded from scientific study (Bohan, 2002, p. 76; Sherwin, 1999). Public debates about mindbody issues (e.g., the influence of cognitive awareness of physical pain on emotion and behavior) among non-academic writers and readers perpetuated popular notions of women's nature and gender differences (e.g., that women were naturally passive, as opposed to men who were thought to have an innate drive to achieve and dominate; Shields, 2007).

Feminism arose as a response to and rejection of such beliefs (Shildrick, 1997). By the 1970s, feminists claimed that the relationship between selves and bodies, along with perceptions of them, is socially constructed. Feminism attempts to redefine this relationship such that the body is more than simply a reproductive object (Bohan, 2002; Cosgrove, 2003; Fernandes et al., 2006). Bohan (2002) described three distinct phases in

the development of feminist psychology. The first phase was characterized by adopting therapeutic techniques that fit into feminist philosophy with the intention of empowering women. The second phase involved integrating feminist philosophy into psychological theories. The final and continuing phase consists of trying to develop a unique and comprehensive theory that explains the common experiences of women.

With regard to the medical field, feminist theory presents a response and challenge to the functionalist model, which asserts that physicians must adopt a position of authority in order to assure patients' recovery, and that patients must accept these roles and trust physicians (Lupton, 2003; Munch, 2004). Feminists argue that patients are the experts of their own medical conditions (Chrisler, 2001; Hoffmann & Tarzian, 2001) and contend that medical knowledge is largely socially constructed—that is, health, chronic illnesses, and medical care are influenced by cultural factors and social norms (Fernandes et al., 2006; Lupton, 2003). Thus, a feminist approach to medicine encourages patients and physicians to question concepts of "normal" and "healthy" and for physicians to consider patients' subjective interpretations of their own illness (Hoffmann & Tarzian, 2001; Wright & Owen, 2001).

According to Verdonk, Benschop, de Haes, and Lagro-Janssen (2008), in the 1990s, studies on women's health began to include women's interpretations of their illness experiences. Such studies continue to be conducted and have expanded to include the influence of gender relations. Nevertheless, medical knowledge is historically based on research in which women were significantly underrepresented (Findlay, 1993; Sherwin, 1999) and the inclusion of female participants in current medical research continues to fall short of male participants. In their paper written on behalf of the

Endocrine Society, Alexander-Bridges and Doan (2007) reported that no mandate currently exists to include women and other minorities in industry-sponsored drug trials. Furthermore, despite the Food and Drug Administration's (FDA) 1993 *Guideline for the Study and Evaluation of Sex Differences in Clinical Evaluation of Drugs*, women continue to be unrepresented in clinical trials for the testing of drugs before marketing (Mastroianni, Faden, & Federman, 1999). According to a study by Yang et al. (2009), in clinical trials for 67 new drugs approved by the FDA between 2000 and 2002, women were significantly underrepresented in early phase trials and certain areas including cardiovascular, renal, and gastroenterology, and psychiatry products.

Sherwin (1999) argued that the process by which research is conducted may maintain and promote medical practices that oppress women. These research and medical practices could have a significant impact on women with thyroid disease, particularly with those that are autoimmune in nature (i.e., Hashimoto's and Grave's disease), as autoimmune diseases are the third-most common diseases in the United States, preceded by heart disease and cancer (Committee on Women's Health Research, 2010). According to the Committee on Women's Health Research (2010), although progress has been made over the past couple decades in knowledge about the pathophysiology of autoimmune diseases in women, research has not yet led to effective treatments beyond managing the symptoms.

Adopting a feminist approach to qualitative research involves accepting the narratives about the history of psychology, philosophy, and medicine that feminism proposes. Female patients' illness experiences can be interpreted in light of this narrative. Alongside social constructionism, a feminist approach suggests that female patients'

interpretations of their experiences are influenced by social constructs related to the female body, gender issues, and the experience of being a woman (Hearn, 2009).

The Doctor-Patient Relationship

According to Dr. Francis Peabody (1927), proper diagnosis and treatment are dependent upon the quality of the relationship between doctor and patient. Despite this widely-acknowledged importance, traditional doctor-patient relationships have been characterized by authoritarian, paternalistic, doctor-centered approaches, and physicians have historically behaved in ways that marginalize women (Ehrenreich & English, 2005; Vanderford et al., 2001). In contrast, research has shown that doctor-patient relationships that are collaborative, respecting of patient autonomy, and non-sexist have a positive impact on treatment outcomes (Chrisler & Parrett, 1995; Dugdale et al., 2008; Fox & Chesla, 2008; Houle et al., 2007; Peck & Connor, 2011). I am not implying that physicians who work in a traditional relational-style deliberately intend to marginalize or oppress women. Rather, as oppressive practices are systemically ingrained in society by historically-based knowledge and beliefs, "conscious and persistent effort [is required] to resist complicity in [the] patterns" of such practices (Sherwin, 1999, p. 11). The characteristics of traditional doctor-patient relationships are discussed in the following paragraphs.

Traditional Doctor-Patient Relationships

Authoritarianism and paternalism. Authoritarian doctor-patient interactions are characterized by a hierarchical relationship wherein the doctor is in a position of authority over the patient. A paternalistic doctor-patient relationship combines this authority with a concern for the patient's well-being (Kittay, 2007). According to Berger (2002) and

Paterson (2000), authoritarian and paternalistic attitudes in medicine stem from the moral authority afforded to doctors upon taking the Hippocratic Oath. In other words, doctors are expected to improve their patients' lives and avoid causing harm, and hence, the doctor acts as a father-like guide for the patient (Berger, 2002). However, doctor-patient relationships based on authoritarianism and paternalism discourage respect for patients' autonomy (Kittay, 2007).

Historically, doctors have possessed specialized knowledge and medical expertise inaccessible to the public. Although this is still the case, today's public has greater access to medical information (Hearn, 2009). Nevertheless, the hierarchy between patients and physicians persists. According to Hearn (2006), physicians feel that their traditional, paternalistic roles are threatened by well-informed patients. McGuire, McCullough, Weller, and Whitney (2005) conducted a qualitative, cross-sectional survey of physicians. The results indicated that, although most physicians have a positive view of patient involvement in medical decision making, physicians view their role as that of an expert whose duty is to educate patients and make recommendations for treatment. In this type of relationship, the physician has decisional priority (i.e., suggests the plan of action) and the patient has decisional authority (i.e., accepts or rejects the plan). McGuire et al. described this one-dimensional model of shared decision making as "ethically inadequate" because it does not account for the variability among patients regarding desire for information and involvement (p. 466).

Based on their study of patient autonomy level and preferred doctor communication style, Kaplan, Schneiderhan, Harrown, and Omens (2002) suggested that physicians should base their approach to information sharing and decision making on

their patients' individual levels of autonomy. Kaplan et al.'s research indicated that for female participants, the higher their level of autonomy, the stronger their preference was for doctors who had an informative versus a paternalistic communication style. Whereas a paternalistic communication style is directive, an informative communication style is participative and encourages patients to make informed treatment decisions. Like female participants, male participants preferred doctors with an informative communication style; however, the male participants' preferences were not influenced by their autonomy levels.

