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DETERMINATION OF SELF-ESTEEM, SEXUAL SELF-EFFICACY, ANXIETY AND DEPRESSION LEVELS OF WOMEN WITH HIRSUTISM

DETERMINAREA STIMEI DE SINE, A AUTOEFICACITĂȚII SEXUALE, A NIVELULUI DE ANXIETATE ŞI DEPRESIE A FEMEILOR CU HIRSUTISM

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Abstract

Aim: The aim of this study was to investigate the self-esteem, sexual self-efficacy, anxiety and depression levels of women with hirsutism.

Method: The population of our study consisted of married women who were diagnosed as hirsutism and who were controlled in a public hospital in Isparta. Hospital Anxiety and Depression Scale (HADS), Sexual self-efficacy scale and Rosenberg Self-Esteem Scale (RSE) are used to determine anxiety, depression, sexual self-efficacy levels and participants' self-esteem.

Results: When the working status of the women was examined, a significant difference was found between the mean scores of RSE and sexual self-efficacy scale. There was a significant relationship between the status of having friends and HAD DEP, self-esteem scale and sexual self-efficacy scale mean scores.

Conclusion: Treatment in women presenting with excessive hair growth should not be considered as a symptomatic treatment plan.

Rezumat

Scop: Scopul acestui studiu a fost de a investiga stima de sine, autoeficacitatea sexuală, nivelurile de anxietate și depresie la femeile cu hirsutism.

Metodă: Populația studiului nostru a constat în femei căsătorite care au fost diagnosticate cu hirsutism și care au fost controlate într-un spital public din Isparta. Scala de Anxietate și Depresiune (HADS), Scala de autoeficiență sexuală și Scala de autostimă Rosenberg (RSE) sunt utilizate pentru a determina anxietatea, depresia, nivelurile de autoeficiență sexuală și respectul de sine al participanților.

Rezultate: Când s-a examinat starea femeilor, s-a constatat o diferență semnificativă între scorurile medii ale RSE și scala de autoeficiență sexuală. A existat o relație semnificativă între statutul de a avea prieteni și HAD DEP, scala de stimă de sine și scala de autoeficiență sexuală.

Concluzie: Schema de tratament la femeile care prezintă o creștere excesivă a părului nu trebuie considerat doar o metodă de tratament a simptomelor.

Key-words: *Hirsutism, quality of life, anxiety, depression, self-esteem*
Cuvinte cheie: *Hirsutismul, calitatea vieții, anxietatea, depresia, respectul de sine*

Introduction

Hirsutism is an endocrinological disorder characterized by undesirable and male pattern hair growth, which can be caused by a wide range of clinical causes, among them it generally develops on the diagnosis of polycystic ovary syndrome *(Pate C, 2013; Ferrante J, 198; Al-Ruhaily AD, 2008).*

It is seen more frequently after puberty and in premenopausal period *(Al-Ruhaily AD, 2008).* In the treatment of hirsutism, hormone suppression therapies, androgen suppressors and different cosmetic hair removal methods (electrical or laser hair removal, depilatory creams, products that block hair growth… etc.) are used *(Azziz R, 2003).* But the most important aspect, the psychological aspect is neglected. Studies show that the quality of women's life is adversely affected by even a small amount of hair growth. (*Lipton MG, 2006; Chachia L,*

2018; Ekback M, 2009; Onselen JV, 2011)

In Turkey, studies in areas such as genetic distribution and prevalence of hirsutism were not encountered too much. In a research, hirsutism was found to be widespread among women in the Black Sea region and Eastern Anatolia ethnically *(Cebeci F, 2014).* Data was found that women with hirsutism should be subjected to multiple evaluations and that treatment should not be considered unidirectional *(Cebeci F, 2014; Akin L, 2012).* In studies examining the genetic structure of Anatolia, it was found that hirsutism is a common problem, and in some accompanying clinical findings it was reported to have negative effects on life and marriage. *(Salman KE, 2017; Polat S, 2019; Demir B, 2011)*

This study was conducted to investigate the self-esteem, sexual self-efficacy, anxiety and depression levels of women with hirsutism.

