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# Psychological perspectives in urinary incontinence: a metasyntesis

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## Abstract

### Introduction

Urinary incontinence with co-morbid depression has been found to have a significant effect on quality of life. Examining the associations between the psychosocial factors related to urinary incontinence and mental health may help in improving the care for patients with these conditions. The aim of this research study is to explore the relationship between mental health status and urinary incontinence, focusing on the role of psychosocial factors.

### Materials and Methods

A search of Medline, CINAHL and SCOPUS databases yielded 15 studies on the topic, and 10 studies were found to be in scope. A metasyntesis using Noblit and Hare's approach of meta-ethnography was undertaken. This involved a number of steps including determining how studies are related and identifying major themes.

### Results

Three psychosocial aspects of urinary incontinence appear to influence mental health status: living with, management of and attitudes about incontinence. Other smaller component themes included control, seeking help and personal beliefs.

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### Discussion

Psychosocial factors appear to mediate the relationship between urinary incontinence and mental health status. An increased awareness of the major psychosocial issues that can influence both incontinence and mental health may contribute to a better management of the condition as well as reduce the burden of the condition on individuals.

### Conclusion

Incontinence and psychological well-being are intertwined and this adversely affects a number of aspects of life. Enquiring about the mental health status of those with incontinence should include an assessment of psychosocial factors to help reduce the burden of incontinence. To improve the management of these conditions, further research should investigate whether psychological issues precede incontinence or vice versa.

### Introduction

Urinary incontinence is not often considered without mentioning the associated psychological effects, such as psychological distress, depression and anxiety<sup>1,2</sup>. The International Continence Society takes great care, in its definition of urinary incontinence (hereon referred to as incontinence), to embrace its association with psychological and psychosocial factors<sup>3</sup>. An examination of mental health in combination with the psychosocial aspects of incontinence has generally been neglected<sup>4-10</sup>.

Many psychosocial factors associated with incontinence may be adversely impacted by depression. Incontinent people experiencing comorbid depression may be less likely

to seek help for their incontinence, their quality of life may be lower, they may be more socially isolated, their perception of symptom severity may be greater and their use of health services may be less when compared to individuals with incontinence who are not depressed<sup>1,11-16</sup>. We do not understand clearly how being depressed interacts with these psychosocial factors<sup>17</sup>.

Qualitative studies present one fruitful avenue to gain a better understanding of the relationships between incontinence, depression and psychosocial factors. Although a number of individual qualitative studies of these relationships have been undertaken, there has been no attempt yet to conduct a metasyntesis of the qualitative literature in this area.

Metasyntesis enables us to become more confident about using qualitative literature to fill the evidence gaps, as findings from a number of studies may become more conclusive after a synthesis is performed<sup>18</sup>. An advantage of this to the individual researcher is that an investigation can be further progressed rather than continuing to undertake smaller pieces of work that may elicit very similar findings<sup>19</sup> and broader perspectives may be achieved than that found by the individual researcher<sup>20</sup>.

One approach favoured by many researchers, possibly because its method is grounded in the originating paradigm of qualitative research<sup>21</sup>, is *meta-ethnography*<sup>22</sup>, which has its origins in educational research. It has often been applied across studies with diverse theoretical foundations<sup>23</sup>. This study explores

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the relationship between mental health status and incontinence in women, focusing on the role of psychosocial factors.

### Materials and Methods

This work conforms to the values laid down in the Declaration of Helsinki (1964). The protocol of this study has been approved by the relevant ethical committee related to our institution in which it was performed. All subjects gave full informed consent to participate in this study.

### Search Methods

Qualitative studies were sought that addressed incontinence and mental health, in either their aims or their findings. To maximise appropriate studies, broad search terms were used to encompass the full range of studies in this area. An electronic search of the Medline, CINAHL and Scopus databases was undertaken combining the terms (1) 'Urinary incontinence' as a MESH heading, and 'urinary incontinence', 'overactive bladder' or 'urethral syndrome' in the title or abstract, and (2) 'Depression', 'depressive disorder', 'mental health', 'social stigma', 'anxiety disorders', 'mood disorders' as a MESH heading, and 'depression', 'depressive', 'phobic', 'phobia\*', 'mental health', 'stigma', 'stigmati\*', 'fear', 'psychol\*' or 'affective' in the title or abstract. To be included in the metasynthesis, studies need to be: concerned with some type of urinary incontinence, overactive bladder or lower urinary tract symptoms; observed from the respondent's own perspective; concerned with adult humans. Only articles written in English were chosen. Studies that included both women and men were included when particular themes concerning women were outlined. When searching for studies to include in this metasynthesis, we included those that concerned different types of incontinence, overactive bladder or lower urinary tract symptoms.