Similar research by Bradley et al. (2001) revealed that regardless of patient gender, patients were more satisfied with physicians who used a consultative (informative) communication style as opposed to an authoritative (paternalistic) communication style. When physicians used a consultative communication style, levels of satisfaction were highest among young participants (less than 30 years of age) regardless of physician gender, and among older participants (between 30 and 49 years of age) when the doctor was male. When an authoritative communication style was used, levels of satisfaction were lowest among middle-aged participants (50 years of age and older), particularly when the physicians were female. Bradley et al. proposed that these results might reflect conventional gender-role expectations among the middle-aged participants.

Research indicates that authoritarian and paternalistic doctor-patient relationships can have negative consequences for both physicians and patients. Stokes et al. (2006) conducted a study of cases in which general practitioners (GPs) in the UK terminated relationships with patients. Based on accounts of the situations given by both the GPs and

the patients, the researchers concluded that the GPs were strategically exercising symbolic power in terminating the relationship (Stokes et al., 2006, p. 613). In the cases considered, this was often due to a conflict between GPs' recommendations and the patients' requests or demands. In such cases, the GPs chose to cease treating the patients rather than adopt a more collaborative approach to healthcare.

According to Risberg, Hamberg, and Johansson (2006), medical knowledge based on biomedical approaches are privileged within the medical field at the top of a hierarchy of research types. This could suggest a tendency among physicians to undervalue patients' knowledge or to undervalue doctor-patient relationships that do not conform to the dominant hierarchies. In fact, patients tend to be viewed by health care professionals as "difficult" when they do not adopt the role expected by the physician (MacDonald, 2003). Risberg et al. (2006) linked this phenomenon to gender bias in the medical field and a resistance to gender awareness. In addition to reinforcing authoritarianism, this state of affairs can result in gender-biased doctor-patient relationships. In their study about the influence of "status characteristics" on doctor-patient interaction, Peck and Connor (2011) interviewed 179 patients regarding their experiences with their physicians. Status characteristics are based on cultural beliefs in which a higher status and level of competence is associated with one group (e.g., men) over another (e.g., women). Results of the study indicated that doctor-patient interactions were more paternalistic and less patient-centered when the doctor was male and the patient was female versus interactions in which the doctor was female and the patient was male or female. Since status beliefs often form and exist at a subconscious level (Rashotte & Webster, 2005), male doctors

may be unaware that they are interacting in a more paternalistic fashion with their female patients than their male patients.

Mutter (1999) discussed the paternalistic influence of the dominant "military metaphor" in modern medicine. This view holds that medicine is a war against disease and death. This type of thinking, according to Mutter, encourages physicians to ignore patients' mental concerns and focus on the physical, emphasizing control over physical forces acting within the patient. This can result in the presumption that the doctor knows more about the patients' experiences of their bodies than the patients themselves.

In a study of 20 women who had had elective hysterectomies, Lorentzen (2008) discovered that, among negative experiences with doctors, those that were most impactful for the participants were those in which physicians attempted to make false claims about the women's bodies. The participants found most disturbing those claims that they described as "inaccurate, potentially harmful, demeaning, and as discounting the women's experiential knowledge of their own bodies" (p. 60). Similarly, female patients in a study by Copeland et al. (2003) complained that doctors did not treat them with respect, did not answer questions without getting impatient, and were judgmental, insensitive, patronizing, and condescending. They explained that they wanted doctors to be sensitive to the whole person, and to express an interest in their feelings, mind, body, and spirit.

Marginalization of women. The marginalization of women by physicians can be viewed as a byproduct of the predominant cultural view, discussed above, of women as physically unstable and mentally fragile (Fernandes et al., 2006). According to Werner and Malterud (2003), at the end of the 19th century, unexplained conditions in women

were often seen as attempts to gain power or attention. Consequently, women risked going without treatment if physicians deemed them either overly feminine or overly aggressive and opinionated.

According to Chrisler (2001), the traditional patient role is similar to traditional female gender roles. Both roles encourage passivity, cooperation, dependence, and acceptance. This marginalizes women by making it difficult for them to be assertive or challenge doctors, lest they be labeled bad patients (Chrisler, 2001). Chrisler argued that this could result in misdiagnosis for women in the early stages of autoimmune disorders because their symptoms are often vague.

Marginalization of women can be seen on both individual and societal levels. At the individual level, marginalization of women is also evident in relationships between women and psychologists. According to Wright and Owen (2001), diagnoses of mental illness tend to devalue the female role as perceived by a socially constructed standard. Thus, women who deviate from the normal female role are often seen as mentally ill, and women who conform to the role could also be diagnosed with mental illness because the role is itself marginalized.

At the societal level, medical research and physician reports have also shown a trend of marginalization. According to Findlay (1993), the biological functions of the female reproductive system have historically been viewed in terms of their teleology, rather than strictly descriptively. For example, researchers in the 1950s claimed that changes in the uterine wall during pregnancy were designed to increase space inside the uterus. Findlay argued that the use of this type of language and this conceptual approach to female reproductive processes revealed a mechanistic, objectifying view of women.

Modern Doctor-Patient Relationships

Collaboration. According to Sacks (1987), a neurologist and essayist, "Whereas modern medicine may provide invaluable insights into chemical and biological courses of disease, only patients hold the clues to what their diseases are really like" (p. 40). Sacks' statement indicates the importance of collaboration between doctors and their patients; doctors cannot gain insight into patients' experiences unless they actively attempt to understand patients' points of view.

With the rise of patient-centered care in the last 10 years, there has been a shift in the communication style of many medical practitioners—a more collaborative approach in which patients' preferences are considered in treatment decisions (Breen et al., 2009; Levinson, Lesser, & Epstein, 2010). In a study by Butalid, Verhaak, Boeije, and Bensing (2012), analogue patients viewed videos of doctor-patient interactions from 1982-1984 and 2000-2001. Analogue patients confirmed a shift from doctor-centered interactions in the earlier videos to patient-centered interactions in the more recent videos, characterized by collaborative, solution-focused communication as opposed to directive, problemfocused communication.

Effective doctor-patient collaboration requires that doctors be willing and able to communicate with patients as individuals. Houle et al. (2007) described the following interpersonal skills as being vital to an effective doctor-patient relationship: (a) understanding, which involves a sincere desire to learn about patients' experiences and results in patients' trust and belief that their doctors know them as individuals; (b) empathy, which is the skill through which doctors express consistent, professional concern for their patients' feelings; and (c) relational versatility, or the ability of the

doctor to match his or her interpersonal approach to the varying communication needs of their patients. According to Houle et al., the skill of relational versatility is dependent upon an attitude of respect for and acceptance of others.

