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Diet Modifications in Older Women with Fecal Incontinence: A Qualitative Study

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Abstract

Objectives: To investigate dietary modification strategies used by community-dwelling older women to manage their fecal incontinence (FI).

Methods: We conducted a qualitative study with focus groups wherein women age 65 and older with FI shared their experiences managing the condition. We explored: (1) association between diet and FI symptoms, (2) dietary strategies and modifications used by older women to manage FI, and (3) patient input about disseminating diet modification information and strategies. All focus groups were audio recorded, transcribed, coded, and qualitatively analyzed to identify relevant themes.

Results: Twenty-one women participated in three focus groups. All participants were aware that diet plays a key role in their experience of FI and women described a method of “trial and error” in identifying specific aspects of their diet that contributed to their FI symptoms. Women reported modifications including avoiding or limiting several foods and food categories, changing certain methods of food preparation, as well as varying the amounts and frequency of meals to manage their FI. Women articulated several suggestions including the importance of physician input, employing a balanced approach when making recommendations, and the value of sharing individual experiences.

Conclusions: Older women with FI make several dietary modifications to manage their symptoms including limiting certain foods, changing methods of food preparation, and decreasing

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the amounts and frequency of meals. These strategies may be considered for inclusion in a diet modification plan that is culturally competent for older women with FI.

Keywords

fecal Incontinence; accidental bowel leakage; diet; dietary modification; older women

Introduction

Fecal Incontinence (FI), also known as accidental bowel leakage, is the involuntary loss of liquid and/or solid stool. FI is a debilitating condition with consequences that include poor self-image, social isolation, depression, and poor quality of life (1,2). FI disproportionally affects older women with a 4-year incidence rate of 17% of community-dwelling women over 65 (3). FI can lead to caregiver fatigue and is a leading cause of the institutionalization of older women in the United States (2).

A conservative treatment approach including education and dietary changes is recommended for the initial management of FI in older women. (2). Providers commonly recommend dietary modifications such as increasing fiber intake and decreasing fatty foods; however, there is limited evidence to support these recommendations. (4). Though several studies suggest that psyllium supplements reduce FI (5-7), data that modifying dietary fiber improves symptoms of FI are lacking. Similarly, a high fat diet has been implicated as a risk factor for FI in epidemiological studies (3, 8-10) but the role of modifying dietary fat to manage FI has not been studied. When examining self-care practices of women with FI, a prior study found that older and younger women differed in the types of dietary modifications they use to control symptoms of FI (11); however, specific dietary recommendations for older women with FI remain unclear.

Women with FI report that health care providers do not provide adequate dietary advice regarding FI. (12) Providers too express a desire to better understand conservative treatment options for older women with FI. (12) Self-care practices used by women to reduce FI symptoms could provide useful insights to patients and providers on dietary approaches to the management of FI. In the present study, we employed a qualitative approach to investigate dietary modifications used by older women to manage their FI. Our aim was to obtain insight from older women with FI to inform the development of a diet modification plan that is culturally competent, age appropriate, and socially relevant for the respective demographic.

Materials and Methods

Women with FI were recruited from Urogynecology and Geriatric practices at the Hospital of University of Pennsylvania. Inclusion criteria were: (1) Age ≥ 65 years, (2) current FI, defined as any uncontrolled loss of liquid or solid fecal material occurring, at least monthly over the preceding 3 months and that is bothersome enough to desire treatment, and (3) subject has control of her diet and is able to make adjustments. Women were excluded from participation if they: (1) resided in a care facility that provides meals and limits the resident's ability to make independent adjustments to their diet (2) had current bloody

diarrhea, (3) had current or past diagnosis of colorectal or anal malignancy, (4) had diagnosis of inflammatory bowel disease. This study was approved by the University of Pennsylvania Institutional Review Board. All participants were compensated for their time and provided written informed consent.

Qualitative research methods are best suited when research is primarily exploratory and the goal is to gain insight that can help develop ideas. Focus groups, a qualitative method in which a group of participants engage in a structured discussion, allows for interaction between participants that can lead to richer discussion and deeper insight as compared to individual interviews.(13, 14) We conducted focus groups wherein women with FI shared their dietary strategies and experiences for managing their condition. The focus groups were moderated by an experienced coordinator (L.F.) with expertise in focus group facilitation and lasted for 60-90 minutes. A moderator guide was developed based on review of the literature and aimed to explore the following: (1) association between diet and FI symptoms, (2) dietary strategies and modifications used by older women to manage FI, and (3) patient input about best practices for assembling and disseminating diet modification information and strategies. We conducted focus groups consistent with guidance from qualitative experts suggesting that 3-6 focus groups are usually necessary to achieve saturation. (14) The size of our focus groups was based on recommendations that each group be large enough to generate rich discussion (6-12 subjects) but not so large that some participants are left out. (14) Each participant could only attend one focus group.

