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Women with urinary incontinence: a look at a multi-faceted universe

Paola Manfredi [1]*, *Vera Pagani* [1]

Abstract

Background: urinary incontinence (UI) is a disease that inevitably affects the quality of women's lives in many ways. In accordance with the analysis of the literature and the specific nature of the disorder, it is believed that two of the relevant factors for assessing the quality of life of these women are sexuality and psychological well-being.

Methods: it proposes a pilot study on a sample of 97 Italian women attending an outpatient urology department to investigate sexuality in women with urinary incontinence. To better understand the way in which these women live their sexuality, this dimension was placed into relation with couple satisfaction, with depression and, for the first time, with alexithymia, trying to determine if there is any correlation between these different variables.

Results: Sexuality plays an important role in women's lives, but in our study, it is a factor that seems a bit inconsistent. About the role of alexithymia, the sample does not differ from the population values, except for the third factor. Moreover, a high percentage seems to be aware of psychological problems, although more related to the past. Normally, couple happiness is expected to include a healthy sex life, but not so in this sample and regardless of age.

Conclusions: The results of the study may suggest that beyond the common symptom, urinary incontinence, women present different characteristics and various psychological functioning, even in the presence of a widespread sexual difficulty. In order to better understand the complex nature of the interplay between these different variables it would be appropriate both to carry out a careful inquiry on the couple's sexuality before the onset of incontinence symptoms and to consider the subjectivity of the experiences of each individual patient during clinical assessment.

[1] University of Brescia, Brescia, Italy

E-mail corresponding author: paola.manfredi@unibs.it

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1. Introduction

Urinary incontinence (UI), is defined as involuntary leakage of urine (Abrams et al., 2003) and it has been recognized by the World Health Organization (WHO) to be one of the current and important health problems. It is divided into different types (stress, urge, mixed, functional and overflow incontinence) according to the causes that originated it.

Numerous studies have evaluated the prevalence of UI and, despite the wide variability of estimates, ranging from 3%-to 65 (Botlero et al., 2008) from 5% to 70% (Milsom & Gyhagen, 2019), depending of urinary incontinence type and considered the different age of population taken in consideration, it appears a rather widespread problem among population, mainly women (Milsom & Gyhagen, 2019). It can be stated that approximately 250 million people are regularly incontinent of urine in the world population (Beji et al., 2010).

As regards the studies on Italian samples can be seen a prevalence of UI around 11% for 50-years-old women (Bortolotti et al., 1999) and around 16.4% for women with an age of 65 years and over (Maggi et al., 2001). The prevalence of urinary incontinence in women under 50 years old was 20% and in a sample of women between 45 and 49.9 years old was found a prevalence of 35% (Siracusano et al., 2003).

Although it isn't a disease which could lead to a life-threatening condition, it has detrimental effects on quality of life. In fact, several studies show that urinary incontinence negatively affects lives of women who suffer from this disease (Coyne et al., 2006; Espuña Pons & Puig Clota, 2008; Holroyd-Leduc & Straus, 2004; Lagro-Janssen et al., 1992; Lopes & Higa, 2006; Saaudoun et al., 2006; Senra & Pereira, 2015; Temml et al., 2000; Van der Vaart et al., 2002). This is particularly true for certain types of UI - stress urinary incontinence (SUI) and urge urinary incontinence (UUI) - that are most bothersome for women; this factor allows to assume that the impact on quality of life is determined in part by the type of UI (Abdel Rahman et al., 2019; Coyne et al. 2006; Lagro-Janssen et al., 1992; Lopes & Higa, 2006; Temml et al., 2000). The symptoms caused by this disease can interfere with women's normal daily activities (domestic, social and occupational), and, consequently, influence their quality of life from social, and physical point of view. In fact, women who suffer from urinary incontinence feel limited in behavior, often refuse to do physical activity, limiting fluid intake, frequently go to the toilet, they do not spend much time away from home and avoiding social situations as much as possible because they might feel embarrassed (Lagro-Janssen et al., 1992; Lopes & Higa 2006; Papanicolaou et al., 2005; Saaudoun et al., 2006).