Collaboration in doctor-patient relationships also requires trust. Trust, as defined by the female participants in a study by Copeland et al. (2003), is "based on feeling confident and comfortable with the care provided…when the doctor appears sympathetic, cares, and takes time to talk" (p. 41). According to Dugdale et al. (2008), patients trust doctors who provide informed consent, are willing to disclose medical errors, and who keep abreast of the current medical literature. Participants in the Copeland et al. (2003) study expressed feeling reluctant to talk to doctors with whom they do not feel comfortable, and were eager for doctors to know that trust affects their willingness to listen and comply with their doctor's advice. Likewise, the female participants in the Houle et al. (2007) study stated that they are more likely to take a doctor's advice if they believe they can trust the doctor. The participants also indicated that, in order to gain their trust, doctors must show an interest in them, listen attentively, conduct a prompt follow-up, and be available to answer their questions.

Empirical support exists for the importance of collaboration in doctor-patient relationships as opposed to a hierarchical relationship wherein the doctor is in a position of authority over the patient. Doctors' attitudes have been shown to have a direct effect on the quality of care patients receive, as well as patients' ability to make informed decisions about their health (Chrisler & Parrett, 1995). Doctor-centered attitudes are associated with lower patient satisfaction and, according to Krupat (1999), may decrease trust in the doctor-patient relationship.

Recent research suggests that there may be a difference in the level of collaboration encouraged by male and female physicians. In a study conducted by Hall, Roter, Blanch, and Frankel (2009), female medical students more accurately interpreted their patients' non-verbal communication (e.g., facial expressions) than did male medical students. Doctor-patient interactions in which doctors demonstrated sensitivity to their patients' non-verbal cues resulted in decreased distress, longer visits, and higher engagement among analogue patients.

A study conducted by Bloor, Freemantle, and Maynard (2008) found that male medical professionals completed, on average, 160 more medical cases each year than their female counterparts. According to Firth-Cozens (2008b), this disparity may reflect the type of care given by female doctors, in contrast to the care given by male doctors. For example, female physicians may spend more time with each patient, encouraging the patient to speak more and be more active in the decision making process. The increased depth of care and collaboration would result in females completing fewer cases over the same period. Female doctors have indeed been shown to use a more patient-centered approach with their patients than male physicians, as evidenced by longer consultations and a more emotional, psychosocial focus in their discussions (Beach, 2000; Firth Cozens, 2008b; Hall & Roter, 2002; Hall et al., 2009; Roter & Hall, 2004; Shin et al., 2015).

The more patient-centered approach adopted by most female practitioners may have a significant positive impact for the professionals as well as for the patients. According to a report by the National Clinical Assessment Service (NCAS, 2006), male doctors are involved in more legal and disciplinary action than female doctors. In 2004,

42% of general practitioners were women, but only 13% of doctors referred to the NCAS for discipline were female. According to Firth-Cozens (2008b), this statistic is a direct result of the more sensitive approach taken by female physicians. Better doctor-patient relationships result from female physicians' greater emotional and communication skills, resulting in a decreased likelihood that the doctors will be involved in disputes or complaints.

Patient autonomy. In contrast to the traditional authoritarian and paternalistic relationship between doctors and patients, a more egalitarian approach to healthcare has been shown to benefit treatment outcomes. Doctors who respect patient autonomy allow patients to participate in decisions about their own health and take patients' concerns, opinions, and preferences into consideration. Empirical evidence indicates that physicians are moving toward this ideal.

Physicians in a study by McGuire et al. (2005) expressed consistently positive attitudes towards patient participation in medical decision making. They identified patient autonomy as essential to the doctor-patient relationship and indicated that they were motivated by the fundamental principle of beneficence, as well as their own personal interest in avoiding legal liability. Similar results were found in Rogers' (2002) study of physicians' attitudes toward patient autonomy in treatment for back pain. The majority of physicians interviewed were in favor of patient autonomy regarding the use of complementary therapies (e.g., massage), but desired to maintain control of treatment decisions involving analgesic narcotics due to their potential for addiction.

In the case of autoimmune disorders such as those that cause hyper- and hypothyroidism, respect for patient autonomy is particularly important (Chrisler &

Parrett, 1995). Because patients can provide important insight into the experience of their own conditions, patients should be seen as experts on their conditions and respected as such. Considering that the majority of physicians wish to respect patient autonomy while avoiding legal liability (McGuire et al., 2005; Rogers, 2002), a "deliberative model" might be appropriate in decision making. As described by Chin (2002), in the deliberative model, the physician is both a teacher and a friend who assists the patient in evaluating the safety and effectiveness of potential treatment modalities. Chin (2002) posited that such a model is particularly relevant in the "Internet age," in which patients are "flooded with information"—not all of which is reputable (p. 154).

The increased availability of medical information to the public makes patient autonomy a growing concern. Tu and Cohen (2008) reported that, according to an HCS survey, in 2007, 56% of American adults sought information about a health concern, compared to only 38% in 2001. Of those individuals who looked for information about a health concern from sources other than a doctor, over half later spoke with a doctor about that same health concern. This indicates that patients exercise their own autonomy and hope to use the information they discover in conjunction with professional consultation. Additionally, those with chronic health concerns are more likely to seek health information from sources other than doctors. According to Fox (2007), among Internet users with disability or chronic illness such as thyroid disease, 86% have searched online for information. Among those without chronic illness, only 79% have searched for medical information online. Individuals with chronic health concerns also reported that their medical decisions are more frequently affected by information found online.

Fox and Jones (2009) reported on a 2008 Pew Research Center study related to patient autonomy in seeking health information from various sources. The study found that 61% of adults use the Internet to search for health information, and over half of online health queries are made on behalf of someone other than the Internet user. Therefore, in order to establish effective doctor-patient relationships, physicians need to take patient autonomy and outside sources into consideration. In addition to consulting professionals, a majority of adults consult friends or family members, books, and other reference material for medical assistance. Significant percentages of those interviewed claimed that information found online affected health-related decisions they made for themselves or someone in their care (Fox & Jones, 2009). These results underscore the importance of online information for individuals with chronic illness, suggesting that doctors treating such patients should be particularly aware of and sensitive to patient autonomy and knowledge.

Non-sexist. As noted above, traditional doctor-patient relationships have tended to marginalize women by virtue of social perceptions of the female role. In addition to being placed in a position of inferiority due to doctors' medical expertise, female patients in the care of male physicians may conform to traditional, submissive feminine roles (Chrisler, 2001). This undermines female patients' autonomy and makes doctor-patient collaboration unlikely. Thus, it is important for women to feel that their feminine status does not affect the quality of the care they receive.