All focus groups were audio recorded and transcribed verbatim. A constant comparison approach was used, whereby each transcript was reviewed by the study team before the next focus group was conducted, this allowed the team to refine the focus group guide and explore participant generated issues across groups. (13) All transcripts were reviewed for accuracy and uploaded into NVivo11 (QSR International, Doncaster, Victoria, Australia). The team developed a codebook to guide the analyses. Codes were developed in two ways: a priori (informed by the literature and focus group guide) and through line-by-line reading of each transcript. Each code was given an explicit definition to ensure coding accuracy. (13). Two members of the team independently coded each transcript (N.E., L.F.). Coding was supervised by a qualitative research scientist (R.F.). Discrepancies in coding were resolved in consensus and reviewed with clinical members of the research team. (15) Throughout the coding process, new codes and their definitions were discussed, added as needed, and previously coded transcripts were revisited to assure no data were overlooked. Following coding of the transcripts, codes were reviewed and grouped together to form thematic categories, from which emergent concepts arose. Summative statements for each thematic category were created and are supported by participant quotations. Intercoder reliability was calculated with Nvivo 11 software by using the k coefficient. The software compares agreement and disagreement between coders in the assignment of specific codes to segments of the interview transcript. Complete agreement in coding correlates with a mean k of 1; near perfect agreement, a mean k of 0.81–0.99; substantial agreement, a mean k of 0.61–0.80; and moderate agreement, a mean k of 0.41–0.60. We planned, a priori, to conduct focus groups iteratively until we achieved saturation, in which no new concepts or themes emerged. (13)

Results

Twenty four women were approached and agreed to participate in the study; 3 women had scheduling conflicts on the day of their scheduled focus group. Thus, 21 women who met inclusion criteria participated in 3 focus groups. Focus group 1 had 6 participants, group 2 had 8 participants and group 3 had 7 participants.. Focus groups were conducted in urban (n=2) and suburban settings (n=1). Mean age of the participants was 72 years (range 65-86) and 62% were Caucasian while 38% were African-American. Women included in the study had moderate to severe FI as evidenced by the frequency of ABL episodes (Table 1). Analysis of intercoder reliability for this study revealed substantial to almost perfect agreement for all codes (mean k = 0.85; range, 0.60–1.00). This result was supported by percentage of agreement analysis, which yielded a mean of 99% (range, 94%–100%) agreement of all codes.

Results were organized into the following thematic categories: discovery of relationship of FI and diet, dietary triggers for FI, modifications/strategies used and suggestions by women for dietary modification as a tool for managing FI. Summative statements for key themes are supported by participants' quotes. (Table 2)

Discovery of relationship of FI to diet

Universally, participants were aware that diet plays a key role in their experience of FI. For many, the realization that diet contributed to their FI symptoms was a lengthy process. Some participants reported that they were initially skeptical that their diet could be contributing to their symptoms but over time, in a process that they described as "trial and error", they were able to determine what specific aspects of their diet contributed to their FI symptoms.

Dietary Triggers for FI

Foods and Food groups: There was a wide range of specific foods reported by participants as triggers. Many participants reported that they had more than one trigger. These included: caffeine (coffee, chocolate especially), dairy (ice cream, cheese), certain meats (ie beef), leafy greens, beans, fruits and fruit juices, and sauces and gravies.

Methods of food preparation: Participants identified frying as a food preparation method that triggered or worsened their FI symptoms. Additionally, they identified spicy foods, greasy foods, "rich" foods and hot foods as contributing to their symptoms.

Size and frequency of Food: Several participants reported that eating large volumes of food in one sitting contributed to FI episodes. There were also a few participants that reported that the mere act of eating—even small amounts—can trigger bowel urgency that results in leakage if they can't immediately get to a bathroom.

Modifications/Strategies Used

Participants identified several modifications strategies that they used to help with their FI symptoms. (Table 3)

Modification to specific foods or food groups: Most women described trying to avoid specific foods contributing to their symptoms. If a particular food or food group could not be avoided entirely, they attempted to decrease the quantity consumed or would make plans for potential accidents that may occur after eating those foods. In particular, women discussed eliminating or decreasing caffeine intake; although many expressed that this was challenging. Participants also discussed decreasing dairy intake. Participants also discussed fiber intake. Many reported that they had been advised that increasing fiber would help with FI although they were not given specific information on the amount to consume. Several participants reported that they had consumed too much fiber and that in turn made their FI worse.

Modifications to preparation methods: Participants described modifying food preparation methods such as foregoing frying foods and either baking or boiling food instead. Participant also reported limiting seasoning or spices when preparing meals. Some participants described the need to avoid eating out or eating food cooked by others because they would not be able to control how the food was prepared. Many participants preferred to prepare their own food.

Modifications to timing and amount of food: Participants described modifying the amount of food they ate. Many described eating smaller, more frequent meals rather than larger meals as they found larger meals triggered their FI.