1.1 Urinary Incontinence and Sexuality

One of the significant factors in the evaluation of quality of life is sexuality. In the urinary incontinence, the sexual dimension is often accompanied by difficulties. The effect of UI on sexual functioning and sexual satisfaction has been investigated in several studies and many have clearly demonstrated the impaired sexual function (Aslan et al., 2005; Azize Turhan et al., 2015; Cohen et al., 2008; Coyne et al., 2007; Papanicolaou et al., 2005; Salonia et al., 2014; Sen et al., 2006, 2007; Senra & Pereira, 2015; Temml et al., 2000) and worsening of sexual function related

to worsening of symptoms sexual function is negatively affected as the severity of symptoms increases (Bilgic, 2019). Yip et al. (2003) claim that sexual satisfaction and incontinence related emotion are associated with married life and negatively affected women who had SUI or Detrusor Overactivity (DO). However, regardless of the type of UI, it is true that this disease can generate in women great concern and anxiety due to odor and urine leakage during sexual intercourse (Aslan et al., 2005; Barber et al., 2006; Lim et al., 2016; Nilsson at al., 2011). This leads women to avoid sexual activity and, as a result, they report low sexual satisfaction in couple (Bekker et al., 2010; Lim et al., 2016). In fact, women's fears are not entirely unfounded, since it has been shown that a third of the women had urine leakage during sexual intercourse (Nilsson et al., 2011). The loss of urine can occur in different phases of the sexual activity, that is to say during arousal, during the penetration of the vagina or during the achievement of orgasm (Vella & Cardozo, 2005).

Certainly, the anatomical factor and the impact of symptoms on daily life have an effect on sexuality. However, if sexuality were compromised by only these two components, we should expect an improvement in sexuality as a result of interventions that improve incontinence. However, in this area, the research is not conclusive. Therefore, we can subscribe to the conclusions of Bezera et al. (2020) that UI has a negative impact on sexual function, although all the mechanisms by which this happens are not clear yet.

1.2 Urinary Incontinence, Sexuality and Depression: A complex mix

A body of research have called attention to the co-occurrence of depression and sexual difficulties among women population (Cyranowski et al., 2004; Kalmbach et al., 2014; Peleg-Sagy & Shahar, 2013; Rindner et al., 2017). Regarding the relationship between depression and sexual dissatisfaction, its direction is unclear. Some studies have tried to assess if there was a possible temporal precedence or a causal relationship between these two factors. Peleg-Sagy and Shahar (2013) for instance, believe that sexual dissatisfaction in turn is likely to bring about "clinical" depression. Instead, Kalmbach et al. (2014), say that there is a temporal precedence of mood on sexual symptoms. In a recent research, emerge correlation between depression and sexual problems (Rindner et al., 2017).

An alternative (though not mutually exclusive) explanation, proposed by Kalmbach et al. (2014), is that the depression and sexual dysfunction symptoms may be manifestations of the same underlying processes and occur simultaneously. According to this framework, it seems clear that the relationship between depression and sexuality becomes further complicated in the case of women with urinary incontinence (Avery et al., 2014; Felde et al., 2012; Heidrich & Wells, 2004). In this respect, several studies have suggested that there is an association between UI and

depression, although, until now, the relationship between these two diseases is not clearly understood (Dugan et al., 2000; Melville et al., 2005; Nygaard et al., 2006; Steers & Lee, 2001; Vigod & Stewart, 2006). However, it appears that the symptoms associated with urinary incontinence together with the functional impairment may increase the risk of depression (Melville et al., 2005). Melville et al. (2005) claim that Major depression is three times more present in women with urinary incontinence than in women who do not suffer from this disease; moreover, the link between depression and UI becomes stronger with increasing severity of this last one. For researcher, the comorbid depression in incontinent women leads to greater perception of symptoms, to an increased risk of social isolation, a decrease of help-seeking behaviors and a lowering of the quality of life (Avery et al., 2013; Stach-Lempinen et al., 2003).