Despite theoretical and empirical evidence that a more collaborative, less doctorcentered model of healthcare promotes positive healthcare outcomes (Houle et al., 2007; Munch, 2004), the traditional forms of doctor-patient relationships persist. Factors

that contribute to the persistence of the traditional model include sexism in healthcare, the medical education system, economics, the culture of the medical profession, and women's communication patterns.

Role of Throat massage in Thyroid Care

As thyroid occurs due to inactivity of Thyroid gland. Now the points arises how to activate the thyroid gland again. In this sexual behaviour plays important part in this. The thyroid gland is located just in front side of throat of a women neck and once a women gets thyroid issues it starts swelling and shows double chin effect on face which disrupts the face and facial expression of a women. The best way to rejuvenate your thyroid gland is to give more blood circulation and massaging action to throat. This helps your thyroid gland to be health and start functioning again. Most women who suffer with PCOD has seen to develop Thyroid issues in early stage. In this case the thyroid massage along with medication is very important. The massaging action must be done from both ends from inner and outer. Give a gentile massage to your thyroid gland early in the morning. Herbal tea that includes Ginger, Tulsi, pinch of black salt will help your Thyroid better thyroid function because it helps increase immunity. The women with Thyroid isues problem of getting allergy and throat infection easily and the herbal tea will help alleviating these symptoms. Now the problems comes how to go for inner massage of throat because inner throat massage is most important for Thyroid gland to work properly. Now a days most of doctors recommend penile massage for inner throat and it has been seen the most effective way for regaining the thyroid gland. In USA women after using six month of penile massage reported their medication dose decreased by

70%. Medically it has proven the Penile massage is best for Thyroid gland. Some women who are allergic to semen may use silicon penis available in market for massaging action. The thyroid in women with PCOD is not due to Iodine deficiency but it is generally because of certain hormone deficiency due to PCOD. So if a women has Thyroid afters PCOD the human penile massage is most important for her then any other medicine because human semen has got Spermidine which is very important for Thyroid Gland. It helps Thyroid to work properly. A woman with PCOD must try to take the semen inside throat as inner side as possible while ejaculation of her partner. Once the thyroid has came to normal limits the regular massage will help to maintain the life of your thyroid gland. The Question comes how much massage is needed ? There is no specific answer of it the more the sooner you get results but at least three times a week is must for show visible results. Approx 98% women with this massage has reported proven benefits and it is widely recommended in world for thyroid in western world.

Hot water bag therapy

Hot water bag therapy is helpful for the women who face swelling due to stiffness of the thyroid gland. The hot water bad will help if you have swelling and pain in thyroid gland but in few cases it has been seen that it disrupts the working of thyroid gland. So, it is advised not to go for hot bag therapy for more than 5 min. In some women the Thyroid occurs because of PCOD and In this type of women if thyroid increases, they face issues of double chin and swallowed thyroid gland. They also have weak digestion and face constipation on regular basis. In this type of women it is found the inactivity of thyroid gland because of hormonal disbalance occurred in PCOD process. In this type of women

hot bag therapy will only help in swelling of throat but must be use not more than three times a week. Women with thyroid occurred due to PCOD are advised for inner thyroid massage with semen intake. This will not only help in maintain normal thyroid level but also helps in removing the symptoms occurred by Thyroid problems.

Early Menopause due to Thyroid issues

It has been found the women with Thyroid faces early Menopause. Generally, it has been seen that women with Thyroid issues faces Menopause in 45 years which is five years earlier than expected. Once a woman faces Menopause she faces many hormonal issues like mood swing, irritation,constipation, weight gain etc. The menopause makes the skin dry and wrinkles stats to appears on skin. On other side the women with Thyroid occurred due to PCOD the menopause starts at early 40s. Which is at least 10 years before than normal women. If a woman starts getting quick than usual periods in early 40s than it is first sign of menopause. Generally a women with PCOD gets their periods late in 40 to 45 days and if it starts coming in 28 to 35 days than its alarming for a female to take steps. The menopause due to thyroid is not normal for a female body but it is a type of disorder a women face due to lack of certain hormones like testosterone, estrogen and DHEA. But the good news is the menopause process due to PCOD occurred thyroid is reversable and can be delayed at least by 5 to 8 years if you keep thyroid in control and take maintain hormonal balance of testosterone, estrogen and DHEA in your body. It has been studied on approx. 1000 women for 10 years and seen that women with PCOD occurred Thyroid were able to delay their menopause by at least 5 to 7 years using semen swallowing and throat massage. So women who has started getting quick periods must go

for these for maximum benefits without any medical complications and medication. This is proved to be most safe and effective way to delay menopause and control thyroid without medication in home.

What if partner is aged and have erectile disfunction issues

In our test sample of 5000 women approx. 1000 women were above 45 and many of their partner have faced erectile issues and were not able to perform sex with their partner. But shockingly the result showed no difference in them because women needs very less amount of hormones for their regular needs and a man can produce this till their lifespan. So its not an issue if they have erectile disfunction they can still ejaculate and its enough for a woman.

The basic thing is hoe you can understand your partner is producing enough hormone for you or not. The answer is simple if the if his scrotum are always relaxed and hanging down the testis then you must go for hormonal check. This may be due to less Harmon production or disorder but this does not mean you cant take it but for certain it has less hormonal level.

On other hand if the scrotum remain stick to body most of the times it means it is health and producing enough hormone for a woman. Try to squeeze the scrotum which sucking as movement of scrotum balls produce more hambones for you. Here are images for reference –

In first image you can see a normal penis. In second image you can see a penis with enough hormonal value. In third image you can see a relaxed penis. It is important to note that this also happens due to temperature difference. So relaxed penis doesn't mean it has not hormonal value. It is important to note if in a day for few hours the scrotum sticks to the body as middle image then its normal penis. Where as if the scrotum remails relaxed all the time it means you need to check the semen quality in lab test.

What is 80:20 Ratio for Women Vs Men

The 80:20 ratio defines that this process helps 80% to female and 20% to male. Now see what main benefits in female are –

1)They can manage thyroid issues better even cure without medication

2)They can have better skin and removed wrinkles on faces.

3) Can have better quality sleep and stress management

4) Can delay menopause for 7 to 8 years.

5) Most important can manage weight and obesity

6)Can help getting better hair and wrinkle free skin

7)Low risk of Heart problems.

8)Improved immunity.

9) Can look younger for years to come and many more...

Now see what benefits men can have with this process–

1) Men can get stress free ejaculation and better satisfaction

2) Regular ejaculation leads to regular hormone production makes him young

3) Helps in stress management and anxiety gives better relationship with partner.

4) Femele sucking works as vacuum pump and helps in erectile disfunction.

