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Talking Points

September 17, 2013

What are we trying to solve?

Urinary incontinence interventions designed for older adults, especially frail and medically complex older adults, are not being refined, tested, and used on a widespread basis.

Issue: There has been no systemic critical evaluation of and development in the *theoretical basis* of for urinary incontinence behavioral research. Behavioral interventions to use in the treatment of geriatric urinary incontinence were first introduced in the 1980s. The most predominant interventions are: 1) prompted voiding based on operant conditioning with antecedent and consequent interventions; 2) bladder retraining based on operant conditioning with antecedent intervention (urge suppression); 3) pelvic muscle exercise (not widely used in geriatric urinary incontinence) is based on operant conditioning and principles of exercise physiology.

In recent years, primary prevention of urinary incontinence in individuals has become an area of research interest and self-efficacy (social cognitive therapy) was the predominantly used model. Other behavioral change theories used in urinary incontinence include theory for planned change, stages of change (trans theoretical), and health belief model. Population based interventions are starting to emerge but have not been translated into practice. These interventions are mainly geared towards healthy individuals.

Theories are meant to evolve as evidence grows. Without systematic evaluation *of theories* used to design interventions we are limited to the past. Since the inception of behavioral research for urinary incontinence, there has been a global response to urinary incontinence. I propose a “think tank” and a “do tank” to critically investigate behavioral theories, propose refinement to describing the problem, refinement of theory, and to develop an agenda to test these theories in the real world.

Some concerns that need to be addressed:

1. Evidence based practices are not being widely used with geriatric individuals.

2. People with complex, multiple co-morbidities may not see urinary symptoms as a priority for behavioral intervention and may use containment measures.

3. Urinary incontinence is not perceived as a public health issue by policy makers.

4. A cohort of urinary incontinence researchers and clinicians are aging out and there are legacy issues.

Here are some questions to consider:

1. Are behavioral theories developed in the western world using assumptions about people and place valid in other parts of the world?
2. What are the societal influences on behavioral theory?
3. How is the gap between theory and real world closed?

I propose that we assemble a think tank with individuals who are involved in engineering, technology, public health, behavioral sciences, continence nursing, and consumers of healthcare. This should be an inclusive group but one that is committed to working towards specific benchmarks.

Conference call”

We discussed these issues and other issues about the lack of research on behavioral intervention to reduce prevalence and incidence of urinary incontinence. We also agreed that continence is not viewed by public health policy makers and practitioners as a significant global public health issue. We also identified some barriers to continence being viewed as a public health issue. Perhaps we need to reframe incontinence as an environmental issue, an infectious disease issue.

Action Items

Identify funding for the think tank

Identify members of the think tank and the format for the think tank

Identify key allies and stakeholders

Continue monthly meetings to refine the issue and action plan.