Looking from a different perspective sexual and psychological problems can be expressed as incontinence or voiding problems and be a symptom of a psychosomatic disease (Lone & Hosp, 1997). Other authors argue that sexual satisfaction appears to be independent of urogynecological problems and sexual life is correlated with depressive mood, which is not based on this kind of diagnosis (Barber et al., 2002; Bodden-Heidrich et al., 1999; Saiki & Meize-Grochowski, 2017; Siff et al., 2016) Additionally, women with incontinence who have a similar frequency of sexual activity to women without incontinence, have less sexual desire, foreplay, harmony with a partner, sexual comfort, and sexual satisfaction than women who have not UI (Felippe et al., 2017).

Leaving aside the question of causal relationship between urinary incontinence, sexual difficulties and depression, there are women with urinary incontinence that present depression (Avery et al., 2013; Coyne et al., 2012; Dugan et al., 2000; Felde et al., 2012, 2020; Lai et al. 2016; Melville et al., 2005; Nygaard et al., 2003; Stach-Lempinen et al., 2003; Steers & Lee 2001; Vigod & Stewart, 2006), repeated sexual problems, reduced sexual activity, low desire, vaginal dryness and dyspareunia (Berrada et al., 2021; Cohen et al., 2008; Dalpiaz et al., 2008; Handa et al., 2004; Jha et al., 2012; Oh et al., 2006; Pereira et al., 2019; Yip et al., 2003).

1.3 The contribution of alexithymia to illness behavior, sexuality and depression

Another element to be considered is the assessment of alexithymia. It is a personality construct that includes the inability to identify, describe and communicate the emotions (Lesser 1985; Sifneos, 1972). This condition of little emotional awareness has also consequences on the interpersonal level: difficulty in differentiating the emotions of others, low degree of empathy and ineffective emotional response.

Historically alexithymia was considered a predisposing factor in the onset of psychosomatic illnesses. This belief arose from the assumption that the inability to experience feelings, to

identify the emotions and express them verbally could lead the person to misinterpret the emotional excitement as illness signal (De Gucht & Heiser, 2003; Lumley et al., 1996; Tuzer et al., 2011) and to develop different somatic symptoms in emotionally stressful situations (Sifneos, 1972; Nemiah et al., 1976). Different contributions (Byrne & Ditto, 2005; Glaros & Lumley, 2005; Kauhanen et al., 1996; Lumley et al., 1996, 1997, 2007; Lumley, 2004; Miranda et al., 2005; Valkamo et al., 2001) suggest that alexithymia is a risk factor in the experience of illness, in reporting symptoms, in unhealthy behavior and in the use of facets. Several studies have found a high level of alexithymia in different diseases (Taylor et al., 1997): irritable bowel syndrome (Berens et al., 2021; Porcelli et al., 1999) cardiac disease (Kojimaa et al., 2001; Wiernik et al., 2018), arthritis (Chimenti et al., 2019; Pop-Jordanova et al., 2013), somatoform disorders (Karvonen et al., 2005; Mattila et al., 2008; Tominaga et al., 2014; Waller & Scheidt, 2004), post-traumatic stress disorder (Fukunishi et al., 1996; Henry et al., 1992; Putica et al., 2021), substance dependence (Haviland et al., 1994; Lumley & Roby, 1995; Palma-Álvarez et al., 2021), pathological gambling (Estévez et al., 2021; Lumley & Roby, 1995; Parker et al., 2005), anxiety (Karukivi et al., 2010), obsessive-compulsive disorder (Grabe et al., 2004; Roh et al., 2011; Rufer et al., 2004), cancer (De Vries et al., 2012; Pop-Jordanova et al., 2013), essential hypertension (Casagrande et al., 2019; Jula et al., 1999; Todarello et al., 1995), diabetes (Friedman et al., 2003), eating disorders (Beales et al., 2003; Carano et al., 2006; De Panfilis et al., 2001; Kessler et al., 2006; Mazzeo & Espelage, 2002; Zonnevylle-Bender et al., 2004), morbid obesity (Marechal et al. 2009; Pinaquy et al., 2003), fibromyalgia (Di Tella & Castelli, 2013; Pedrosa-Gil et al., 2008; Sayar et al., 2004), kidney failure (Pop-Jordanova et al., 2013) etc.