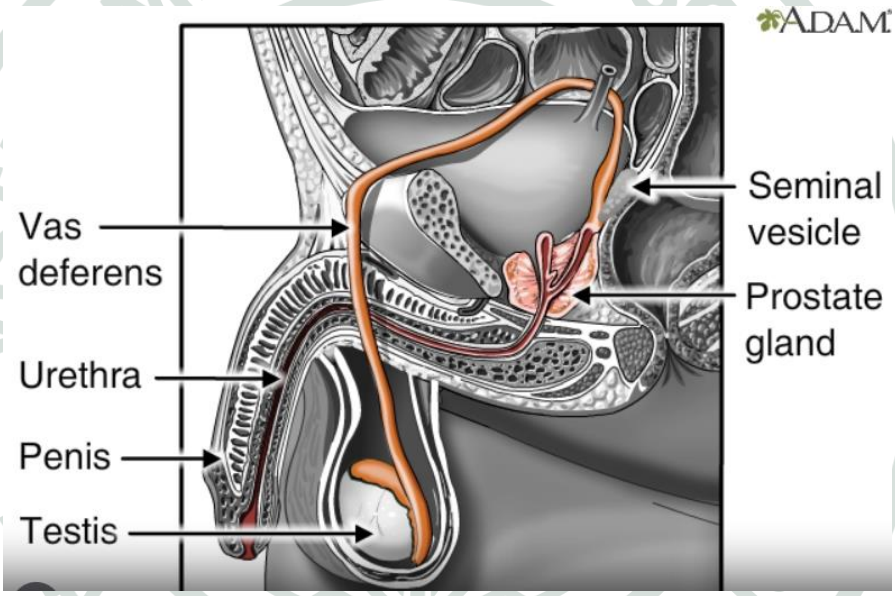
Why oral have more benefits for females

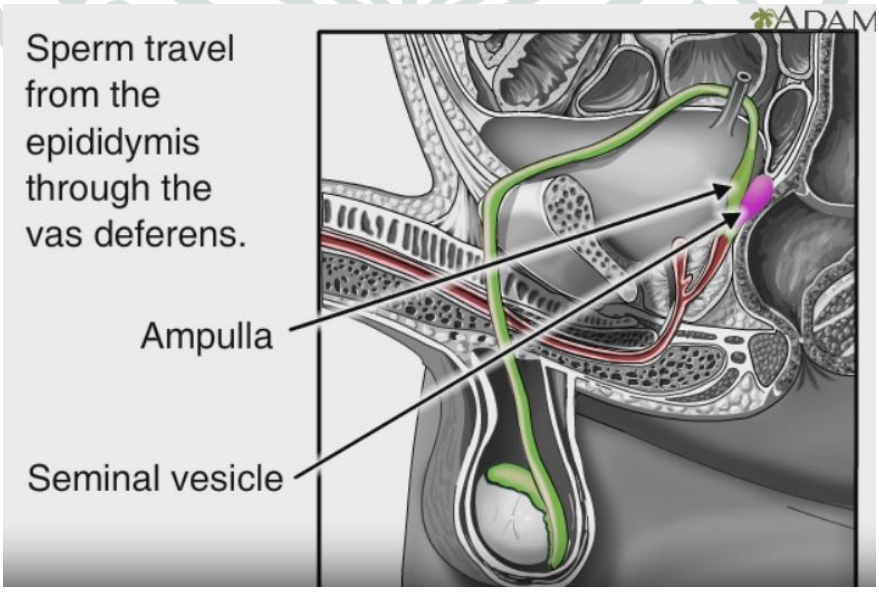
It is seen that oral give more hormonal benefits to female then vaginal sex the reason behind is that

1) At the time of oral men concentrates only on ejaculation so the quality of semen produced is better.
2) At this the men have no performance pressure so the whole body is engaged in producing best quality of semen.
3) Men use less energy in oral so energy is saved and men can go for oral sex for several times in quick intervals.

Why semen has smell and bitter taste? Does it contain urine?

The simple answer is no. once a man gets exited the urinary tract is locked by blood vessels. Even if a man wants to urinate or pee, he can't do that till the penis comes to its initial position and in relaxed mode. So, there is no chance of smell due to urine or pee mixed with semen. Nature has made it beautifully because even a drop of urine in vagina could crate infection in uterus of a woman, so the pathway of semen and urination is kept different by nature for safety of women itself by nature. You can click and see the semen pathway and know why its important to massage the balls for getting good quality semen from men.





For full video click - https://medlineplus.gov/ency/videos/mov/200019_eng.mp4

Then the question arises what the smell and taste is made of. The simple answer is the semen is base by nature so the taste of base is bitter. For example detergent used in our home are base so the tase you can relate. And the smell is due to hormones present in the semen. As the age progresses the taste and smell of the semen fades and its effectiveness also decreases. Unlikely female vagina male penis is outer part of body so its easily cleanable and free from infection. So, this makes semen the best hormonal dose for women health and beauty. Recently in western world even most celebrities, gynaecologist and female sexologist are taking semen dose as daily routine to be fit, maintain beauty. Semen is also used an cosmetics industry and the product cost is too high because of limited supply and high demand.

- As previously noted, the traditional doctor-patient relationship involves a marginalization of women, which is partly a result of the historical view of women as overly emotional. In addition, it has been argued that the medical profession encourages a normative, gendered view of illness, which results in a perceived need for women to work harder in order to be perceived as credible patients (Werner & Malterud, 2003).

The gendered view of illness is exemplified by Kempner's (2003) discussion of the common perception of migraine as a women's illness, which is due in part to the higher incidence of migraine among females. The author reviewed evidence suggesting that gendering migraine has a significant impact on health and doctor-patient relationships. Diagnosis rates and the perception of the legitimacy of migraine complaints among female and male patients are affected. Munch (2004) noted that many such

gender biases in diagnoses were uncovered by second-wave feminist research between 1970 and 1995.

The cultural marginalization of women in healthcare extends not only to female patients, but to female doctors and nurses, as well. Due to women's history of oppression and the nature of medical training, it is not uncommon for women entering medical professions to maintain patriarchal attitudes (Carter, 1994). This phenomenon is particularly evident in nurse-physician relationships. According to Carter, there are "unspoken rules of communication" between nurses, who are primarily female, and physicians (p. 368). These rules require nurses to refrain from disagreeing with physicians and place a low value on nurses' suggestions. However, it is not clear that gender bias accounts for all interactions between nurses and physicians. In a surveybased study of 125 nurses, Rothstein and Hannum (2007) found that nurses had similar perceptions of female and male physicians with whom they interacted, suggesting that professional differences play a role in addition to gender differences.

Kilminster, Downes, Gough, Murdoch-Eaton, and Roberts (2007) pointed out that gender bias in research may contribute to the uncertainty regarding women's place in the medical field and the effect of changes in gender composition within the field. In an extensive review of literature related to women in medicine, the authors found little strong evidence of gender differences in practical areas of healthcare. Instead, gender expectations in education and clinical practice were found to have a larger effect. The researchers concluded that there has been very little research specifically focusing on male doctors. Research practices are already gendered, treating women as the subject to be examined.