### Search Outcome

Fifteen studies from 1993 until 2011 were identified. After reading through the articles, five were found to be out of scope; that is they did not provide discussions of incontinence and mental health status from the point of view of the person themselves (sometimes it was carer or health professional perceptions), they concentrated on service use, stigma or quality of life or they were not predominantly a qualitative study.

No previous studies were found that looked at the experiences of living with incontinence primarily from the perspective of mental health status. The studies focused on incontinence, and mental health issues arose as part of the examination. Table 1 summarises each article with regard to the sample, methodology, aims and finding of the study.

The quality of each of the included study was scrutinised using the Critical Appraisal Skills Program tool<sup>24</sup>. All included studies were found to sufficiently address all the criteria.

Using thematic analysis, each study included in the metasynthesis was initially read a number of times to identify overarching themes<sup>25</sup>. Once the major themes were determined, the studies were coded using Nvivo 9<sup>26</sup>. The results from the studies themselves were coded as themes and subthemes using a constant comparative method<sup>27</sup>. Then, the emerging themes from each of the studies were compared against each other, to examine important psychosocial aspects that mediated incontinence and mental health.

### Results

Incontinence is associated with a number of psychological issues. Some of these issues are primarily defined as major mental health issues, such as depression and anxiety; there are also other psychological issues connected with incontinence such as embarrassment, fear, self-esteem

issues, worry, vulnerability, shame, paranoia and uncleanliness<sup>28-36</sup>.

Three main psychosocial themes became evident from the literature as potential influences on the association between incontinence and mental health: day-to-day living with incontinence; the management of incontinence; and attitudes about incontinence (Figure 1).

### Living with urinary incontinence

A first major theme emerged from the literature related to living with incontinence. This theme concerned relationships, particularly those of an intimate nature not only with a partner or spouse but also with friends, family; restrictions on activities; as well as overall quality of life. The nature of incontinence, with its complex issues in many different areas, means that, particularly when seeking help, those with incontinence do not know where to start discussing their problem<sup>30</sup>. Some papers described the problem in terms of its practical effects, but others concentrated on how the condition affected them emotionally. The greatest effect on quality of life appeared to result from coping with urgency<sup>29</sup>. The mental health of those with incontinence was affected on a day-to-day basis, and included depression, hopelessness, as well as anxiety. The exhaustion from broken sleep could compound such feelings. Some incontinent women also felt that their depression was making them ill in other ways<sup>29</sup>.

The effect incontinence had on relationships, both intimate and social, was a major issue. Avoiding any kind of sexual relationship, even with a longstanding partner was common.

*'You can't be physically attractive if you are not clean'<sup>29</sup>.*

*'Aye it is terrible. Good job I don't have a man, my husband is dead. I am by myself. But it is really embarrassing'<sup>29</sup>.*

It seemed, for those with incontinence, that not having an intimate relationship could be best for all



Table 1 Analyses of qualitative studies concerning incontinence and depression

Author	Date	Country	Condition, sample, survey setting/methods	Aim	Questions	Findings/main themes
Ashworth, P.D., Hagan, M.T	1993	United Kingdom,	UI 28 women 25–55 years In-depth interviews phenomenological	To discover the meaning of their condition for the sufferers themselves	Concerned the subject's experience of incontinence these include her attitude to her body, her perceptions of other people and their reactions to her, her attitude to herself, and the impact of incontinence on her daily activities	Incontinence is a taboo, a socially unacceptable topic of conversation (inhibiting the approach to health professionals). Reactions of apathy, or may perpetually teeter on the edge of taking ameliorative action: rational ways of tackling the problem are often not followed. The problem is seen as one of personal control.
Mason, L. Glenn, S. Walton, I. Appleton, C.	1999	United Kingdom	SUI 42 postpartum women 21–45 years Part of larger study, interviews discourse analysis	To examine the effects of SUI on women in their childbearing years	Please describe how having stress incontinence affects your life?	Many experience physical and psychological symptoms of SUI after delivery, few sought professional care or advice for their symptoms.
Horrocks, S. Somerset, M. Stoddart, H. Peters, T.	2004	United Kingdom,	UI 9 men, 2 women, over 65 Semi-structured interviews grounded theory	Explore reasons why older people living in the community do not present for help with problems of UI and to identify was in which they may be assisted to access continence services	<i>13 questions:</i> 'How would you describe your general health at the moment? I noticed from your questionnaire that you experienced some urine leakage. When did you first become aware that this was happening? How did you feel about it?' etc.	Personal attitudes and practical; barriers prevent older people for seeking help for UI.
Teunissen, D. Van Den Bosch, W. Van Weel, C. Lagro-Janssen, T.	2006	The Netherlands	UI 56 men and 314 women independently living aged 60 and over. In depth interviews, grounded theory.	To determine the impact of uncomplicated UI incontinence on quality of life in elderly men and women in the general population and to identify factors with the greatest effect	Does UI impact your daily life and if so what are the most troubling aspects?	UI in the elderly affects mostly emotional wellbeing. Men report 'being out of control as most important. Women consider 'being impelled to take precautions' to be most important.