Methods

Study Design

In this study, the self-esteem, sexual self-efficacy, anxiety and depression levels of women with hirsutism were defined as descriptive.

Population and Sample

The population of our study consisted of married women who were diagnosed as hirsutism and who were controlled in endocrine and metabolic diseases polyclinics and gynecology and obstetrics clinics of a public hospital in Isparta. The sample group consisted of women who accepted the study and came to clinic control during the study period.

Procedure

The data in our study was collected between October 2018 and December 2018 with all necessary permissions. The data collection form used in our study was prepared by the researchers after reviewing the literature. The main purpose of using this form is to obtain more detailed information about the sample group and to obtain a more comprehensive opinion on the subject and thus, to make the analysis and interpretation of the data more clear. For the diagnosis of hirsutism, patients were evaluated by the Endocrinologist. Modified Ferriman-Gallwey (FG) scoring was used to evaluate hirsutism. Scoring was performed according to thickness, frequency and length of terminal hairs in eight different body regions (upper lip, chin, chest, back, waist, upper abdomen, lower abdomen, arm, and thigh). These areas were scored on a scale of 0 (no terminal hair growth) and 4 (dense terminal hair growth). Patients with a total score of 8 or more were defined as patients with hirsutism.

Data collection tools:

Sexual self-efficacy scale

It is a one-dimensional scale developed to determine the sexual self-efficacy levels of individuals. It is based on patients' giving information about themselves. It is a 5-point Likert type scale. (1 strongly disagrees - 8 strongly agree). While scoring the scale, questions 3 and 4 were evaluated in reverse order. Score increase indicates a high level of sexual self-efficacy. In the reliability study, Cronbach's Alpha coefficient was found to be 0.71. Sexual self-efficacy scale was developed by Humphreys et al. in 1983 and adapted to Turkish with a validity and reliability study by Çelik in 1983.

Hospital Anxiety and Depression Scale (HADS)

Hospital Anxiety and Depression Scale (HADS) was developed by Zigmond and Snaith in 1983 and adapted to Turkish with validity and reliability study by Aydemir et al. in 1997. HADS comprises 14 questions. In the reliability study, Cronbach's Alpha coefficient for anxiety subscales was found to be 0.85 and depression subscales it was found to be 0.77. The lowest score for each subscale is 0 and the highest score is 21. Those who score above 10 for Hospital Anxiety Scale (HAD ANK) subscale and 7 for Hospital Depression Scale (HAD DEP) subscale are considered as risk group. HADS is also used to assess the change in the emotional state of the patient.

Rosenberg Self-Esteem Scale (RSE)

The Rosenberg Self-Esteem Scale (RSE) was developed in 1963 by Morris Rosenberg; The scale was frequently used in adult and adolescence in line with reliability studies. The Turkish validity and reliability study of RSE in adolescents was conducted in 1986 by Çuhadaroğlu 1986. The validity and reliability of the RSE-Adult version, which we used in our study, was done by Korkmaz et al. in 1996. RSE comprises 14 questions and it is a multidimensional scale consisting of 63

multiple-choice questions and 12 sub-areas. The first area directly measures self-esteem, whereas the other sub-areas measure factors associated with self-esteem. Sub-domains are, respectively; Self-esteem, Continuity of the concept of self, Trust in people, Sensitivity to criticism, Depressive affect, Dreaminess, Psychosomatic information, Feeling threat in interpersonal relations, Participation in discussions, Parental interest, Relationship with father, Psychic isolation. The first of these sub-domains, the Self-esteem subscale, contains 10 items and it has 5 inverse questions. The scores of this field are evaluated out of 6 points and the self-esteem is inversely proportional to the points.

Statistical analysis

Data were analyzed using SPSS 20.0 program by transferring to a computer.

