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MENTAL HEALTH AND QUALITY OF LIFE AMONG WOMEN WITH INCONTINENCE

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ABSTRACT

Incontinence is an individual's involuntary incontinence of urine and/or feces. It is a serious health problem that significantly affects the individual's mental health and quality of life. Women experience incontinence 3-4 times higher than men, and the prevalence of incontinence continuously increases with age in both sexes.

The diagnosis, treatment, and rehabilitation process affect an individual psychologically, physically, socially, and emotionally. Women who suffer from incontinence restrict daily life, such as not exercising, traveling, and having social and emotional interactions. Over time women socially isolated and may lose their self-confidence. It decreases the quality of life with feelings of shame, depression, anxiety, and discomfort. This process affects women's mental health.

The review aims to examine the effects of incontinence on women's mental health and quality of life in line with current researches and suggestions that women's health and psychiatric nurses implement in the clinic areas.

Keywords: Mental Health, Depression, Quality of Life, Women, Incontinence

INTRODUCTION

Urinary incontinence (UI) is defined as involuntary loss of urine that causes social and hygienic problems, and fecal incontinence (FI) is defined as involuntary loss of solid or liquid feces by the International Continence Society (ICS) (1). There are three sub-types of UI, which are stress urinary incontinence (SUI), urgency urinary incontinence (UUI), and mixed urinary incontinence (MUI). SUI occurs during physical activity or exertion that increases the intra-abdominal pressure (e.g., sneezing, coughing, laughing, swimming, running). On the other hand, UUI occurs when bladder muscles contract involuntarily with a feeling of strong urge. Additionally, MUI is a combination where the patient experiences both SUI and UUI symptoms simultaneously (2-5).

In society, UI is a common disorder and affects women from all walks of life. The prevalence of UI is

expected to be higher due to the lack of reporting (6). In women, the prevalence is 2-3 times higher than in men. Despite the fact that most studies demonstrate that incontinence is more common in older women, it can affect any woman at any age (7, 8). In a systematic review and meta-analysis by Pizzol et al. (2021), it was shown that the rates of UI in the studies were found to have a wide range (9). The wide range of it can be caused by the sampling, UI reporting, and research methodology. The rate of UI among women aged 60 and over is 25% in America and 56.3% in Korea (10, 11). The prevalence among women is ranged from 8.7% to 69.8% in China and varies between 25-45% in Australia and 20.9-37.1% in Turkey (12, 13, 14). There is uncertainty in the prevalence and incidence rates of FI. The reasons are the different examination methods used in the doctor's visit, people with FI tend to hide it, and it is not easy to diagnose. In the epidemiological studies

conducted in other countries, it is stated that FI prevalence varies between 1.4 to 12.7% (15). Further, these rates are considered to be higher in places such as geriatric wards and nursing homes. Several factors increase the chance of developing both UI and FI. Age, urinary infections, chronic constipation, surgical operations such as hysterectomy, episiotomy, menopause, and comorbid conditions such as obesity, diabetes, and/or stroke are among the risk factors. In the studies conducted by Yılmaz et al. with 200 women and Terzi et al. with 555 women, menopause was an important one among the UI risk factors (16, 17). Furthermore, smoking, one of the modifiable risk factors, increases the prevalence of UI (18). Risk factors for FI are obstetric traumas, comorbid neurological disorders, diabetes, and, more importantly, chronic diarrhea (19).

Women with incontinence have problems such as shame, decreased self-esteem and self-confidence, social phobia, social isolation, and difficulty performing daily living activities (20, 21). Moreover, women have to deal with the health care expenditure burden of care. Consequently, women with UI have a low tendency to seek help. In a study, it takes three years of 66.4% of women who had incontinence problems to visit a doctor (22). Similar results were found in Ozturk et al.'s (2012) study, and it was found that most of the women did not visit a doctor with the complaint of incontinence, and during doctor's visit, the problem never questioned (23). Women are ashamed of UI and not seeing it as a health problem.

Most women have perceived it as a natural result of aging, and they have a low tendency to seek any treatment for incontinence. In the study of Southall et al. (2017), the primary reason for it was determined to be self-stigma and a lack of knowledge about the treatment (24).