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Table 1 (Continued)						
Author	Date	Country	Condition, sample, survey setting/ methods	Aim	Questions	Findings/main themes
Hägglund, D., Ahlström, G.	2007	Sweden	UI 14 women 34–52 years Had sought professional help interviews, phenomenological hermeneutic	Illuminate the meanings of women's experiences with UI	'Could you tell me about your experiences with urine leakage, please?' 'Can you tell me more about this situation when you leak urine?' 'What did you feel?' 'How did you experience the situation?' 'What happened?' 'How do you deal with the situation?'	Being in a vulnerable position means that women had no control over UI and experience powerlessness. Striving for adjustment means that women tried to handle their UI in different ways to regain power and continue to live as normal. <i>Subthemes:</i> living in readiness, making urine leakage comprehensible, accepting living with UI and being familiar with the situation.
Doshani, A. Pitchforth, E. Mayne, C.J. Tincello, D.G.	2007	United Kingdom	UI South Asian Indian Women 30–85 years Focus groups Grounded theory/constant comparative method.	To explore views and experiences of UI and perceptions of care among South Asian Indian women.	1. Have you heard about anyone having UI? 2. How did you or they (relatives or friends who suffer from UI) cope with it? 3. Why do you think UI occurs? 4. Do you know of any treatment available for UI? 5. Would you be willing to try alternative therapies? 6. Who would you like to see if you developed this condition and why? 7. Why do you think most women don't seek help for this problem? 8. How do you think we can increase awareness within the community about UI? 9. How do you think we can improve the services provided in the NHS for managing women with UI? 10. If any of the participants answered that they or a family or friend suffered from UI, they would be asked if they would be willing to share the experience with the group, including issues around access to care, treatment and how satisfied they were with the received care.	Normalization/ management of symptoms Help seeking/access to health care Suggestion for improved service.

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Table 1 (Continued)

Author	Date	Country	Condition, sample, survey setting/ methods	Aim	Questions	Findings/main themes
Hagglund, D. Wadensten, B.	2007	Sweden	UI 13 women 37–52 years had not sought professional help Interviews, Phenomenological hermeneutic	To illuminate the meaning of women's lived experiences of their behaviour when seeking care for long term UI.	Please tell me what you feel would lead you to seek professional help for UI. When do you need professional help, what treatment do you need, and how do you deal with the UI?	Being in an affected situation; Having personal beliefs about seeking care Having desired expectations about care
Nicolson, P. Kopp, Z. Chapple, C.R. Kelleher, C.	2008	United Kingdom	OAB Men and women 51–85 years 8/10 In-depth semi-structured interviews and group interviews Thematic and interpretive analysis	Report the perceptions of patients with OAB about their health related quality of life and psychological consequences	Explored issues around health related quality of life	Experience of urgency Fear and coping strategies Anxiety about everyday living Depression and hopelessness Embarrassment Self-esteem sexuality and embodiment Many sufferers avoid admitting to the condition and/or seeking treatment, the psychological costs to them are even greater than with a diagnosed illness because the disruption remains unacknowledged and therefore unresolved.
Hemachandra, N.N. Rajapaksa, L.C. Manderson, L.	2009	Sri Lanka	SUI married women, aged 15–49, 6 focus group discussions, 8 key informant interviews, 5 case studies, Phenomenological	To discuss how SUI affects women's lives and how they manage the problem	Detailed information on perceptions, decision making around seeking medical advice, actual help seeking and management strategies and the mental, emotional, physical and sexual consequences of SUI	Although UI affected outdoor activities, sexual life, and sense of wellbeing, women did not consider it a health problem, rarely discussed it with others, and rarely sought treatment.