Results

The research was attended by a total of 986 women. The mean age was 31.97±8.76 years. It was found that 470 (47.7%) of the women lived in the province for the longest time, more than half of them (52.9%) had moderate economic status, nearly half (49.1%) were university graduates (Table 1). The total score averages of women obtained from the scales used in the research were; 10.80 ± 4.18 from HAD ANK, 9.98 ± 4.85 from HAD DEP, 3.38 ± 1.57 from RSE, and 19.12 ± 7.12 from sexual self-efficacy scale. The descriptive characteristics of women and the distribution of the mean scores obtained from the scales used in the research were shown in table 1. A statistically significant difference was found between the mean scores of HAD DEP and self-esteem scale according to where women lived for the longest time ($p < 0.05$). A statistically significant difference was found between educational status and mean HAD DEP score ($p < 0.05$). When the working status of the women was examined, a significant difference was found between the mean scores of RSE and sexual self-efficacy scale ($p < 0.05$). There was a statistically significant difference between social security status and HAD DEP mean scores ($p < 0.05$). There was no statistically significant difference between the mean scores of HADS ANK and the place where women lived for the longest time, educational status, working status, social security status and family structures ($p > 0.05$). There was no statistically significant difference between the economic status, working status, family structure and HAD DEP mean scores of women ($p > 0.05$). There was no statistically significant difference between the descriptive characteristics of women, economic status, educational status, social security status, family structure and RSE scores ($p > 0.05$). No statistically significant difference was found between the place of residence, economic status, educational status, social security status, family structure and sexual self-efficacy scale scores of the women participating in the study ($p > 0.05$) (Table 1).

		n	**%**	**HAD ANK**	**HAD DEP**	**RSE**	**Sexual self-efficacy**
Longest-lived place	Big city	278	28,2	10,63±4,14	9,45±4,54	3,17±1,50	19,37±6,88
	City	470	47,7	10,86±4,22	9,98±4,95	3,42±1,62	19,15±7,45
	Town	148	15,0	10,75±4,33	10,19±5,26	3,40±1,63	18,93±6,93
	Village	90	9,1	11,07±3,90	11,31±4,37	3,74±1,36	18,53±6,46
			KW	0,910	10,932	9,563	1,374
			p	0,823	0,012	0,023	0,712
Economic Status	Very good	51	5,2	10,56±2,97	10,11±4,38	3,41±1,48	18,70±6,75
	Good	389	39,5	10,80±4,32	9,83±4,80	3,45±1,59	18,84±7,01
	Moderate	522	52,9	11,00±4,15	10,09±4,91	3,33±1,58	19,38±7,16
	Bad	24	2,4	6,66±2,53	9,75±5,58	3,25±1,35	18,95±8,77
			KW	25,517	0,688	1,716	1,454
			p	0,000	0,876	0,633	0,693
Education	Not Literate	11	1,1	9,54±2,87	7,63±2,57	3,72±1,42	19,54±4,39
	Literate	116	11,8	10,99±4,47	9,71±4,91	3,32±1,41	20,39±7,77
	Primary school	79	8,0	10,65±3,65	9,69±4,40	3,10±1,61	20,18±7,63
	Secondary school	73	7,4	10,80±4,13	10,50±4,75	3,20±1,64	17,94±7,27
	High school	223	22,6	10,32±4,08	9,18±4,70	3,65±1,56	19,66±7,12
	University	484	49,1	11,02±4,27	10,44±4,98	3,33±1,59	18,57±6,84
			KW	6,234	14,871	10,747	10,255
			p	0,284	0,011	0,057	0,068

Working status	Yes	405	41,1	10,36±4,18	9,72±4,90	3,54±1,56	19,99±7,16
	No	581	58,9	11,10±4,16	10,16±4,81	3,15±1,56	18,52±7,04
			t	-2,752	-1,409	-3,859	3,200
			p	0,006	0,159	0,000	0,001
Social security status	Yes	737	74,7	10,66±4,19	9,75±4,89	3,34±1,56	19,19±7,01
	No	249	25,3	11,21±4,16	10,67±4,67	3,48±1,61	18,91±7,44
			Z	-1,632	-2,634	-1,356	-0,845
			p	0,103	0,008	0,175	0,398
Family type	Nuclear family	868	88,0	10,81±4,21	10,07±4,85	3,37±1,57	19,11±7,05
	Extended family	118	12,0	10,72±3,99	9,36±4,88	3,44±1,57	19,23±7,63
			Z	-0,346	-1,267	-0,323	-0,318
			p	0,730	0,205	0,747	0,750

Table 1. Distribution of descriptive characteristics of women according to scale scores [n=986]

The distribution of the social circle status of the women participating in the study, according to the mean scores of the scales used in the study is shown in Table 2. There was a significant relationship between the status of having friends and HAD DEP, self-esteem scale and sexual self-efficacy scale mean scores ($p < 0.05$), whereas there was an insignificant relationship between mean HAD ANK scores ($p > 0.05$).