Incontinence, which affects the lives of women, may trigger depression after a while. According to the World Health Organization (WHO), depression is the leading cause of diseases' global burden (25). Both incontinence and depression are among the disorders exposed to social stigma, where patients' help-seeking behavior is low, and being diagnosed is difficult. Depression comorbidity to incontinence causes the woman to feel more embarrassed, having fewer social interactions, and eventually increase social isolation and decrease in quality of life (26). The review aims to examine the effect of incontinence on women's mental health and quality of life and are in line with current studies to suggest nurses who work on women's health and/or psychiatric ward.

Mental Health of Women with Incontinence

UI incidence increases day by day and affects the physical, mental, and social well-being of women and the quality of life. Incontinence also has adverse psychosocial effects on women, such as bad smell, feeling dirty and inadequate, decreased self-esteem, shame, stigma, sadness, stress, aggression, depression, decreased sexual arousal and avoiding sexual activity (8, 27, 28). It has been reported that women with incontinence experience more social

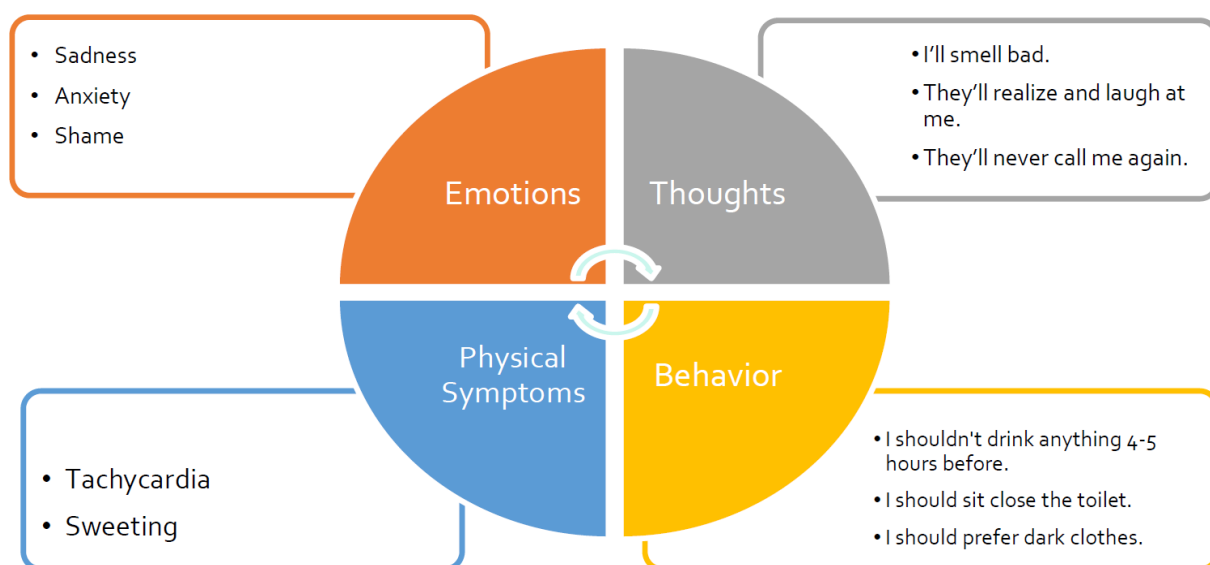


Figure 1. Psychosocial experiences of a woman invited to chat with her friends.

isolation, stress, loneliness, anxiety, and depression than women who are not incontinent over time (11, 29). The depression rate was found to be higher in the elderly and those with incontinence. The reason is that incontinence affects social interaction negatively. Further, depression, anxiety, and incontinence are among the disorders that social stigma appears. Therefore, there may be difficulties in diagnosis by healthcare professionals (30). (Figure 1)

The literature shows that depression and/or anxiety are frequently seen in individuals with incontinence (8, 28, 31, 32). UUI can cause social stigma and anxiety in women. Due to concerns such as not being able to go to the toilet quickly, a feeling of wetness, and a bad smell, she does not want to perform daily life activities and lead a more isolated life (33). Likewise, depression can be observed in these women due to a decrease in social functionality.