Therefore, can be said that alexithymia is not specific for psychosomatic disorders, but it intervenes in all those physical and mental health problems that are influenced by emotion regulation, including undifferentiated negative moods such as depression (Honkalampi et al., 2001; Luminet et al., 2001; Taylor et al., 1997). Depression must be taken into account as a confounding factor when studying alexithymia in general populations due to the strong association between alexithymia and depression (Honkalampi et al., 2000; Marchesi et al., 2000). Various epidemiological studies show an overlap between alexithymia and depression and it is believed that depression contributes to explain the variance of alexithymia in a measure estimated to be between 10 and 20% (Farges et al., 2004).

As it regards the connection between alexithymia and sexuality in women it is only known that the alexithymia for females is associated with lower frequency of penile-vaginal intercourse (Brody, 2003). Just as specifically penile– vaginal intercourse, but not other sexual behavior, has been shown to scores be associated with more favorable indices of health (Brody et al., 2000).

In a study with patients with type 2 diabetes during COVID-19, Dincer et al. (2021) found that high levels of alexithymia, anxiety, and depression affected negatively sexual functioning.

However, in literature, the association between alexithymia and UI is not investigated, although alexithymia is significant in emotional relationships and in the expression of sexuality. This last point, therefore, is still an open field study. The analysis of the literature shows, therefore, a complex vision in which the female incontinence problems are interwoven with those of sexuality and depression without a unanimous agreement with respect to the co-occurrence of these factors.

On the basis of these assumptions, we have proposed a pilot study on a sample of Italian women attending an outpatient urology department in northern Italy. It was also decided to expand the focus to other variables that, according to an analysis of the literature on other populations that have similarities with our sample, may be related to each other.

1.4 Aim

The main aim of this research is to investigate sexuality in women with urinary incontinence with a focus on sexual difficulties. To better understand the way in which these women live their sexuality, it was placed into relation with couple satisfaction, with depression and, for the first time, with alexithymia, trying to determine if there is any correlation between these different variables. It is assumed that these different variables, if related, self-sustaining each other in order to create a sort of vicious circle.

In particular, the first objective of the research is to descriptively evaluate the presence of sexual problems, depression, alexithymia and couple functioning in the sample of women, who go to the specialized urodynamics center in Brescia.

A second goal is to evaluate the correlations between sexual disorders and couple satisfaction, sexuality and depression, sexuality and alexithymia. The last objective is to evaluate the correlations with respect to age and urinary pathology.

2. Methods

2.1 Setting and Procedure

This study was conducted in the outpatient urology department of the Brescia Civil Hospital, in the northern Italy. We were contacted by clinicians for help them in understanding patients. After a period of department observation and literature study, we proposed the research protocol. The study was conducted in compliance with the Ethical Principles for Medical Research Involving Human Subjects of the Helsinki Declaration.

During regular visits at the outpatient department, doctor proposed to the female patients to participate at the research. Interested patients found a researcher in the waiting room, providing additional information and handing out the questionnaires in an envelope. A large box was placed in the waiting room, like a letterbox, where patients could insert the envelope with the completed protocols. Personal data was not requested.