In addition, a significant relationship was found between the age groups of the female friends and the frequency of meeting with friends and the mean scores of all scales used in the study ($p < 0.05$). The distribution of the hirsutism status of the women participating in the study according to their scale scores is shown in Table 2. The mean FGS score of women was 14.94 ± 6.75.

		n	**%**	**HAD ANK**	**HAD DEP**	**RSE**	**Sexual self-efficacy**
Social Circle	Yes	865	87,7	10,84±4,25	10,19±4,95	3,44±1,59	18,78±7.05
	No	121	12,3	10,50±3,70	8,49±3,78	2,92±1,40	21,57±7,17
			Z	-1,252	-3,513	-3,510	-4,186
			p	0,211	0,000	0,000	0,000
Friends age group	Same age	552	56,0	10,73±4,29	9,94±5,00	3,35±1,61	19,04±6,97
	Older	31	3,1	9,29±4,32	8,67±5,02	2,90±1,73	22,00±7,64
	Younger	24	2,4	9,45±4,19	10,79±5,80	4,00±1,35	18,29±7,75
	All ages	258	26,2	11,38±4,08	10,86±4,68	3,64±1,51	17,87±6,96
			KW	11,486	10,825	11,375	11,789
			p	0,009	0,013	0,010	0,008
Frequency of meeting friends	Too often	132	13,4	12,80±3,54	13,30±4,26	3,77±1,40	16,09±5,22
	Quite often	485	49,2	12,12±3,62	11,83±4,02	3,49±1,59	18,29±7,04
	Rarely	369	37,4	8,34±3,93	6,36±3,70	3,08±1,56	21,30±7,21
			KW	212,708	350,490	24,080	65,970
			p	0,000	0,000	0,000	0,000

Table 2. Distribution of social status of women according to scale scores

Significant differences were found between the initiation of hirsutism treatment, regular physician control, support type to manage hirsutism, anxiety after non-drug methods and scales used in the study ($p < 0.05$). Furthermore no statistically significant difference was found between patients' going to the endocrine doctor control, the use of non-drug methods, and the scales used in the study ($p > 0.05$). There was a statistically insignificant difference between hirsutism knowledge levels of women and HAD ANK, RSE, sexual self-

efficacy scale (p> 0.05). There was an insignificant relationship between women's sources of information about hirsutism and HAD ANK, HAD DEP, RSE (p> 0.05). A statistically significant difference was found between the clinic of diagnosis of hirsutism and HAD DEP and sexual self-efficacy scales (p <0.05). A significant difference was found between HAD ANK, HAD DEP, RSE and non-drug method used by women for a long time (p <0.05).