Assessment methods cannot provide a healthy result of the relationship between incontinence and depression and/or anxiety. In the study by Felde et al. (2012), using the "*Hospital Depression and Anxiety Scale - HADS*"; it was determined that the rate of major depression in women with incontinence is 11.8% (7.2% in women with continence), and anxiety rate is 25.8% (17.6 in women with continence) (31). In another study conducted in the US, "*Beck Depression*" and "*Beck Anxiety*" scales were used, and depression was found in one of every three women. 20.4% of women with incontinence have severe depression (32). In a study conducted in Korea, the level of depression and anxiety was questioned with "yes" and "no" questions form, and the presence of depression/anxiety was found at the rate of 8.3% (n = 189) (11). In another study women with incontinence in Ireland, 6903 women participated in this study. UCLA-Loneliness Scale, Depression CES-D, and HADS-Anxiety scales were used, and as a result, UI was found to be a factor related to depression, which increases loneliness (8).

In the study of Felde et al., rates of depression and anxiety vary according to the type of incontinence. In the literature, depression was 9%, and anxiety was 22.9% in women diagnosed with SUI; depression 11.7%, anxiety 28.1% in women diagnosed with UUI; depression is 16.9% and anxiety 32.0% in women diagnosed with MUI (31). In the study conducted with 15,860 women in Sweden, England, and America, anxiety and depression were found high in women diagnosed with UI. When UI sub-types are analyzed,

it is found that women's mental health diagnosed with UUI are more affected than others (34). Similarly, in another study conducted with 1116 women diagnosed with UI in Korea, the rate of depression in women with moderate UI was 7.0% and was 16.8% in severe cases. There was a strong relationship between incontinence and depression (35).

When the outcomes of the treatments are examine in a systematic review by Radzimińska et al. in 2018, there is evidence that the positive outcomes of incontinence treatment result in the regression of psychiatric symptoms. Concurrently, many patients' quality of life is thought to be improved by incontinence treatment (36). However, treatment of depression and anxiety accompanying incontinence should also be planned.

Pharmacotherapy and psychosocial interventions are recommended to be used in the treatment of psychiatric disorders (37). In treating depression with psychopharmacological agents; Selective serotonin reuptake inhibitors (SSRI) such as Paroxetine, Fluoxetine, Sertraline, Citalopram, and Escitalopram are preferred by clinicians because they have the least side effects. Caution should be exercised in the elderly since medications in the tricyclic antidepressant group such as Amitriptyline, Desipramine, Doxepin, Imipramine, and Nortriptyline have side effects such as orthostatic hypotension and confusion. However, this class of drugs can improve some types of incontinence. Monoamine oxidase inhibitors (MAOI such as Phenelzine, Tranylcypromine) cause severe hypertension when taken together with tyramine-containing foods (some cheeses, wine, and beer) and are less preferred due to drug-drug interactions (38, 39). In addition to pharmacotherapy, the problem-oriented "*Cognitive Behavioral Therapy (CBT)*" developed by Beck based on behavioral, psychological counseling theories in the 1960s is used. Besides, "*Interpersonal Psychotherapy (IPT)*", which describes depression with interpersonal situations, focuses on "now and here" and is a time-limited form of therapy (40, 41).

In treating anxiety, the drugs belonging to the benzodiazepine group such as *Alprazolam*, *Clonazepam*, *Diazepam*, *Lorazepam*, and *Oxazepam* are used, and additionally, suitable antidepressants can be used together in the treatment. In addition to CBT, "*Behavioral Therapy with Applied Relaxation Therapy*" is applied to treat anxiety (38). Nowadays, routine psychological evaluations are not made during the diagnosis and treatment process.

Consultation-liaison units, which include health professionals in the field of urogynecology and psychiatry, should be established in healthcare institutions to be in contact with patients. Patients with suicidal potential should be prioritized among patients who show advanced depression or anxiety symptoms during the evaluations. In this case, the patient may need to be admitted to the psychiatric units. Cooperation with the family can help overcome this process more comfortably, other cases that do not require hospitalization. While the female patient manages incontinence and treatment, she cannot adapt to the treatment of depression. In cases of severe depression, discharge training should be conducted on the subjects that depression is repetitive, and drug compliance is essential in the effective management of treatment (42, 43).

