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Margie Polden Memorial Lecture: The psychology of incontinence – why successful treatments fail

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Abstract

Over the past 20 years, treatments for incontinence have undergone a revolution. However, the results for some patients remain disappointing. There are two possible explanations for this: first, whilst a treatment may address a symptom, it does not always treat the impact of that symptom; and secondly, there can be a mismatch between physicians' and patients' expectations of what a treatment will achieve. The present authors discuss some of the issues surrounding patient perceptions of the impact of incontinence, and also recent research undertaken to investigate the differences in perception between doctors and their patients. George Kelly outlined the theory of personal constructs, which highlighted how individual expectations can be based on experience. The present authors' research utilized repertory grids to identify themes that may be important in decision-making. The results highlight the diversity of options required to meet all expectations. A further study in the present authors' unit demonstrated the potential impact of urodynamics on patients' subsequent compliance with therapy. It is interesting that, at a time when there is an increasing focus on treating the whole patient, the Government has highlighted behavioural therapy as an important area to develop in managing patients with anxiety and depression.

Keywords: incontinence, psychology, treatment.

Introduction

The advent of ambulatory surgical procedures and more-effective medications with multiple routes of administration has led to a revolution in the management of urinary incontinence over the past 20 years. As a result, surgical success rates are now frequently quoted as being in the 85–90% range (Nilsson 2004; Richter *et al.* 2005). Despite this, there appears to be a sub-group of women who, seemingly having had successful surgery, remain dissatisfied with the outcome of their treatment, and it is these women who now present one of the more challenging dilemmas in urogynaecology. There may be two reasons for this apparent discrepancy:

(1) These women may demonstrate a failure to adapt or modify behaviour after physical treatment, as is exemplified by a woman who wears a pad 'just in case'. In many ways, these women represent the worst possible outcome, since their failure to change their behaviour means that they may be difficult to manage.
(2) Treatment and assessment of outcome may have failed to set measures relevant to the woman's lifestyle.

The relationship between the psyche and the bladder has long been recognized. In the 1970s, Stone & Judd (1978) noted that patients with overactive bladder symptoms who remained refractory to conventional treatments had a high incidence of depression. As long ago as the 1940s, Straub *et al.* (1949) observed increased bladder pressures in patients when he discussed stressful situations, with the pressures returning back to normal during relaxing conversations.

There are many differing personality theories. For example, Jung divided brain function into the conscious, and the personal and collective unconscious. George Kelly (1991) first looked at

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integrating the conscious and the unconscious as a working unit in his theory of personal constructs. He proposed that life is lived as a series of experiments. Prior to each event, an individual has expectations of what will happen based on previous experience. If the occurrence is different from what they were expecting, they then modify their own personal constructs to incorporate the new information. Therefore, people modify their expectations as a result of experience.

Materials and methods

At Birmingham Women's Hospital, Birmingham, UK, a programme of research was designed using some of the principles of Personal Construct Psychology to study women's experiences of urinary incontinence and its treatment. The ultimate aim is to establish whether it is possible to identify women who will not adapt to their treatment regardless of the physical success of treatment modalities.

The Repertory Grid Technique (Bannister 1965; Bannister & Fransella 1989) is an integral part of Personal Construct Psychology and was used in the present study to develop patient constructs in a variety of situations. Additionally, qualitative interviews were used. Readers with exposure to quality of life (QoL) questionnaire designs will notice the overlap with the basic research in developing these assessment tools. This work varies from QoL assessment tools because the aim of the psychology tool is to help formulate management plans rather than to measure the outcome of treatments.

Put simply, the aim was to develop a system from which the patient could derive the optimal benefit from an appropriate therapy rather than a suboptimal outcome from the treatment viewed as the best.

Preliminary analyses identified a number of organizing themes, as seen in Box 1.

Much of what was highlighted may seem obvious; however, these matters are seldom discussed in terms of patient treatment. The effect of the problem included basic issues, such as practical concerns regarding clothing and carrying pads. Frequent concerns included smell, hygiene and social restrictions, including limitations on travel or impact on sex.