		n	%	HAD ANK	HAD DEP	RSE	Sexual self-efficacy
The level of knowledge about hirsutism	Adequate	491	49,8	11,02±4,05	10,44±4,95	3,31±1,59	18,99±7,02
	Partially adequate	391	39,7	10,54±4,27	9,49±4,59	3,45±1,55	19,05±7,38
	Inadequate	104	10,5	10,72±4,48	9,65±5,19	3,41±1,59	20,02±6,57
			KW	3,002	8,276	1,783	2,724
			p	0,223	0,016	0,410	0,256
Hirsutism information source	Doctor	209	21,2	10,61±4,08	10,20±4,97	3,59±1,62	17,51±7,04
	TV / Press	148	15,0	10,68±3,85	9,45±4,50	3,29±1,56	19,53±7,48
	Family	100	10,1	10,68±4,17	9,96±5,13	3,05±1,65	19,89±7,40
	Close circle	142	14,4	11,41±4,21	10,29±5,05	3,20±1,54	19,93±6,38
	Others	283	28,7	10,75±4,31	10,08±4,62	3,46±1,52	19,09±7,29
	I haven't information	104	10,5	10,72±4,48	9,65±5,19	3,41±1,59	20,02±6,57
			KW	4,120	3,447	10,049	19,004
			p	0,532	0,631	0,074	0,002
Clinic which the patients diagnosed as hirsutism	Gynecology clinic	260	26,4	10,80±4,26	10,62±4,98	3,50±1,51	18,40±7,22
	Internal Medicine Outpatient Clinic	170	17,2	11,21±4,36	9,96±4,39	3,29±1,51	19,42±7,16
	Endocrine Outpatient clinic	219	22,2	10,38±3,96	9,32±4,73	3,37±1,71	18,85±7,29
	Dermatology clinic	174	17,6	11,21±4,07	10,27±4,86	3,48±1,50	18,61±6,45
	Other clinics	134	13,6	10,49±4,24	9,65±5,20	3,17±1,65	21,61±6,97
	I wasn't diagnosed	29	2,9	10,44±4,29	9,20±4,98	3,24±1,47	17,44±7,08
			KW	6,450	11,731	5,758	23,762
			p	0,265	0,039	0,330	0,000
The control of the Endocrinologist	Yes	551	55,9	11,02±4,08	10,21±4,79	3,31±1,57	18,90±6,99
	No	435	44,1	10,51±4,30	9,70±4,92	3,46±1,58	19,40±7,29
			t	1,879	1,642	-1,550	-1,088
			p	0,061	0,101	0,122	0,277
Starting treatment	Yes	411	41,7	11,18±4,14	10,76±4,80	3,73±1,45	17,30±6,54
	No	575	58,3	10,52±4,20	9,42±4,81	3,12±1,61	20,42±7,24
			t	2,454	4,313	6,094	-6,942
			p	0,014	0,000	0,000	0,000
Regular control	Yes	390	39,6	11,39±3,99	11,02±4,60	3,72±1,47	17,27±6,49
	No	596	60,4	10,41±4,27	9,30±4,90	3,15±1,60	20,34±7,26
			Z	-3,624	-5,436	-6,575	-5,484
			p	0,000	0,000	0,000	0,000

Way of getting rid of hirsutism	Hormone Therapy	81	8,2	11,24±3,76	10,96±5,02	3,30±1,54	19,30±6,08
	Psychological support	23	2,3	8,21±2,77	6,91±2,42	4,30±1,45	20,86±10,39
	Hormone and psychological support	89	9,0	12,32±4,01	12,41±4,42	4,08±1,41	16,17±7,12
	Only regular control	112	11,4	10,17±4,35	9,43±5,08	3,25±1,58	19,49±7,19
	Aesthetic centers	425	43,1	10,71±4,22	9,95±4,96	3,22±1,56	19,62±6,75
	Other methods	181	18,4	10,62±4,15	9,33±4,47	3,20±1,67	19,20±8,04
	Treatment started but not using	75	7,6	11,13±4,26	9,57±4,48	3,81±1,25	18,32±5,72
			KW	24,266	41,454	35,971	23,667
			p	0,000	0,000	0,000	0,001
Hair removal with a non-drug method	Yes	822	83,4	10,89±4,17	10,00±4,72	3,39±1,55	19,05±7,00
	No	164	16,6	10,34±4,23	9,87±5,46	3,32±1,71	19,49±7,72
			Z	-1,587	-0,664	-0,589	-0,459
			p	0,113	0,507	0,556	0,647
What is your non-medication method	Laser	194	19,7	10,50±4,30	9,41±4,61	3,52±1,62	18,75±6,98
	Needle	455	46,1	10,91±4,20	10,16±4,91	3,34±1,52	19,18±7,20
	Wax	91	9,2	11,54±3,94	10,75±4,88	3,13±1,43	20,07±6,29
	Cream	53	5,4	12,15±3,42	11,37±3,60	3,35±1,53	17,33±6,55
	Tea	29	2,9	10,17±3,53	9,34±3,91	4,06±1,55	18,10±6,00
			KW	11,142	9,836	10,731	7,602
			p	0,025	0,043	0,030	0,107
Worry and anxiety level after drug use	Less worried	372	37,7	10,48±4,26	9,41±4,91	3,28±1,54	20,19±6,98
	More worried	210	21,3	10,99±4,02	10,32±4,67	3,66±1,54	17,43±7,02
	No	240	24,3	11,61±3,98	10,96±4,42	3,30±1,53	18,58±6,69
			KW	10,281	15,413	9,281	25,057
			p	0,006	0,000	0,010	0,000