While working with a case diagnosed with incontinence and depression, nurses can feel anger and helplessness. As a result of not noticing their feelings, there are possibilities to enter into unrealistic expectations and negatively affect the maintenance process. In this case, it is necessary to get supervision (42).

Quality of Life among Women with Incontinence

In the definition of health by WHO (1948), attention was paid to the psychological aspect, and the importance of ensuring complete well-being was emphasized (44). Incontinence is a significant health problem that does not threaten life but negatively affects life quality and general health perception. Therefore, along with the physical dimension, it should be examined in terms of psychological, social, and economic aspects. Incontinence is considered an embarrassing situation by women who experience it and is often kept confidential. There are reasons such as not caring about the incident to the doctor, rejecting the problem, seeing the situation as a natural result of women or aging, the thought that the doctor will consider the problem insignificant, lack of information about the treatment process, fear of operation, and disbelief that it can pass with treatment (45). These reasons affect the quality of life of the woman in a negative way.

While evaluating the quality of life, psychometric measurements should be included in the evaluation process since it is not sufficient to be based on a single measurement. "*Health-related quality of life (HRQoL)*" defines the situation of the individual's well-being. HRQoL measurements help determine the

need for medical treatment and the effects of treatment. HRQoL is divided into two groups, general and disease-specific. While general HRQoL tools investigate the impact of diseases on the quality of life in large groups of patients (SF-36, Euro QoL, and EQ-5D), disease-specific HRQoL is used to measure a specific disease' effect on HRQoL. While "*Incontinence Impact Questionnaire (IIQ and short-form IIQ-7)*", which is in the category of the most recommended scale by the ICS and is used for UI, "*Fecal Incontinence QoL Scale (FIQL)*" is used for FI (38, 45). UI causes impairment in quality of life, in a study conducted with 200 women using the "*Incontinence Quality of Life Scale (I-QOL)*", "*Urogenital Distress Inventory (UDI-6)*" and "*IIQ-7*" (15). In another study in which women over the age of sixty-five participated, the I-QOL scale was used, and there was a significant decrease in the quality of life of elderly individuals due to UI (46).

Along with the different quality of life assessment tools, the type of incontinence also impacts the quality of life. Studies indicate that the quality of life of women diagnosed with UUI and MUI is more negatively affected than SUI (34, 36). However, in the study of Kaya et al. (2015), the quality of life-related to UI was examined, and no difference was found between the groups (47). Studies examining the effect and severity of incontinence on quality of life are also minimal in the literature. In another study conducted with 391 women with UI in the Czech Republic, it was concluded that incontinence affects the quality of life regardless of severity (48).

It is known that most women see incontinence as usual with increasing age, therefore they think that incontinence is a social problem rather than a medical problem and their tendency to seek help is low. It was found that women did not want to participate in activities outside the home due to their UI complaints, and they were disappointed with them (20, 21). Demirci et al. (2012), in the sample group of 259 people; it was observed that at least one of every four women (26.6%) had UI, and the quality of life, especially the psychosocial health of women with UI, was also negatively affected (46). In another study conducted with 140 Iranian women with incontinence, UI negatively affects mental health and quality of life. Also, this ratio was found to be higher in women with MUI (49).

Regarding the relationship between FI and quality of life, FI's frequency affects the quality of life negatively. They stated that they did not feel well psychosocially.

In a study conducted by Smith et al. (2012), it was reported that 35.6% of 226 women's quality of life was negatively affected (50).

CONCLUSION

In this review, it is emphasized in the light of the studies in the literature that women diagnosed with all types of incontinence experience stress, anxiety, and depression, and their quality of life is negatively affected. Health professionals have essential duties to treat this problem and improve the quality of life. In particular, nurses working in clinics where pelvic floor problems are evaluated, should consider the effects of incontinence on women's mental health and refer to the psychiatric nurse and psychiatrist when necessary. It is also recommended to help women and their husbands to participate actively in the treatment and rehabilitation process.

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