Box 1. Organizing themes

Effect of problems
Investigations and treatment
Emotional reaction to problems
Opinion on care
The future
Start of condition
Other people
Body
Coping

Results and discussion

One of the key findings was that women's views on investigations and treatments were extremely varied, including satisfaction/dissatisfaction with management, and varying motivations and attitudes towards different treatment modalities. What is interesting here is that women had a whole spectrum of expectations of their management, from wanting a 'quick fix' solution to wanting thorough investigation prior to treatment. In addition, some patients would want medication to avoid surgery, whilst others wanted surgery to avoid medication.

The results also suggest that women may have a whole variety of emotional problems as a result of their symptoms, including issues such embarrassment regarding leakage, worry and fear. The future seemed to be of grave concern to some participants even more than their present problems. Sometimes there was an expectation that things were bound to get worse for the women and that they would not be able to cope at a later date.

Conversely, healthcare professionals have paid lip service to patients' views on outcome. Traditionally, surgeons have, overall, felt that surgery offers good results and much of the recent literature has supported various new procedures. The fact that there has continued to be development and surgical innovation suggests that, in the real world, the results may not always be as good as at first reported!

The lack of 'success' with surgery was investigated by Black *et al.* (1997). These authors reported that surgeons felt that their surgery was successful in 85% of cases, but only 66% of patients felt that their expectations had been met, with only 28% being fully continent. These figures are not dissimilar to the success rates reported in the tension-free vaginal tape versus colposuspension randomized controlled trial (RCT) by Ward & Hilton (2002). They reported that any single parameter of success fared well, but when two or more criteria were used, including objective, subjective and QoL measures, the accumulative 'absolute' success rapidly fell.

Robinson *et al.* (2007) investigated this discrepancy further and found that there was poor agreement between clinicians' and patients' attitudes to the acceptability of symptoms. These authors also reported large variations in the outcome measures used and identified a need for some consistency. This discordance between patient and physician assessment of the impact of symptoms, coupled with differing expectations of surgery, has lead to the development of the idea of patient-centred goals (Hullfish *et al.* 2002), whereby the patient expresses exactly what she would wish to gain from her treatment. In doing so, she would then help to define the treatment that may best help realize her ideals.

The idea of patient-centred goals has been developed into EGGS: Expectations, Goal-Setting, Goal Achievement and Satisfaction with Outcomes (Brubaker & Shull 2005). However, this does not in itself necessarily allow the physician to help the patient manage expectations effectively, since goals may change with time. An example would be where an anticholinergic medication improves urinary frequency, but the dry mouth becomes troublesome, leading to discontinuation of an initially successful treatment. It is this identification of perhaps more basic emotional responses (e.g. 'I feel old' or 'I don't want to end up like my mother') rather than improving physical symptoms (e.g. 'I want to be able to play tennis again') that may hold the key to improving outcomes.

Investigations may play a vital role in forming or shaping a patient's views on treatment. Urodynamics remains highly contentious as an investigation, with health professionals being polarized in their opinions about its value and place. One of the strands of the research at Birmingham was to develop a comprehensive cohort study, encompassing a RCT with patient preference arms, to examine women's preferences for investigation. This study recruited over 300 women as new referrals for conservative management. Surprisingly, 50% opted for urodynamic assessment (UDA), with only 19% opting for treatment based on symptoms. However, the most surprising finding was that the women opting for UDA had a much-reduced subsequent 'did not attend' rate, suggesting a greater compliance with treatment.

These results were mirrored in the women randomized to UDA compared to those randomized to treatment based on symptoms, suggesting that this is not just a patient preference. The findings suggest that there may be utility in involving women in understanding pathophysiology and in counselling, which may relate to women being able to feel that they have had an opportunity to discuss their symptoms, and understand the pathology and, possibly more importantly, the impact of their symptoms in greater detail than perhaps would occur in a normal clinical history.

At a time when there is increasing recognition that the whole patient may need treatment, not just the bladder, it is interesting that the Government has announced the importance of counselling and cognitive behavioural therapy as an important area of treatment of anxiety and depression. Recognition of the impact of urinary symptoms on mood and the impact of mood on the treatment of urinary symptoms is crucial in order to offer a proper service. In a lot of ways, this now has turned a full circle, and recognition that stressful situations affect the bladder and that the bladder can make situations stressful may help healthcare professionals to treat women more effectively.

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