Some suggest, in contrast to Kilminster et al. (2007), that gender-aware research practices are positive. For example, Munch (2004) conducted a review of literature related to second-wave feminist approaches to diagnoses from 1970 to 1995. The review revealed that feminist perspectives were instrumental in uncovering a number of areas where gender bias problematically affects women's healthcare. Gender awareness in research, therefore, may be important in uncovering areas in which the culture of the medical profession marginalizes women.

Treatment of Chronic Illness

Another cultural factor contributing to problematic doctor-patient relationships relates specifically to patients with chronic illnesses. According to Chrisler (2001), the culture of the medical profession is not supportive of chronic illness, as evidenced by the belief among physicians that, for example, women over-report pain, and that vague symptoms are unworthy of serious consideration. Instead of crediting patients' reports about their conditions, medical professionals tend to focus on acute conditions and verifiable complaints.

Martin and Peterson (2009) defined chronic illness as "a state or passage of care for long-term pain and suffering that may not be cured" (p. 579). These authors discussed the social context of chronic illness from a constructionist perspective. Perhaps more than other medical complaints, chronic illnesses require a highly personal process of meaning construction. According to the authors, proper management of illness involves active interpretation, not "simple biomedical labeling" (p. 580). Although doctors may provide interpretations of chronic illness, biomedical interpretations cannot help patients understand and experience the illness and long-term treatment. Additionally, the culture

of the medical profession may encourage patients to withhold details of their experiences of chronic illness from physicians in order to avoid being judged as complaining.

Even when medical professionals do take patients' experiences into account, there is evidence suggesting that they interpret experiences according to rigid models. Telford, Kralik, and Koch (2006) conducted a review of literature related to the view of patients with chronic illness as understood through the terms *acceptance* and *denial*. The researchers found that medical professionals tend to place patient experiences within this framework, even when the experiences do not fit the framework. According to the authors, this tendency may affect patients' understanding of their own experiences and cause them to internalize predefined labels in their self-understanding. This suggests that preconceptions and biases related to chronic illness may have a significant effect on learning to cope with chronic illness.

The medical profession's inability to address chronic illness in a meaningful way and to place little importance on chronic pain may interact with the marginalization of women, placing female patients with chronic illness and disability at risk of receiving inadequate treatment (Thomas, 2001). Fernandes et al. (2006) suggested that understanding and constructing meaning for chronic illness may be particularly important for women because issues related to the body are instrumental in the formation of female self-identity. This underscores the impact that gender has in every area of the medical profession and its culture.

doctor, and six participants had difficulty with accessing thyroid medication.

Feeling rushed. Three out of the 11 total participants (Autumn, Jessica, and Leanne) whose treatment experiences were influenced by economics reported feeling rushed by their doctors.

"Most [doctors] are just in and out doing as little as they possibly have to do…It would help if they weren't so rushed." (Autumn)

"[I wish doctors would] take more time to figure stuff out and explain things." (Jessica)

Access to doctor. Eight out of the 11 total participants (Autumn, Carla, Jenna, Kim, Leanne, Michelle, Sarah, and Shawna) whose treatment experiences were influenced by economics had difficulty with accessing a doctor.

"I was very comfortable with Angela [the doctor who quit]…have no clue about the new one." (Autumn)

"I got bad sick…and no insurance…couldn't go see a doc…[then, finally] for the first time in 15 years I had access to a doc again [when I] became eligible for a few things, including medical care…" (Carla)

"I think [my doctor] could be a little more up to date but again, going through a free clinic I am limited." (Jenna)

"[My relationship with my doctor is] not ideal, but the best I can have here…There is not Endo around for at least 150 miles and I can't make these long trips." (Kari)

"This doctor was the first one ever to test my frees and also the first and only to test me for Hashi's antibodies. He has recently passed away, so I've had to find a new doctor again." (Kim)

"When I was finally diagnosed in 2005 after many years of begging [doctors] to be diagnosed (numbers were "normal"), I found a female PCP to diagnose me. She was a teaching Dr. and taught me how to read the numbers on all the appropriate tests---not just TSH, but also FT3 & FT4. Followup PCP Drs continued to test TSH only & when I kept saying the Synthroid was making me feel bad, I was told "that's all we can prescribe"!!" (Michelle)

"[My Naturopath] cancelled my August recheck because she was too busy as a school nurse. Said to wait until Nov since I was doing fine." (Shawna)

Access to medication. Six out of the 11 total participants (Anne, April, Carla, Karen, Kim, and Shawna) whose treatment experiences were influenced by economics had difficulty with accessing thyroid medication.

"I was happy until the Armour shortage hit. When that happened, this doctor knew of nothing else to do but go back to synthroid and did not understand when I was upset at that suggestion." (Anne)

"I used Synthroid 150 and Cytomel for almost 3 years but it was costing $60+ a month. I recently switched to Armour and it is less than $8 a month." (April)

"[My doctor] allowed me to stay on the replacements that I've been taking when we found that my state assistance insurance only covers synthetic T4 and I have a very poor body response to that." (Carla)

"I was happy but now that the FDA no longer approves Armour as a medication I will have to start all over again trying to find a natural product my system can work with. I have a very sensitive system so it is hard to find a good treatment." (Karen)

"[I had] no problems until I changed to Synthroid. When I found it didn't work as well and I wanted to change back to Armour I could not find a doctor who would permit the change. They all said Armour was outmoded and Synthroid was better." (Kim)

"I had taken my labs to the primary doc's office when I went in for a tick bite, and asked him to get back with me about what he thought and whether I could switch from the compounded to something [that would] be covered by insurance, but he never got back to me." (Shawna)

Additional Findings

As previously mentioned, I recognized some additional findings that were meaningful to some participants. Although these findings do not represent the treatment experiences of the participants as a whole, these data are nevertheless poignant examples of the phenomenon from individuals who have lived the phenomenon. Additional findings include the belief that the public is misinformed about thyroid disease (Diane), the experience of grief (Carla), the experience of empathy from one's doctor (Michelle), and the experience of respect from one's doctor (Michelle).

Public is misinformed. Diane reported a belief that the public is misinformed about thyroid disease.

"[I] think the public is grossly misinformed. Their impression is that you just take a little pill and all is well. This is far from the truth, as it can be very complicated."

Experience of grief. In sharing her thyroid disease treatment experience, one of Carla's comments was indicative of grief.

"I got to watch my iodine uptake...I had such a perfect gland...It was just twice normal size. I have two half siblings with the same genetic defect I have. Both got proper care in a timely manner. Both are doing fine. Healthy weight, good jobs, real lives."

Experience of empathy. Michelle indicated that she experienced empathy from her doctor.

"[My doctor] is very caring and listens to my needs…he has made clear that he is a good listener and has my best interest at heart."

Experience of respect. Michelle indicated that she experienced respect from her doctor.

"I think [my doctor] is so respectful of his patients that it does not matter if [it is a] male or female patient."