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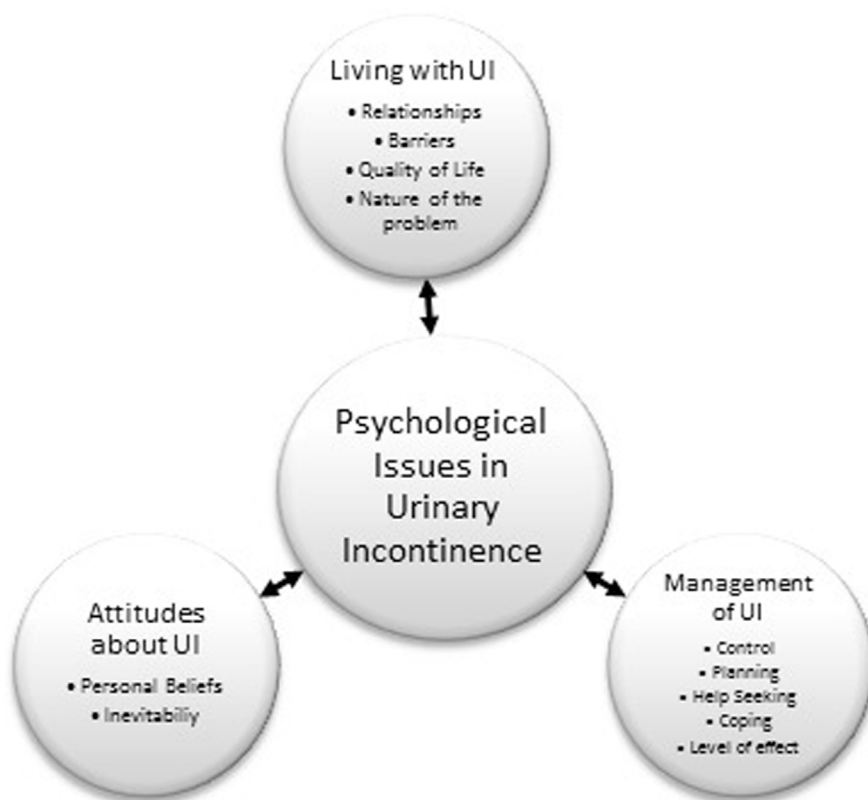
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All authors abide by the Association for Medical Ethics (AME) ethical rules of disclosure.



Author	Date	Country	Condition, sample, survey setting/ methods	Aim	Questions	Findings/main themes
Elstad, E.A. Taubenberger, S.P. Botelho, E.M. Tennstedt, S.L.	2010	USA	LUTS 151 black, white and Hispanic men and women In-depth interviews Grounded theory	Characterise the stigma of daytime frequency and urgency and differentiate it from the stigma of UI Describe race/ethnic and gender differences in the experience of stigma among a diverse sample of individuals with LUTS	Questions related to own experiences of having LUTS, as well as their impression on what other people think of individuals with LUTS and 1. Speculate on how they might feel in certain situations; 2. Provide their perception of how others view them; and 3. Discuss their own opinions about others who experience LUTS.	Stigma associated with frequency and urgency – not just UI Stigma of frequency/urgency is rooted in social interruption, Loss of control of the body, and speculation as to the nature of a non-specific 'problem'. Stigma of LUTS goes beyond incontinence to include behaviours associated with frequency and urgency

UI, urinary incontinence; SUI, stress urinary incontinence; LUTS, lower urinary tract symptoms; OAB, overactive bladder.



**Figure 1:** Psychological factors influencing psychosocial issues in urinary incontinence

concerned, particularly if partners commented on the smell or leakage during sexual relations<sup>28,29,34</sup>. However, lack of intimacy seemed to also increase tension in the household as well as negative feelings.

*'My husband says that I stink (muthra gadai) because of it. Sometimes he does not like to be near me. He no longer has sex with me. I am always worrying whether he sees other women. Then I feel sorry for myself. But who can help me with this?' (Renuka, 40 years)*<sup>31</sup>.

As a result of the condition, a woman's body became irrelevant, that is she may no longer feel attractive, resulting in further self-esteem issues<sup>30</sup>. These themes illustrate the pressure for satisfactory relationships and intimacy, and this may contribute to poorer mental health in those with incontinence.

Major restrictions in many life activities also occurred because of incontinence, including the inability to exercise, especially aerobics or swimming. Running for the bus or playing

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with children was also restricted. The role as mother was interrupted because of incontinence.

*'My little girl's eight now, and I can't run around and play with her. If she says 'race you,' I say 'no - you'll have to race your dad.'*<sup>28</sup>.

Even coughing, sneezing or raising one's voice could cause an accident, and this was quite a problem in the public setting<sup>28,30,37</sup>. Social roles were greatly restricted: working, going to visit friends, going to the cinema or shopping<sup>31</sup> were all activities that were found to be problematic. Physical activity, appropriate social roles and social inclusion are important factors for good mental health, and it is evident that these were affected by incontinence.

A range of other feelings were also associated with incontinence, which in turn affected day-to-day living. These included embarrassment in discussing their condition with family, friends and care providers, which affected help-seeking behaviour<sup>28,29,31,33,34</sup>. The women experienced embarrassment when having to make frequent trips to the bathroom<sup>32</sup>. Experiences of associated shame with a problem of such a private nature contributed towards such feelings<sup>35</sup>.

Constantly aware, stressed and worried about having an accident and others finding out, or not being able to find a bathroom in time, weighed heavily on these people<sup>28,29,31</sup>. Fear also pervaded any sense of wellbeing that could occur, as there was always the chance of an accident or leakage<sup>28,29,31</sup>. For those with incontinence, the psychosocial aspects of day-to-day living adversely affected psychological wellbeing.

### Management of urinary incontinence

Another consistent theme in the literature was the need for people with incontinence to 'manage' their condition. Managing incontinence had

both practical and psychological components. The practical management themes included planning, constant awareness, specific behaviours, avoidance of activities, barriers to adequate management and help-seeking. Psychological management themes included those of coping, disclosure, explanations of causes and control.