Table 3. Distribution of hirsutism status of women according to scale scores

Table 4 shows the distribution of women's concerns about hirsutism. It was found that 84,1% of the women were worried frequently after hair growth, 80,4% of them were worried frequently due to the deterioration of their relationship with their husband, 71,6% of them were worried frequently due to the deterioration of their economic situation. It was found that 49,4% of the women were worried occasionally because their body was becoming uglier, 44,6% were worried occasionally because of breaking their relations with their neighbors, and 16,6% were never worried about their relationship with their children.

Concerns about hirsutism	**Often**		**Sometimes**		**Never**	
	n	**%**	**n**	**%**	**n**	**%**
Gender acceptance status	406	41,2	387	39,2	193	19,6
Regretting being a woman after hair growth	829	84,1	131	13,3	26	2,6
Losing physical health	636	64,5	297	30,1	53	5,4

Disfiguration of my body	364	36,9	487	49,4	135	13,7
Impairment of my mental health	677	68,7	274	27,8	35	3,5
Deterioration of my relationship with my husband	793	80,4	172	17,4	21	2,1
Disruption of my relationship with my children	456	46,2	366	37,1	164	16,6
Breaking my relationship with my friends	626	63,5	261	26,5	99	10,0
Breaking my relations with my neighbors	308	31,2	440	44,6	238	24,1
Deterioration of our economic situation	706	71,6	236	23,9	44	4,5

Table 4. Distribution of women's anxiety about hirsutism

Discussion

Hirsutism is an undesirable situation for women. Although the relationship between the psychological and social conditions of women diagnosed with hirsutism seems complex; Hirsutism causes problems such as anxiety and depression in 80% of women *(Dawber RP, 2005).* Especially hair growth in the face area causes deterioration in the perception of body image in women. In these cases, quality of life is adversely affected *(Pate C, 2013).* In order to struggle with known or unknown causes of hirsutism, cosmetic products (shaving, depilatory or bleaching products, herbal creams, waxing, laser types electrolysis…) can be preferred even if treatment is not started since it can slow the growth of hairs. Particularly as a result of hairs' thinning and decreasing after laser, an increase in positive opinions and more psychological healing are stated *(Dawber RP, 2005; Grippaudo FR, 2009; Loo WJ, 2002).*

In this study, it was found that women spent a lot of time and money especially for the treatment of facial hairs. The most common and long-term method that the women in our study used is needle hair removal. It was found that HAD ANK, HAD DEP, self-esteem and sexual self-efficacy scores increased as their worry and anxiety level increased when they could not achieve the expected benefit from the method they used. Also in our study, the data obtained from the questions about social environments showed that HAD ANK and HAD DEP levels were high, patients' self-esteem and sexual self-efficacy were low ($p<0.001$).

Similarly, in other studies, it was reported that hirsutism affects women's social status and it may cause emotional stress and clinical anxiety. *(Lipton MG, 2006; Loo WJ, 2002)*

In our study, high anxiety and depression due to low economic and educational level of women, not knowing or not buying alternatives about hirsutism treatment were found associated with bad self-esteem and sexual self-efficacy ($p<0.05$). In our study, it was found that women who felt more hairy had higher FSG score and high anxiety levels. In a similar study, the rate of women who personally perceived the hairy body was found to be higher than the clinically really hairy ones, and it was found that this group had higher anxiety rates *(Chachia L, 2018).* In the literature, the presence of hirsutism as a subdimension in women diagnosed with polycystic ovary was examined. Not much research on just idiopathic hirsutism was found. Hirsutism not only reduces the quality of life of women, but also has a negative impact on psychology. In studies conducted about women with hirsutism, contradictory results were initially revealed between depression levels and difficulties in social life. *(Pate C, 2016; Sonino N, 1993; Keegan A, 2003).* In another study, self-esteem was found high in women with hirsutism *(Keegan A, 2003).*

In many studies in which women with hirsutism were questioned about their approach to patient examination, it was found that women could not tell their history of the disease, they were not taken seriously, their complaints were not listened properly, and therefore they felt rejected and left on their own for treatment.

