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INCONTINENCE: DO PATIENTS AND HEALTH PROFESSIONALS SHARE COHERENT VIEWS REGARDING TREATMENT?

Hypothesis / aims of study

(1) To explore women's and health professionals' perceptions regarding conservative treatment of urinary incontinence; (2) identify shared (coherent) or mismatched views about this treatment, and (3) discuss the implications of coherent beliefs in understanding long-term treatment adherence.

Study design, materials and methods

This qualitative study comprised in depth audio-taped interviews with six women over 40 years of age referred for conservative treatment of stress or urge urinary incontinence symptoms for the first time, and the four physiotherapists / two continence advisors who provided treatment. Women with any physical or psychological co-morbidity that rendered usual conservative treatment inappropriate were excluded.

Participants were interviewed twice: at the start and end of treatment. Transcribed interview data were explored using Interpretative Phenomenological Analysis (IPA).[1] This qualitative approach has explored individual experiences of health related issues, and of rehabilitation adherence. Three levels of analysis occurred: 1) a content analysis whereby transcripts were repeatedly read and line by line analysis notation made of key words or sentences that gave insight into participants' experiences producing the emergent themes; 2) a re-iterative process developed the themes, ensuring the in-depth and detailed case by case analysis afforded by small participant numbers (and characteristic of this methodology) could occur; 3) robust verification procedures refined the themes. In IPA verification is akin to establishing reliability and validity, it also occurs in stages: 1) researchers, who were independent from data gathering, commented on the themes. These researchers were experienced users of IPA and/or expert in management of urinary incontinence; 2) discussion occurred with regard to final themes and interpretation and 3) agreement was made on the extent to which raw data represented themes and interpretations. Participants also had opportunity to comment upon their transcripts, pseudonyms ensured anonymity, clarification comments are in italics.

Results

Two themes are presented, reflecting models of health behaviour change: contemplation and intention to engage in treatment; adopting and maintaining the treatment programme.

"It's not good enough"

This theme revealed shared views between participants about reasons why women intended to engage in conservative treatment:

> *"There's a continuum here when it's not bad enough perhaps to worry about, it happens occasionally, but it is something that gets worse… I'm a fairly tolerant person, but it got to the point where I was not enjoying this and its not good enough… I thought I'm not ok with this and I need to do something about it" (patient Hazel).*
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> *"so whilst they may have had the problem a long time… it becomes more bothersome. Depending on the degree of bothersomeness, then they will seek help"* (professional Sue).

Health professionals estimated that they saw only one third of people who could be helped:

> *"They think they have got this problem by themselves, where in fact, you know it is a huge amount of people in the community that suffer from lesser or greater incontinence. So you know there are lots of people out there with some degree of a problem… "*(professional Ellen):

Patients shared the view of a hidden or silent condition: they discussed continence with few people beyond their health professional:

> *"It's a silent issue. You just don't want to talk about it…it's just getting people to admit …that I actually have a problem…[and being]…. reassured that you're not just some oddball that's having a problem"* (patient Hazel).

"Brain to pelvic floor"

Once patients decided to engage in treatment they are required to master skills, such as pelvic floor muscle training:

> *"I never knew whether I was doing it properly."* (patient Ruby).

However, even when a patient knew how to do the exercises it did necessarily lead to on-going adherence:

> *"I just want them to get the messages from their brain to their pelvic floor and the discipline of regularly doing exercises and … associating it with something that they do routinely, then they're more likely to remember to do them"* (professional Harriet).

Establishing the routine was clearly difficult for patients:

> *"I felt awful going to her [the health professional] and saying I hadn't done [the exercises]. I said to [the health professional] that I've been naughty because I've been going to work and I always put myself last, do everything else first. I realise there are some things that you've got to keep doing…"* (patient Ruby).

Having the right frame of mind seemed important not only for the neuro-muscular connections needed to master exercises but also for adopting a lifelong routine:

> [*I know it is*] *"up to me.. I know the exercises are for life… I don't want to grow old and drippy….It is a brain thing, a mental thing, remembering."* (patient Hazel)

Interpretation of results

The literature indicates that bothersomeness [2] is a main trigger for initiating treatment; this was true for our patient participants and our health professionals acknowledged the degree of bother was very personal: physical (i.e. leakage); social (interrupting daily life); related to psychological distress. Perceptions concerning the prevalence of incontinence were not shared between our participants; only after initiating treatment did patients appreciate they were not alone and knowing this information was reassuring, helping them to engage in the on-going rehabilitation. By the end of the rehabilitation patients shared the health professionals view that exercise adherence was "a mind thing" suggesting psychological approaches based on models of health behaviour change that empower engagement in self-management are needed to support and maintain their motivation to continue with a lifelong exercise routine.

Concluding message

Knowing how to do the exercises and adopting them long term was difficult. The mind-body connection and the need for establishing a life-long routine mentioned by both patients and health professionals indicate potential for cognitive-behavioural approaches to be used in the rehabilitation of uncomplicated urinary incontinence.[3]

1. Qualitative Research in Psychology 1:30-54 (2004)
2. Journal Advanced Nursing18:1415-1423 (1994)
3. Nursing Research 53:6 supplement. (2004)

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