2.2 Participants

Participants consisted of 97 female patients aged between 23 and 68 years old (M = 44.96; SD = 11.46). The inclusion criterion of patients is the presence of UI (stress, urge, mixed, functional and overflow incontinence). The exclusion criterion was that incontinence linked to the presence of cancer. The majority of the sample suffers from stress incontinence. Concerning education, 5 had attended primary school, 23 middle school, 37 had a high school degree, 10 a diploma and 21 a university degree. As regards marital status we registered that 69 women were married, 10 were single, 4 widows, 2 separated, 7 had a common-law husband and 4 were divorced. The sample was also divided into three according to age: the first group up to 38 years old (33 subjects), the second group from 39 to 50 years old (31 subjects), and the third group from 51 to 68 (33 subjects). In the variables considered no differences emerged in the three groups, for this reason, a sample with a wide age range was kept. When measuring how long these women suffer from IU, we can see that the average is 5 years.

2.3 Instruments

The assessment form includes various instruments.

Cognitive Behavioural Assessment 2.0 (CBA – 2.0) a multiple-choice questionnaire, is used to collect medical and psychological history information (Sanavio et al., 1986). In particular, it was also investigated the sexual life of the patients thanks to Schedule 4 of CBA 2.0, which contain a specific question about Affective-Sexual Area.

In addition, the interest about psychological treatment was evaluated.

Couple satisfaction was assessed using the dyadic fit scale - Short Form (DAS-7) (Hunsley et al., 2001). It is a short form of seven voices of Spanier's (1976) dyadic adjustment scale (DAS items 8, 10, 11, 25, 27, 28, and 31). It is composed of three items that evaluate the dyadic consensus, three elements that evaluate dyadic cohesion, and one element that evaluates the global dyad satisfaction. The internal consistency for the DAS-7 using the Cronbach coefficient was 0.79. the reliability of the DAS-7 varied from .75 to .80, the internal consistency of the scale has an average value of almost 0.80.

Depressive symptoms are detected by the Symptom Checklist-90-R (SCL-90-R) (Derogatis, 1994). The SCL-90-R depression scale (Derogatis, 1983) is a 5-point Likert scale (1 = not at all to 5 = extremely). Investigate specific symptoms, such as feeling down, losing interest or sexual pleasure, crying easily, and not being interested in things. The internal consistency is between. 89 to .91.

Finally, it is asked to fill out Toronto Alexithymia Scale (TAS-20) (Bagby et al., 1994) a self-report questionnaire for alexithymia, which is a condition characterized by difficulty identifying feeling (DIF), difficulty describing feelings and differentiating between emotions and bodily sensations of emotional arousal (DDF) and an externally oriented cognitive style (EOT). Each of the twenty items is rated on a 5-point Likert scale. A total score of 51 and below indicates a normal status, a score of between 52 and 60 points at a possible alexithymia condition, and a score of 61 and above refers to alexithymia. In the initial TAS-20 derivation and validation studies, Cronbach's alpha coefficients were 0.80 and 0.79 for the DIF factor scale; 0.75 for the DDF factor scale; 0.66 for the EOT factor scale. The mean inter-item correlation coefficients (AICs) for these two samples were in the range from acceptable to optimal for scale homogeneity.

For the Italian normal adult sample, populations goodness-of-fit (GFI) is 0.88, adjusted goodness-of-fit (AGFI) is 0.84, the root-mean-square residual (RMSR) is 0.07, and Tucker-Lewis index (TLI) is 0.80, indicating the adequacy of the fit. The internal consistency and homogeneity of the items of the Italian translation of the TAS-20 were evaluated: the alpha coefficients of Cronbach and the average interitem correlation coefficients for the full scale were .75 and .13 The alpha coefficients obtained for the Italian translation of the TAS-20 are similar in size to those obtained with the English version and indicate that the scale is a reliable tool for the evaluation of the construct of alexithymia in Italian population (Bressi et al., 1996).

2.4 Statistical analysis

Statistical analysis was performed using software called SPSS 22.0. It was preferred to use non-parametric tests, respecting the nature of the data, which are for the majority ordinal data, but, according to common practice, parametric analyses were used when conditions allow.

The analysis on samples divided by age groups was not significant therefore the analysis was carried out on the entire sample of women.

The non-homogeneous distribution of the sample with respect to the different types of UI did not allow analyzes respect to the pathology.