It was also reported that they had to allow hair to grow in order to prove the reality of the problem they were experiencing, and that examination makes them feel seriously vulnerable and embarrassed. In addition, other studies were found that women with hirsutism have low self-confidence *(Keegan A, 2003; Ekbäck M, 2013; Ekbäck M, 2011; Hahn S, 2005).*

In trainings given to health professionals, approaches that cause such communication and idea problems can be corrected by empathy, reflection, professionalism and role play approaches. These trainings may improve the perspectives of health professionals so they may find different approaches for coping with the patient's condition in treatment (*Charon R, 2001).* Problems related to sexuality, which is an important basis of marriage, can be experienced. Problems are not limited to sexuality only. Marriage has relation with basic factors such as harmony and quality of life. There are also ideas that hirsutism cause personality disorders, psychological problems and adjustment disorders. In the study of Çelik, the concept of sexual self-efficacy was defined as 'Individuals' beliefs about their ability to perform the emotional reactions and behaviors in sexual context successfully. Based on this definition, high level of sexual self-efficacy is an important factor that will positively affect sexual adaptation and satisfaction and at the same time it decreases the incidence of psychological problems arising from sexuality.

In addition, relationship was found between the lack of sufficient information about hirsutism, the lack of adequate explanation in the outpatient clinic, the preference for managing the diagnosis of hirsutism, the presence of decreased body hair and sexual self-efficacy. With good and accurate informing; accurate planning of treatment and disease management can effect body perception, psychological status and self-esteem by increasing sexual self-efficacy perceptions positively. Sexual attraction that people perceive about themselves is a personal perception that directly affects sexuality and body image. People's perception of being attractive, having the ability to evoke sexual desire in others, providing more sexual pleasure, affect the competence of issues related to addressing another person's sexual desire *(Townsend JM, 1997; Amos N, 2015).*

Partner's sexual respect is one of the factors that increase sexual self-efficacy. It has been shown that individuals who do not feel sexually attractive have less sexual orientation, feel more insecure, feel uncomfortable in their social environments, and experience anxiety of failure and error more *(Amos N, 2015; Rudy BM, 2012; Thomasson P, 2010).*

It has been shown that individuals with psychological negative thoughts show more avoidance behaviors and they have less sexual self-confidence and self-efficacy *(Dosch A, 2016).* Unlike our study, Reissing et al. (2005) reported in a study that sexual self-efficacy affects sexual adaptation. For him negative body image was associated with the increase of sexual reluctance but it was not significantly related to sexual adaptation and sexual self-efficacy.

Conclusion and Recommendations

Treatment in women presenting with excessive hair growth should not be considered as a symptomatic treatment plan. In addition, who women admitted to the clinic, do not meet diagnostic criteria according to FG scoring, ıt should be noted that it is important that they feel extremely hairy.

Due to the high number of patients in our country, only hair growth levels are generally considered in order to evaluate patients more rapidly during the examination. The results of our study point out that this evaluation method is quite incomplete and inadequate. Hirsutism should not only be considered a physical problem, but also its psychological aspects. The psychological, social and sexual problems of the affected patients in the future may cause social problems, isolation, and a more challenging and longer treatment process including psychological problems and disruptions in marital life. The uneasiness of the patients who come to the examination should be removed, their privacy should be respected and they should be encouraged to express themselves. It is also important to question patients' social adaptation, anxiety, depression, sexual self-efficacy and to guide treatment and care.

Limitations of the study

The results obtained in this study can be generalised only to its sample and are limited by the scope of the scales used.

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