Composite Description

According to Moustakas (1994), integrating participants' textural-structural descriptions into one composite description provides the reader with a deeper understanding of the phenomenon being studied. Based on the themes identified from the individual participant interviews, the following composite description provides answers to the research questions: "What are the treatment experiences of women with thyroid disease?"; "How does the doctor-patient relationship affect their experiences?"; "Do their experiences differ based on the doctor's gender?" and represents the experience of the group as a whole with thyroid disease treatment and the doctor-patient relationship.

Women who develop thyroid disease experience a number of disturbing physical and emotional symptoms, sometimes years before obtaining a diagnosis. When reported to their doctors, symptoms are often considered to be "normal" aspects of aging,

particularly when test results indicate no thyroid dysfunction. Nevertheless, many of the women in this study continued to report a feeling that "something is wrong" (Alicia). Whether they chose to believe that "doctor knows best" (Karen) or to pursue further information or a second opinion, these women sought support from others with similar experiences. Due to its convenience and wealth of information, the Internet is a popular medium for individuals seeking information or interaction with other people. Online support groups enable their members to interact anonymously, thus providing members with a safe and supportive environment in which to share their experiences, information, and resources. The women in this study found The Thyroid Support Group to be a reliable source for support and information about thyroid disease symptoms, treatment approaches, testing for thyroid disease, how to interpret such tests, and the names of recommended doctors.

For the women in this study, dissatisfaction with one's doctor seemed to result from feeling unheard and invalidated by one's doctor, more so than misdiagnosis in general. When these women shared their concerns with their doctors, they trusted that they would be listened to and taken seriously. When these women brought information to their doctors, they expected their doctors to review the information and to include their thoughts and concerns in the diagnostic and treatment planning processes. The women in this study felt disrespected when their doctors rushed or interrupted them. Feelings of distrust in doctors developed when these women felt dismissed or as if their doctors did not care about them—when their doctors seemed to view them and their experiences by "the numbers" (Michelle) rather than as people. For some of the women in this study, their dissatisfaction with their doctors lead to feelings of hopelessness.

Feeling heard and validated by one's doctor, on the other hand, engenders trust. When the thoughts and concerns of the women in this study were considered—when they were taken seriously—they felt hopeful that they would someday feel well instead of constantly feeling tired, "foggy," anxious, and depressed. According to the women in this study, not rushing or interrupting one's patient demonstrates respect for the patient, which in turn, leads to respect for one's doctor. In addition, including women with thyroid disease in the diagnostic and treatment planning processes encourages authentic communication and patient satisfaction.

Many of the women in this study who did not feel heard or taken seriously by their doctors advocated for themselves—conducted research, sought new doctors, refused treatment, self-treated, and kept secrets if they believed it is necessary—including individuals who believed (at least at one point) that "doctor knows best." The majority of the women interviewed expressed no preference for their doctors to be female or male. They simply wished to be heard and taken seriously. Some of these women in this study feared not being taken seriously because they tend to show emotion as they describe their symptoms and share their experiences. They feared being viewed as weak and unintelligent by their doctors.

The general culture of the medical profession seemed to devalue the experiences of the women in this study—labeling their symptoms as psychosomatic, as solely related to diet and exercise, or due to "women's problems" for which there are clear treatment guidelines. When these women questioned their diagnosis or did not feel better after following their doctor's orders, they were labeled as difficult—and sometimes even "fired" by their doctors (Anne). Based on what they learned in medical school, both male

and female doctors tend to value the TSH blood test above all other tests available for thyroid disease—despite the fact that a "full thyroid panel" offers the most thorough analysis of thyroid function. The women in this study who were aware of this discrepancy and brought it to the attention of their doctors because they were still not feeling well were often dismissed.

Similarly, although synthetic thyroid medication is standard in treating hypothyroidism, it does not work for everyone. Some of the women in this study actually felt worse on synthetic thyroid medication than on no medication at all. The women who learned about natural thyroid treatments and who brought information about this option to the attention of their doctors were often told that such treatments are outdated or ineffective. Even the women who had taken natural thyroid medication in the past and felt better were told that natural thyroid medication was not a treatment option. But these women knew otherwise—they had learned from their own experiences or from others like them that doctors who prescribe natural thyroid medication *do* exist. Through sharing with other women with thyroid disease, they had learned that it *is* possible that they might feel better taking natural thyroid medication.

For some of the women in this study, financial difficulties, limited health insurance benefits, and geographic location sometimes interfered with finding a good doctor or the medication needed for thyroid disease. In addition, many of the women in this study had the impression that they were more knowledgeable about thyroid disease than their doctors. For the women whose doctors were receptive to a collaborative relationship, treatment planning ensued with shared information, respect for experience, patience, and the understanding that medication would be adjusted until the patients felt

well. Some of the women with doctors who functioned in a more paternalistic manner were told to "get off Google" (April). Regardless of their relationship style, it seems that doctors (and their patients, in turn) might benefit from continuing education on thyroid disease—particularly considering its prevalence. Likewise, it seems prudent that research be conducted on the use of natural thyroid medication because of the many women in this study did not feel better while taking synthetic thyroid medication.

Doctors who diagnose and treat women with thyroid disease are in a position to empower their patients ("I have chosen to stay with the physician because I believe he will listen to me. I research, bring my research to him and we discuss what to do with it [and we will] continue working on treatment until I am thriving"; Alicia) or to respond in a manner that elicits feelings of hopelessness and devastation: "It is enough to make one feel hopeless at times…I would get my hopes up that this doctor was the ONE who would help me. The letdown after each appointment was devastating" (Anne). Based on the experiences of the women in this study, it seems that women with thyroid disease grieve their health and long to feel well again. They desperately wish for their experiences to be known and understood" "Listen to someone that is 'living it' and throw away the Synthroid book" (Carla).

Summary

In Chapter 4, I described the findings from this phenomenological study of female thyroid patients' experiences of treatment and the doctor-patient relationship. Upon analyzing the participants' interview transcripts, four themes emerged: (a) doctor-patient relationship, (b) patient self-advocacy, (c) doctor-patient communication, (d) and culture

of the medical profession (see Appendix H). Within the main themes, 11 subthemes emerged. Appendix H presents the full list of themes and subthemes. An interpretation of findings follows in Chapter 5.

Chapter 5: Summary and Recommendations

Introduction

The purpose of this chapter is to summarize and discuss the findings presented in Chapter 4 about the treatment experiences of a sample of women with thyroid disease. A review of the research literature in Chapter 2 revealed a significant gap specifically concerning the treatment experiences of women with thyroid disease diagnoses and the doctor-patient relationship. An understanding of how women with thyroid disease experience treatment and the doctor-patient relationship can enhance doctors' knowledge of women's health and chronic illness and can help to determine factors related to positive treatment outcomes. Between January 12, 2014 and February 5, 2014, I individually interviewed via online chat 16 female thyroid patients who were members of The Thyroid Support Group. This phenomenological study resulted in a rich description of the participants' experiences with thyroid disease treatment and the doctor-patient relationship.