Management of incontinence was most commonly undertaken by planning. People with incontinence discussed 'designing their life around it'<sup>29</sup>, using protection, taking precautions or preventing accidents in a number of different ways<sup>28-32,37</sup>.

*'I think to myself, when I get to the hill with the birch trees I'm not going to have to urinate, and when I get to the boulder, I can't hold myself any longer. But just quitting thinking about it, having someone along with me on the walk, then the thought doesn't enter my mind and I manage the walk, it is psychological'*<sup>34</sup>

Not disclosing their condition was one way that life could be made more bearable. Some people kept their condition hidden, even from their partners and family<sup>28</sup>. Others were worried that if they revealed their condition, even by using others' toilets, they would become stigmatized<sup>30-32,34</sup>. Further, incontinence was particularly hidden for men, as it was seen as a woman's problem and as a private thing, not to be disclosed<sup>35</sup>.

*'Because as long as nobody knew - so in a way it was a problem. Didn't want my husband to find out.'*<sup>28</sup>

Control of one's incontinence could be construed either positively or negatively. Some women had only a minor problem that they had 'control over'; however, others saw their problem as something they could not control, leading to desperation, powerlessness and anger<sup>28,36,37</sup>. Some of those experiencing incontinence felt that it reflected a lack of control in their life more generally<sup>30</sup>, as they were not able to control their own bodily functions<sup>35</sup>.

A number of other issues surrounded the management of incontinence. Coping referred to the management of urgency and preventing accidents<sup>29</sup>, but it also concerned the ability to just get on with life, by having various strategies to get through each day, including denial of the situation<sup>30</sup>. Having to be constantly aware of the situation was necessary but tiresome<sup>28</sup>. Avoiding activities that would lead those with incontinence into dangerous situations seemed to be a much used tactic, as well as the use of camouflaging clothing<sup>29,35</sup>.

*'Well I am going out tonight and I am sick [with worry]. I don't go out normally - I don't. Not even like say going to the doctor's, because if I have an 'accident' I will die.'* (female patient)<sup>29</sup>

Finally, behaviours that could lead to the person with incontinence to be seen as different were undertaken. These included the constant use of toilets at functions, frequent use of toilets at private residences when visiting, trying to avoid having accidents, avoiding intimate activities such as sex, or flying on planes, going for long walks and other activities, which led sufferers to become socially undesirable<sup>32</sup>. Not being in control contributed towards the level of anxiety.

One important component of managing incontinence is help-seeking, specifically addressed in seven of the studies, and a major focus in five. Hagglund and Ahlstrom report that women felt 'wounded by health care staff'; they were not followed up in the provision of protective pads, particularly if they were younger<sup>36</sup>. In all studies, the theme of embarrassment with regard to help-seeking emerged<sup>28,31,34</sup>. Confidentiality and privacy were other barriers. A number of papers suggested that certain characteristics of the health practitioner could assist in encouraging help-seeking, such as the gender of the practitioner<sup>31,33</sup>, ethnicity<sup>33</sup>, or the type of health professional,





for example general practitioner<sup>31,33</sup>, nurse<sup>33,34</sup> or allied health professional<sup>33</sup>.

*'You know, in our area, all the doctors are men. Then how can I discuss 'woman's stuff' with them. I feel embarrassed'*<sup>31</sup>

The women in the studies found that they were treated differently by different practitioners; however, overall they were not satisfied with the information and care that they had received. Problems such as these were regarded as barriers to help-seeking<sup>35</sup>.

### Attitudes about urinary incontinence

People experiencing incontinence held a number of different attitudes along a continuum, from those who completely normalised their symptoms, to those that found the whole experience taboo.

At one end of the continuum, some women saw incontinence as a sequel to pregnancy and birth and accepted that it was inevitable<sup>28,31</sup>. Ageing was also cited as a reason for the problem, along with associated weakness of the body, previous surgery and medication use, as well as compounding chronic conditions<sup>33,35</sup>. Rationalising incontinence in this way made it a little easier to cope with it<sup>34</sup>.

If the symptoms of incontinence could be normalised in ways such as above, associated problems could be minimised<sup>28</sup>. Incontinence was not often mentioned as a disease or a health problem, and arguments were made that it was a normal state:

*'I think it is a usual occurrence in women. It is not a disease. Child bearing, aging, heavy work may aggravate it' (Malini, 34 years, focus group discussion).*<sup>31</sup>

It was taken for granted that incontinence was just a normal part of ageing or having children<sup>33,35</sup>, and it was also seen as a 'natural thing'<sup>34</sup>.

