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PSYCHO-SOCIAL IMPACT IN URINARY INCONTINENCE

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INTRODUCTION

Loosing control over the act of micturition can have a significant impact on mental and social well-being of women affected. It is a matter of health and hygiene of a real seriousness, which is hard to be accepted by women. Loss of control and associated psychosocial stress are perceived by women as handicap or shame.

OBJECTIVE

The purpose of this study is to provide a better understanding of this devastating situation and to provide solutions. In an attempt to provide an incentive for social and psychological programs in order to help women who are unfortunate victims of such situations.

MATERIAL AND METHODS

200 female patients were included in the study ,the vast majority were married very young, as a result they started the reproductive life early too ,90% are housewife, 30% are literate.

RESULTS

Incontinence is a complex phenomenon with a multitude of causative factors, including psychogenic causes, psychiatric analysis in women with urinary incontinence are depression, anxiety. Psychological change is likely to be related to symptomatology and related disability and concerns rather than the specific urogynecology conditions. Many studies suggest that psychological factors associated with urinary incontinence can be changed with therapy (1).

Individual effect and feeling of insecurity, anger, apathy, dependency, guilt, lack of dignity, sense of abandonment, shame, embarrassment, depression and denial are common. Women feel loss of self-confidence and self-esteem. Lack of personal hygiene worsens the situation and sexual difficulties are common. Women tend to disengage and withdraw socially. Psychological and functional decline prevails and potential institutionalization occurs.

The effect on the family, as economic worries are enormous, burden on family companions and emotional stress is phenomenal. Deteriorating health of the primary caregiver and impaired interpersonal relationships are common. Potential abuse or neglect is real. The decision to institutionalize and delayed reintegration of institutions are frequently observed.

Relationships with caregivers: negative feelings and behaviors towards the patients with urinary incontinence is sometimes observed. Patients are considered to be responsible for additional care and "Burn-out" syndrome is prevalent among healthcare providers for women with urinary incontinence.

Urinary incontinence can result in such disability and dependency of family or caregivers who have difficulty adapting and responding to increased demands. Incontinence may be the last drop in a family's attempts to take care of a disabled woman. This is a major factor leading to institutionalization and may be a secondary reason for many more. (Wyman et Colab 1990) examined epidemiologically and clinically studied the psychosocial impact of urinary incontinence in institutionalized women (2). They noted variations between studies on patient populations surveyed, evaluation methods and definitions used. Reports of interference with social activities ranged from 8% to 52%. Areas affected include leisure activities, social, family, physical and work place.

Patients may waive or restrict certain chores, visiting holy places, shopping, travel, vacations, physical recreation, entertainment events outside the home, and hobbies. They may avoid activities outside the home if they are not sure of the location of the toilet. Some women with insatiable incontinence become more isolated by limiting their social activities and social contacts. Even housewives have significantly fewer social interactions, especially with family members. Conjugal relations seem to be the

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most affected, probably due to an additional negative effect on sexual relationships. It is widely accepted that urinary incontinence is underestimated and insufficiently treated. Less than half of people with incontinence go to healthcare providers to consult on the issue. Reasons for this include embarrassment, absorbent product availability, low expectations of benefit from treatment, and the lack of information on treatment options.

Anatomical proximity of the bladder, urethra, and rectum with the vagina allow an association between lower urinary tract and sexual difficulties. The effects may be bidirectional; Sexual activity can cause or aggravate bladder problems and / or bladder problems can lead to sexual dysfunction. The association between urological symptoms and sexual problems can occur in several ways. Urinary symptoms may be a direct cause of sexual difficulties, if not previously exist. Alternatively, urinary symptoms can be used (consciously or unconsciously) as an excuse to avoid sex, in the presence of pre-existing symptoms, or unrecognized sexual problems. General health can affect a woman's sexual activity. Thus, many complex factors affecting the quality of the sexual function (3).

Sexual function may be positively or negatively affected by the surgical treatment of urinary incontinence. Damage is often seen after extensive repair of the pelvic floor.

DISCUSSIONS

Despite the prevalence of urinary incontinence, economic impact studies are limited primarily due to lack of reliable prevalence and cost data because deprives a large variety of treatment methods. The estimated costs of urinary incontinence should include direct and indirect costs and the cost of treating complications related to incontinence. Direct costs are the economic resources used to diagnose, treat, care and rehabilitate incontinent patients. Indirect incontinence costs include lost productivity, incontinence consequences ranging from skin ulcers to mortality and the cost of time spent by those unpaid caregivers. The sum of direct and indirect costs of urinary incontinence reflects the total economic burden on the entire economy (4).

Direct costs: These include costs of diagnosis and assessment, counseling and physical examination. Costs include medical and surgical treatment, routine care costs - healthcare work, supplies and laundry services. Rehabilitation costs include healthcare work, supplies, and costs of incontinence complications such as skin ulcers, urinary tract infection, prolonged hospitalization and ambulatory monitoring.

CONCLUSIONS

The bio-psychosocial and morbidity presence of incontinence and dyspareunia may be severe. Pelvic dysfunction may contribute to relationship problems of patients with their infants or their partner. Addressing the general morbidity and maternal needs associated with pelvic dysfunction could play a role in the management of these patients and the development of relevant support services.

At least in the short term, quality of life and other benefits should be taken into account when continence rehabilitation is appropriate. It is very useful in improving the status of women in society by encouraging them to learn about the proper care. Interventions in women's health are among the most effective investment in health. Good maternal health services can strengthen the entire health system. Pregnancy-related complications are among the leading causes of death and disability for women aged 15-49 in developing countries. A safe motherhood is a vital economic and social investment. Motherhood means ensuring that all women receive the care they need to be safe and healthy throughout pregnancy and childbirth.

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