3. Results

3.1 Sexuality and Couple Satisfaction in UI Women

Each item related to sexual difficulties had/provided 4 points Likert scale without mid-point (0 = no; 1 = for months; 2 = for years; 3 = always). This kind of items has found a strong drop-out: from 15 to 26 women do not respond to the proposed questions. This is particularly surprising when we consider the specific nature of the medical problem and the research context: questions are certainly intimate, but it should not have been disregarded. A narrow range (10-15%) of the sample reveals wider disturbances in sexuality (too brief reports, annoyance and lack of interest for the partner). Concerning, in particular, sexual desire, it is important to highlight that, although 22 subjects did not respond, and 18.7% of the sample declares an absence of sexual desire (10.7% = for months; 8% = for years), the decrease of the same interests 43.9%. (15 subjects do not respond and 36, out of a total of 82 respondents, say they suffer this discomfort). Given the limited numerosity of data, it cannot propose a detailed investigation, however, is already very significant narrative information according to which only 14.4% of the sample believed that their sexual life is completely satisfactory.

Significant negative correlation emerges between the quality of the relationship with the partner and decreased sexual desire (r_s (97) = .31, p <.01) and positive correlation between the quality of the relationship and the couple happiness (r_s (97) = .46, p < .001). However, there isn't statistically significant correlation between the decrease of the sexual desire and the couple happiness. In other words, you can have a couple happiness even in the presence of a diminished sexual desire.

The items concerning the relational aspects have apparently given very positive data: 88 subjects (90.7%) claim to have a stable emotional relationship and, as regards DAS-7, its result of dyadic satisfaction (item 7) show that 67% of the samples define the degree of happiness in their relationship from "happy" to "perfect".

The other items of DAS-7 indicate that the women in our sample present high couple agreement not only on the consensus (philosophy of life, values, time spent together), but also on the cohesion, which is expressed as frequency of couples activities (work activities, discuss something together, exchange of ideas).

Over time, this relationship would then have remained stable and even increased some positive characteristics, such as a feeling of closeness, dialogue, complicity; the feature that has grown more over time and is linked to " esteem and respect " (35%).

3.2 Sexuality and Depression in UI Women

The assessment of depression, according to SCL-90-R, show that little less than one third of the subjects is depressed: 17.5% is moderately depressed and 11.3% is severely depressed.

The results about the relationship between depression and sexual problems highlight various significant correlation independently from the type of UI. Depression correlates positively with the decrease of sexual desire (r_s (82) = .42, $p < .001$), the lack of desire (r_s (75) = .42, $p < .001$), the absence of sexual pleasure during intercourse (r_s(78) = .33, $p < .01$), the annoyance about the thought of having sexual intercourse (r_s(79) = .41, $p < .001$), partner's unpleasant demands (r_s(76) = .29, $p < .05$), too brief sexual intercourse (r_s(71) = .26, $p < .05$) and lack of sexual satisfaction derived from partner (r_s(77) = .29, $p < .01$).

3.3 Sexuality and Alexithymia in UI Women

Regarding TAS-20 the distribution is comparable to the reference population with the exclusion of the third factor. In fact, the sample reports a higher level of operating-concrete thought (M = 18.94, SD = 4) that significantly differs (t (97) = 4.55, $p < .001$) from the Italian healthy normative population. In addition, the third factor positively correlates with age (r (97) = .24, $p < .05$). There are no significant correlations with other variables.