*'I didn't bring this injury on myself, I've ended up with a bladder control problem, I associate it with giving*

*birth and having children since it didn't happen before that, it's a natural thing, it's nothing I could do something about'*<sup>34</sup>

Many people with incontinence did not consider that it was actually a medical condition<sup>30</sup>. These attitudes affected their help-seeking behaviour, as well as perceptions about the condition<sup>35</sup>. Some of those with incontinence were very clear in the attribution of cause they gave to their condition so that they blamed themselves, believing they could have prevented it through pelvic exercise<sup>28,36</sup>.

At the other end of the continuum, the shame and embarrassment of incontinence meant for some that it was a taboo subject with stigma attached. It could not be discussed with friends and family. Those who were incontinent worried about the smell, having accidents and the frequency with which they visited the bathroom. They were often very concerned by what other people thought, and many spent much time concealing their condition<sup>28,31,32</sup>. The attitudes these women attributed to other people were often unfounded.

*'If I go to someone's house and I have to go to the bathroom a lot, maybe it might not be the right time to go to the bathroom to pee, but since I have this weakness in my bladder, I have to go right away... I worry because I think other people are going to think 'what's wrong with her? Why is she going to the bathroom so much?'... It's truly not normal for someone to need to go to the bathroom so much!' (Hispanic woman)*<sup>32</sup>

The age of the affected person affected their attitudes, with younger people more likely to conceal their problem at all costs<sup>36</sup>. The taboo about incontinence also affected help-seeking behaviour<sup>29,34,35</sup>. Some women experienced stigma as a result of the relationship of incontinence to the genital area, as it was 'bad' or 'dirty', and needed to be concealed<sup>30,31</sup>. Others thought that it would be less of a problem if it was

talked about more publicly, perhaps if there were a 'champion' with incontinence who wanted to share their experiences<sup>33</sup>.

If people with incontinence believed they were not in control of their own bodies, they could experience a kind of disembodiment, which led to low self-esteem, resulting in other problems either physical or psychological. Feelings of vulnerability developed from a lack of control in one's life<sup>36</sup>.

*'But making light of it does not always work: I try to make a joke of it, but sometimes you've really got to feel down. You know, you get awful down.'*<sup>29</sup>

The impact of the condition had much to do with how those with incontinence perceived it. Did they accept the condition, or deny it? Did they think that their personality was such that they would not let it become a problem? Did they feel that it would get better, thus showing signs of hope? Positive perceptions such as these meant a reduced impact on life.

*'Won't let it become a problem; it's not in my personality, will always find ways round it.'*<sup>28</sup>

The opposite was also the case, where those who worried about incontinence, more likely to be impacted<sup>28</sup>. It was also evident that, once people got older and experienced other conditions, the impact of incontinence, in the scheme of things, was lessened<sup>33,35</sup>. Further, with women, as the role of women included both family and career duties, the problems of incontinence, and things that affected the women themselves, were less of a priority<sup>34</sup>.

### Discussion

Incontinence is associated with poorer mental health<sup>38</sup>, and there are many psychosocial factors that mediate this relationship. Qualitative studies investigating incontinence are often concerned with particular aspects of the condition, such as quality of life or help seeking.



However, the impact incontinence has on mental health is part of a bigger story. The synthesis of studies in this area demonstrates that psychological factors mediate a number of other issues, such as help seeking, related to incontinence.

Three main psychosocial themes—living with, management of, and attitudes about incontinence—were identified from the nine studies analysed, with a number of subthemes falling under each of these areas. When the three main themes were examined in each study, key components emerged: how living with incontinence affected relationships and quality of life, the restrictions that occurred and the actual nature of the problem; how the management of incontinence included control, planning, coping and seeking help, and that the level of effect on one's life could be due to their own feelings about the condition; and attitudes about incontinence that included personal beliefs about aspects of the condition, such as the inevitability of it, and anxiety about, what other people thought.

The studies included in this meta-synthesis also covered different population groups of people with incontinence, with variation by gender, age, ethnicity and whether or not help had been sought. Although some differences between groups, such as gender and ethnic groups, could be found, the similarities between such groups may enable more directed assistance for the management of incontinence and similar conditions, as these findings show that many of the practical problems of incontinence can have an impact on emotional problems, and taking care of the psychological wellbeing may reduce the burden of managing the condition and increase overall quality of life.

As no previous studies have been found that addressed women's experiences of living with incontinence primarily from the

perspective of their mental health status, the strength of this synthesis is it combines the evidence from a number of studies, enabling us to draw wider conclusions about our research questions. This metasynthesis indicates the importance of alleviating the psychological issues associated with incontinence, via a consideration of the major psychosocial aspects. If the condition is treated, taking into account the aspects of management, day-to-day living and attitudes, there may be reduced psychological burden and better outcomes for those with the condition.