Criterion sampling was used to recruit 16 participants who were female, who were aged 18 years and older, who had self-proclaimed thyroid disease diagnoses, and who were members of The Thyroid Support Group. Data were collected using an interview guide that I created, which was validated by an external panel of three experts in qualitative methods (see Appendix A). The data analysis revealed four themes and 11 subthemes. The four themes consisted of experiences surrounding (a) the doctor-patient

relationship, (b) patient self-advocacy, (c) doctor-patient communication, (d) and the culture of the medical profession. Appendix H presents the full list of themes and subthemes that emerged from the data analysis.

Exploration of the manner in which people assign meaning to their thoughts, feelings, and actions is required for understanding human behavior (Marshall & Rossman, 2006, p. 53). Thus, the participants' experiences with thyroid disease treatment and the doctor-patient relationship were formed into textural-structural descriptions (see Appendix G) within the conceptual frameworks introduced in Chapters 1 and 2: phenomenology, social constructionism, and feminism. Both social constructionism and feminism emphasize individuals' experiences in social contexts (Docherty & McColl, 2003; Fernandes et al., 2006; Hearn, 2009), and together, they suggest that social constructs associated with gender issues and the female body have an effect on female patients' interpretations of their experiences (Hearn, 2009). In the sample interviewed, participants shared their thoughts and experiences regarding the influence of gender, autonomy, knowledge, and communication on their perceptions of thyroid disease treatment and doctor-patient relationships.

The remainder of the chapter presents an interpretation of findings by major themes and subthemes, a discussion of the limitations of the study, recommendations for future research, implications for social change, and conclusions.

Interpretation of Findings

The textural-structural descriptions of a sample of 16 women with thyroid disease provide information with which one might begin to understand the treatment experiences of women with thyroid disease and their relationships with their doctors. Numerous

factors influenced each participant's experience with thyroid disease treatment. The following four themes were identified: (a) doctor-patient relationship, (b) patient selfadvocacy, (c) doctor-patient communication, (d) and culture of the medical profession. Within these four main themes, 11 subthemes emerged (see Table 4 and Appendix H). In the following sections, the themes and subthemes are discussed in detail through the

lenses of social constructionism and feminism.

Table 4

Themes and Subthemes

Themes	Subthemes	Sub-subthemes
Doctor-patient relationship	Traditional relationships	Feeling unheard Feeling invalidated Feeling dismissed Experienced a lack of empathy Feeling disrespected Feeling heard
	Collaborative relationships	Feeling validated Feeling unrushed Shared decision making
Patient self-advocacy	Health information seeking	None
	Switching doctors	None
	Belief that "doctor knows best"	None
Doctor-patient communication	Desire to be informed	None
	Role of trust	Lack of trust in doctor Treatment refusal Secret keeping Self-treatment
	Role of gender	No preference for specific doctor gender Preference for female doctor Being taken seriously Presence of emotion
Culture of the medical profession	Diagnostic bias	Symptoms considered psychosomatic Symptoms attributed to lifestyle
	Medical knowledge	TSH testing is standard Synthetic medication is standard Continuing education may be needed
	Economics	Feeling rushed Access to doctor Access to medication

Note. Additional findings included the following: public is misinformed, experience of grief, experience of empathy, and experience of respect.

Appendix H: Themes and Subthemes

Themes	Subthemes	Participant Pseudonyms
Doctor-Patient Relationship		
	Traditional Relationships	
	Feeling Unheard	April, Carla, Diane, Jenna, Jessica, Leanne, Sarah, Shawna
	Feeling Invalidated	Anne, April, Carla, Diane, Jenna, Jessica, Kim, Leanne, Sarah, Shawna
	Feeling Dismissed	Anne, April, Carla, Diane, Jenna, Leanne, Sarah, Shawna
	Experienced a Lack of Empathy	Emily, Jessica, Leanne, Shawna
	Feeling Disrespected	Carla, Leanne, Shawna
	Collaborative Relationships	
	Feeling Heard	Alicia, April, Autumn, Diane, Emily, Karen, Kari, Kim, Leanne, Michelle
	Feeling Validated	Alicia, April, Diane, Emily, Karen, Kim, Leanne, Michelle

Feeling Unrushed	Emily, Kari, Leanne, Shawna
Shared Decision making	Alicia, April, Carla, Diane, Emily, Jenna, Karen, Kari, Kim, Leanne, Michelle, Shawna

Patient Self-Advocacy

Health Information-Seeking	Alicia, Anne, April, Carla, Diane, Emily, Jenna, Karen, Kari, Kim, Leanne, Shawna
Switching Doctors	Anne, April, Diane, Jessica, Karen, Kim, Leanne, Michelle, Shawna
Belief that "Doctor Knows Best"	Karen, Kim

Doctor-Patient Communication

Desire to be Informed	Anne, April, Emily, Kim, Leanne, Michelle
Role of Trust	
Lack of Trust in Doctor	Carla, Leanne, Sarah, Shawna
Treatment Refusal	Anne, April, Jenna, Leanne, Michelle, Sarah
Secret-Keeping	Kim, Leanne, Sarah

Self-Treatment	Anne, Carla, Jenna, Leanne, Michelle, Sarah, Shawna

Role of Gender

No Preference for Specific Doctor Gender	Alicia, Anne, April, Autumn, Diane, Emily, Jessica, Karen, Kim, Leanne, Michelle, Sarah, Shawna
Preference for Female Doctor	Carla, Jenna, Kari
Being Taken Seriously	Alicia, Anne, April, Carla, Diane, Emily, Jenna, Leanne, Sarah
Presence of Emotion	Alicia, Anne, Leanne

Culture of the Medical Profession

Diagnostic Bias

Symptoms Considered Psychosomatic	Alicia, Anne, Diane, Jenna, Jessica, Kim, Leanne
Symptoms Attributed to Lifestyle	Carla, Jenna, Leanne

Medical Knowledge

TSH Testing is Standard	Anne, Carla, Diane, Jenna, Karen, Kim, Michelle, Sarah, Shawna
Synthetic Medication is	

Standard	Anne, Carla, Emily, Karen, Jessica, Kim, Leanne, Michelle, Sarah, Shawna
Continuing Education May Be Needed	Anne, April, Autumn, Carla, Diane, Emily, Jenna, Jessica, Karen, Kari, Kim, Leanne, Michelle, Sarah, Shawna

Economics

Feeling Rushed	Autumn, Jessica, Leanne
Access to Doctor	Autumn, Carla, Jenna, Kari, Kim, Leanne, Michelle, Shawna
Access to Medication	Anne, April, Carla, Karen, Kim, Shawna

Additional Findings

Public is Misinformed	Diane
Experience of Grief	Carla
Experience of Empathy	Michelle
Experience of Respect	Michelle