3.4 Psychological distress and help-seeking behaviors in UI Women

Given the fact that the symptoms of urinary incontinence in women, if associated with psychological distress, can reduce help-seeking behaviors, it was decided to ask some questions about this kind of behavior. As regards the more specific questions about psychological distress more than half of the sample (58.7%) said that they had psychological problems in the past, while only 32% said they currently had. Compared to the suffering in the past, most showed having professional help (18.4% said they were helped by psychotherapy, 8.4% by medical specialists and 4.1% by drugs) and not so many by emotional relationships (11.2% from family, 1% from friends). In addition, although the proposed protocols did not indicate clear data of psychological suffering, in the face of the possibility of psychological help, only 12.9% of the sample declared its disinterest. When asked if they were interested in following psychological treatment if it proved useful for a greater comfort, 12 subjects answered no (12.9%), 18 had to think about it and 13 had to ask for advice (19.4% and 14.0%), 19 would only follow if it was short (20.4%) and 21 although long (22.6%), 10 already had treatment in progress (10.8%). Overall, 76.4% of the respondents would be willing to consider a kind of care that also deepened the emotional aspects. This information is particularly significant because the question was worded so as not to connect the resolution of the somatic problem to psychological treatment.

4. Discussion

It should be noted the high percentage of people who report psychological problems and more in the past (almost twice) than in the present, but the data in our possession do not allow us to draw definitive conclusions on urinary incontinence, sexual problems, couple satisfaction, depression, and alexithymia, therefore, the hypothesis that these different components, if related, support each other to create a sort of vicious circle, cannot be confirmed.

There is only a clear correlation between depression and some type of sexual problem (decreased sexual desire, lack of desire, absence of sexual pleasure during sexual intercourse, annoyance at the thought of having sexual intercourse, unpleasant partner requests, too short sexual intercourse and lack of sexual satisfaction derived from the partner). The correlation between depression and sexual difficulties is therefore confirmed but in the lack of direction of the association between these two variables. However, it is necessary to remember that the percentage of depressed women is 28.8% (17.5% is moderately depressed, 11.3% is severely depressed) and that the percentage of women who report having a sex life fully satisfactory is limited to 14.4% of the sample. There is, therefore, a large percentage of women in the sample who are not depressed but, in any case, do not have a satisfactory sex life.

A significant element is the strong abandonment of the population in response to questions about sexual difficulties. The investigation of sexuality in other studies generally has an answer, while in our study the lack of response to this problem is high, despite the specific nature of the medical problem and the research context: this can confirm the idea of difficulty in this sector. On the other hand, it is important to note that couple relationships are very positive.

In the study by Soja et al. (2020) low satisfaction with sex was strong predictor of low satisfaction with relationships. This is consistent with what happens in the normal population, for which the level of sexual satisfaction is considered a key factor in relationship satisfaction (Byers, 2005; Brutzer & Campbell, 2008; Heiman et al., 2011). However, in our sample, this link does not have a clear answer. A key to understanding can be found in the research by Mark & Jozkowski (2013). In a sample made up of young couples, the researchers emphasize the mediating role of communication (sexual and not) between relationship and sexual satisfaction. Therefore, in our sample we can hypothesize that the communication is not very much important component in the construction of the couple harmony.

Furthermore, dissatisfaction with sexual relations is much wider than dissatisfaction with their frequency; this is also a fact in contrast to the normal population (Smith et al., 2011): many men and women are dissatisfied with their sexual frequency, but a large majority report feeling fully satisfied with the sex. Our data are in line with research by Felippe et al. (2017) who find sexual

dissatisfaction even in women who have a frequency of intercourse equal to the healthy population. However, it should be emphasized that our assessment was related to sexual relations and not to the wider range of sexual practices.

Also, a careful investigation of the couple's sexuality before the onset of urinary incontinence symptoms would be appropriate. This study is certainly complicated given the late access to healthcare facilities and the possible distortion of distant memories. One possible way would be to evaluate the underlying dynamics involved in the representation of sexuality and the representation of their body image on sexuality (Settineri et al., 2015). It could be assumed that in highly idealized relationships there is a greater difficulty in living sexuality which by its nature is rather concrete and carnal, and perhaps even aspects of urinary disease emphasize these dimensions, even more, connoting sex in a way that does not it is very in tune with the characteristics of these couples. This interpretative hypothesis should be evaluated in future studies because it cannot be claimed by our data, which, moreover, belong only to a female sample, while nothing is known about the evaluation of sexuality by the partners.