Incontinent people experiencing co-morbid depression may be less likely to seek help for their incontinence, their quality of life may be lower, they may be more socially isolated, their perception of symptom severity may be greater and their use of health services may be less when compared to individuals with incontinence who are not depressed<sup>1,11-16</sup>. Clearly, for the 30% of those with incontinence who also suffer from depression, an opportunity to reduce the burden of incontinence is presented, as treating depression may be more successful than treating incontinence<sup>4,39-41</sup>.

### Conclusion

Previous studies have described the relationship between incontinence and mental health, and poorer mental health is associated with a reduced help seeking. There have been no studies exploring the interaction of incontinence, depression and help seeking, a combination, which we would expect to be common. Additionally, few recent investigations have concentrated on the impact of mental health problems upon psychosocial issues that relate to incontinence such as on quality of life, management and coping behaviours, social connectedness and beliefs and knowledge of the condition, focussing more on risk factors such

as gender, age, cognitive impairment and physical health.

Here, an opportunity for further investigations into these interactions is presented. When managing a condition such as incontinence, especially when treatment is not successful, it is imperative to take into account lifestyle, coping and management strategies, as well as attitudes surrounding the condition. Routine questions could be asked of patients attending general practices regarding symptoms to identify those with incontinence who may not be aware of available treatments. Referral should be encouraged to specialist services, because, for instance, continence advisors can provide detailed information and advice about day-to-day living. In turn, those with the condition may be able to assist in breaking down the taboos surrounding the condition by sharing their stories.

Incontinence and psychological wellbeing are intertwined and this adversely affects a number of aspects of life. Enquiring about the mental health status of those with incontinence should include an assessment of psychosocial factors to help reduce the burden of incontinence. To improve the management of these conditions, further research should investigate whether psychological issues precede incontinence or vice versa.

### References

1. Heymen S. Psychological and cognitive variables affecting treatment outcomes for urinary and fecal incontinence. *Gastroenterology*. 2004 Jan;126(1 Suppl 1):S146-51.
2. Haag A. The link between poor bladder or bowel control and depression. <http://www.confound.org.au/pdf/resessionIncontinenceRef.pdf> [Accessed 09Jan 2005].
3. Abrams P, Cardozo L, Fall M, Griffiths D, Rosier P, Ulmsten U, et al. The standardization of terminology of lower urinary tract function: report from the Standardisation Sub-committee of the

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International Continence Society. *Neuro-urol Urodyn*. 2002;21(2):167–78.

4. Fultz NH, Herzog AR. Self-reported social and emotional impact of urinary incontinence. *J Am Geriatr Soc*. 2001 Jul;49(7):892–9.
5. Lagro-Janssen AL, Smits A, Van Weel C. Urinary incontinence in women and the effects on their lives. *Scand J Prim Health Care*. 1992 Sep;10(3):211–6.
6. LaRocco-Cockburn A, Melville J, Bell M, Katon W. Depression screening attitudes and practices among obstetrician-gynecologists. *Obstet Gynecol*. 2003 May;101(5 Pt 1):892–8.
7. Moore KN, Gray M. Urinary incontinence in men: current status and future directions. *Nurs Res*. 2004 Nov–Dec;53(6 Suppl):S36–41.
8. Seim A, Hermsstad R, Hunskaar S. Management in general practice significantly reduced psychosocial consequences of female urinary incontinence. *Qual Life Res*. 1997 Apr;6(3):257–64.
9. Shaw C. A review of the psychosocial predictors of help-seeking behaviour and impact on quality of life in people with urinary incontinence. *J Clin Nurs*. 2001 Jan;10(1):15–24.
10. Valerius AJ. The psychosocial impact of urinary incontinence on women aged 25 to 45 years. *Urol Nurs*. 1997 Sep;17(3):96–103.
11. Bogner HR. Urinary incontinence and psychological distress in community-dwelling older African Americans and whites. *J Am Geriatr Soc*. 2004 Nov;52(11):1870–4.
12. Avery JC, Gill TK, MacLennan AH, Chittleborough CR, Grant JF, Taylor AW. The impact of incontinence on health-related quality of life in a South Australian population sample. *Aust NZ J Public Health*. 2004 Apr;28(2):173–9.
13. Costa P, Mottet N. Assessing the impact of urinary incontinence in a female population. *Eur Urol*. 1997;32(Suppl 2):25–7.
14. Gallagher MS. Urogenital distress and the psychosocial impact of urinary incontinence on elderly women. *Rehabil Nurs*. 1998 Jul–Aug;23(4):192–7.
15. Heidrich SM, Wells TJ. Effects of urinary incontinence: psychological well-being and distress in older community-dwelling women. *J Gerontol Nurs*. 2004 May;30(5):47–54.
16. Gartley C. Research priorities for urinary incontinence from the patient

perspective. [www.simonfoundation.org/html/d/speech01.htm](http://www.simonfoundation.org/html/d/speech01.htm); 2004 [Accessed 25 Jul 04].

17. Avery J, Stocks N, Duggan P, Braunack-Mayer A, Taylor A, Goldney R, et al. Identifying the quality of life effects of urinary incontinence with depression in an Australian population. *BMC Urol*. 2013 Feb;13:11.
18. Thorne S, Jensen L, Kearney MH, Noblit G, Sandelowski M. Qualitative meta-synthesis: reflections on methodological orientation and ideological agenda. *Qual Health Res*. 2004 Dec;14(10):1342–65.
19. Finfgeld DL. Metasynthesis: the state of the art—so far. *Qual Health Res*. 2003 Sep;13(7):893–904.
20. McCormick J, Rodney P, Varcoe C. Reinterpretations across studies: an approach to meta-analysis. *Qual Health Res*. 2003 Sep;13(7):933–44.
21. Britten N, Campbell R, Pope C, Donovan J, Morgan M, Pill R. Using meta ethnography to synthesise qualitative research: a worked example. *J Health Serv Res Policy*. 2002 Oct;7(4):209–15.
22. Noblit GW, Hare RD. Meta-ethnography: synthesizing qualitative studies. Sage University Paper series on Qualitative Research Methods. Vol. 11. Sage Publications; 1988.
23. Downe S. Metasynthesis: a guide to knitting smoke. *Evid Based Midwifery*. 2008;6(1):4.
24. Critical Appraisal Skills Program. 10 Questions to Help You Make Sense of Qualitative Research. [www.casp-uk.net/index.aspx?o=1152](http://www.casp-uk.net/index.aspx?o=1152); 2012 [Accessed 11 Jun 12].
25. Ezzy D. Qualitative analysis. Practice and innovation. Crows Nest: Allen and Unwin; 2002.
26. QSR. NVivo 9.
27. Strauss A, Corbin J. Basics of qualitative research. London: Sage; 1990.
28. Mason L, Glenn S, Walton I, Appleton C. The experience of stress incontinence after childbirth. *Birth*. 1999 Sep;26(3):164–71.
29. Nicolson P, Kopp Z, Chapple CR, Kelleher C. It's just the worry about not being able to control it! A qualitative study of living with overactive bladder. *Br J Health Psychol*. 2008 May;13(Pt 2):343–59.
30. Ashworth PD, Hagan MT. The meaning of incontinence: a qualitative study of non-geriatric urinary incontinence sufferers. *J Adv Nurs*. 1993 Sep;18(9):1415–23.

31. Hemachandra NN, Rajapaksa LC, Manderson L. A “usual occurrence:” stress incontinence among reproductive aged women in Sri Lanka. *Soc Sci Med*. 2009 Nov;69(9):1395–401.

32. Elstad EA, Taubenberger SP, Botelho EM, Tennstedt SL. Beyond incontinence: the stigma of other urinary symptoms. *J Adv Nurs*. 2010 Nov;66(11):2460–70.
33. Doshani A, Pitchforth E, Mayne CJ, Tincello DG. Culturally sensitive continence care: a qualitative study among South Asian Indian women in Leicester. *Fam Pract*. 2007 Dec;24(6):585–93.
34. Hagglund D, Wadensten B. Fear of humiliation inhibits women's care-seeking behaviour for long-term urinary incontinence. *Scand J Caring Sci*. 2007 Sep;21(3):305–12.
35. Horrocks S, Somerset M, Stoddart H, Peters TJ. What prevents older people from seeking treatment for urinary incontinence? A qualitative exploration of barriers to the use of community continence services. *Fam Pract*. 2004 Dec;21(6):689–96.
36. Hagglund D, Ahlstrom G. The meaning of women's experience of living with long-term urinary incontinence is powerlessness. *J Clin Nurs*. 2007 Oct;16(10):1946–54.
37. Teunissen D, Van Den Bosch W, Van Weel C, Lagro-Janssen T. “It can always happen”: the impact of urinary incontinence on elderly men and women. *Scand J Prim Health Care*. 2006 Sep;24(3):166–73.
38. Melville JL, Fan MY, Rau H, Nygaard IE, Katon WJ. Major depression and urinary incontinence in women: temporal associations in an epidemiologic sample. *Am J Obstet Gynecol*. 2009 Nov;201(5):490.e1–7.
39. Dugan E, Cohen SJ, Robinson D, Anderson R, Preisser J, Suggs P, et al. The quality of life of older adults with urinary incontinence: determining generic and condition-specific predictors. *Qual Life Res*. 1998 May;7(4):337–44.
40. Zorn BH, Montgomery H, Pieper K, Gray M, Steers WD. Urinary incontinence and depression. *J Urol*. 1999 Jul;162(1):82–4.
41. Stach-Lempinen B, Hakala AL, Laipala P, Lehtinen K, Metsanoja R, Kujan-suu E. Severe depression determines quality of life in urinary incontinent women. *Neuro-urol Urodyn*. 2003;22(6):563–8.

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