Analyzing the results of the TAS-20, through the comparison of the sample with the reference population, we notice a significant difference compared to the third factor called "externally oriented thinking". There is no specific literature on the third factor of TAS-20 on the user interface, but in some other research on somatic or mental disorders it emerges that it behaves differently from the other two factors, namely "identify" and "describe feelings".

It would seem that in the case of somatic disorders the strongest association is given by the "externally oriented thinking" factor, while in the case of psychic suffering it is not associated, but the other two factors are significant (Fukunishi & Kaji, 1997; Gao et al., 2015; Korkoliakou et al., 2014; Pilar Martínez et al., 2015). Moreover, it is interesting to note how the third factor appears to play a particularly pertinent role in terms of inhibiting negative material (Dressaire et al., 2015). The role of the externally oriented thinking could be twofold: on the one hand may lead to an underestimation of the negative components, on the other hand, the third factor of the TAS 20 may signal an increased anchoring to the operational dimension, a propensity to process more concrete data, which would translate into a representation of reality in which the physical and somatic aspects are more important than psychological components. It can be hypothesized that the underestimation of negative elements has influenced the assessments of happiness and depression, while it has had no effect on the evaluation of sexuality, due to its greater concreteness. As for the availability of a possible psychological treatment, the data relating to the third factor TAS indicate a sample that is not inclined to awareness of psychological distress, but the same sample declares to be open to a type of treatment that leads

to investigating emotional aspects. According to the reference framework of the Multiple Code Theory (Bucci, 1997), we can hypothesize in these women a mental functioning that tends to lower the excitement. The somatic symptom would remain to signal discomfort and to represent a key to access psychological suffering. It may be thought that the psychological work with these people must start from the concreteness of the symptom, to investigate its meaning and function in the couple's economy and personal functioning.

Finally, we propose an interpretation relating to the lack of significant differences in age-differentiated subsamples. The literature reports that older women have generally more severe urinary tract infections (Arinzon et al., 2012) and that there is also an increase in depressive symptoms (Kwon et al., 2021). It is also underlined how referral rates decreased with age: older women with UI are less likely to receive care according to existing clinical guidelines (Gurol-Urganci et al., 2020). Our sample was drawn, unlike various other studies, in a specialist service, which in addition to diagnosis offers treatment paths, from pelvic rehabilitation to surgery. The women in our sample are therefore likely to be active and motivated to find a solution to their problem. Therefore, we assume that for this reason no age differences were found. Felde et al. (2020) show that mixed UI was most strongly associated with high depression and anxiety, but the unequal distribution of our sample over UI types did not show statistical significance.

We, therefore, emphasize that in approaching these women it is necessary not to use purely descriptive classifications, but to focus on the specificity of the subject presenting the disorder.

5. Conclusions

While the UI has, from a medical point of view, its certain definition and delimitation (there are, in fact, various forms of UI), from the psychological point of view there isn't a correspondence, but there are multiple mental operations, a varied universe, in which takes place the severely depressed person with sexual difficulties, as well as the person not at all depressed, with satisfactory couple life and without sexual problems. This great variety, even more, accentuates the responsibility of clinicians, who have the task of performing a wide and proper evaluation. Furthermore, the results show that despite the presence of a good couple relationship, there is a difficulty in the sexual sphere. Depressive aspects effect a limited part of the sample and, if compared to the reference population, these women present a significant difference in one dimension of alexithymia called "externally oriented thinking". From our study, it emerges that there is no connection between the variables considered: sexual problems, couple satisfaction, depression, alexithymia, and even for the type of incontinence. The only exception is the correlation between depression and some type of sexual problem, despite the substantial drop-out in response to questions about sexual difficulties.

In future research, a more in-depth investigation into sexuality, its representative psychological, identity, and relational components may be useful: perhaps the somatic symptom highlights and emphasizes the pre-existing difficulties.

Conflict of Interest Statement

The authors declare that the research was conducted in the absence of any potential conflict of interest.

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