Suggestions for Dietary Modifications for FI Management

Importance of health care provider input—Participants reported that there is a level of shame that deters women with FI from seeking care and discussing dietary habits with providers. Participants felt this impediment would be best addressed if providers were more proactive about addressing the problem and discussing their diets with them. Participants reported frustration with knowing which physician (Primary Care, Gynecologist, Gastroenterologist) or health care provider would be most knowledgeable about dietary modifications and had the expectation that their primary physicians would have some understanding of about the impact of diet on FI.

Importance of a balanced approach—Participants generally reported a willingness to modify their diets to help with FI. However, participants also expressed hesitation in making modifications for foods they really enjoyed especially if the improvement to their FI symptoms were only modest.

Sharing the individual experience—Participants developed a sense of comradery given their shared experience with FI and stressed the importance of sharing dietary techniques that that worked for one individual with others with FI. Participants felt that although different strategies work differently from one individual to another, given the debilitating nature of the disease and limited availability of conservative treatment options, it was important to share information between individuals. In particular, participants felt that it would be helpful to share food substitutions and recipes. Participants voiced a desire for support groups where this information could be easily exchanged. In one of the focus

groups, six out of the seven participants indicated that they would be interested in a focus group.

Discussion

Using a qualitative approach, we identified several dietary modifications that older women with FI use to manage their symptoms. First, most women with FI reported using a strategy of trial and error for eliminating triggers that precipitate episodes of FI. In addition to well-known triggers such as fat (fried food) and dairy, women in our focus groups identified several other foods that worsened FI symptoms including certain meats, leafy greens, beans, fruits and fruit juices, and sauces and gravies. Women emphasized that the process of trial and error allowed them to identify triggers that were specific for them. In addition, women with FI identified portion size control, modifying preparation methods (to decrease fat and spice content), and changing timing of meals as helpful strategies for controlling symptoms. Finally, several women reported that the most common advice they had received from their provider was to increase their fiber intake. However, our study participants did not find this information helpful because they were unclear as how to precisely how much fiber they should consume, and some even reported that increasing fiber worsened their symptoms. Taken together, these findings suggest that modifying diet to improve FI symptoms requires a systematic and iterative approach that should be individualized for specific patients.

Prior research has documented that most women do not discuss their FI symptoms with their providers due to shame as well as the sense that there is not much that can be done about the condition. (16) In our study, women with FI expressed a strong desire that providers should not only initiate conversations about FI but also provide them with dietary information. Our study identified some dietary modification strategies that providers taking care of women with FI could discuss with their patients. These principles extend beyond increasing fiber and may include advice on trigger elimination, portion size control, modifying preparation methods, and changing the time of meals. Given the emphasis on trial and error in our study participants and the lack of definitive evidence behind many of these strategies, at the very least, our data suggests that providers should counsel patients about the possible role for dietary modifications to improve symptoms of FI, emphasizing that the science is limited and most patients use trial and error to identify which strategies work for them. Our study identifies a need for more evidence-based dietary modification programs to help older women manage their FI symptoms.

Our study also identified other findings that will be helpful in developing a comprehensive dietary program for older women with FI. Several participants reported that they frequently ate foods that they knew would make their FI worse, however, they were unwilling to give them up because this would seriously impact their quality of life. In these situations, women with FI seek support from their physicians in the form of practical advice on how to manage episodes of non-compliance such as loperamide or staying close to home to manage the consequences of a bowel accident. These findings also suggest that any diet modification plans for women with FI should include an assessment of readiness for change as this has been shown to predict adherence to and success with making dietary changes. (17) We also found that older women with FI value the opportunity to share effective dietary strategies

amongst each other including food substitutions and recipes. A recent trial found that a group-administered behavioral therapy program was safe and modestly effective in the management of urinary incontinence in older women. (18). Our findings suggest that a group-administered behavioral therapy that includes information on dietary modification and an opportunity for participants to engage with each other may help older women with FI.

The strengths of our study include the use of a rigorous qualitative approach with iterative analysis to ensure that we captured the participants' input as well as racially and culturally diverse participants who ate a variety of foods. Our study also has certain limitations. Our study only included women who could prepare their own meals which limits generalizability of our findings to non-institutionalized women. Dietary modifications unearthed in our study may also not apply to community dwelling women who do not have control over all aspects of their meal preparation. We conducted 3 focus groups, which has been suggested in the literature as adequate to reach saturation of themes; however, an additional group could have been conducted to confirm that saturation had been reached. While we were able to generate several ideas on dietary modification for older women with FI, we are unable to quantify the effect of these modifications. A quantitative study is needed to assess the impact of the dietary strategies that we have uncovered.

In conclusion, dietary modifications are important for managing FI among older community-dwelling women. We plan to use these preliminary data to inform development of an intervention that we plan to test to determine the level of evidence behind these dietary modifications and strategies.

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Table 1:

Focus Group Participant Demographics

Demographic Variable	**N=21**
Age(mean, range)	72 (65-86)
Race	
African American	8/21(38%)
Caucasian	13/21(62%)
Location of focus group participation	
Suburban	7/21(33%)
Urban	14/21(67%)
Comorbidities(n, %)	
Obesity(BMI>30)	5/21(24%)
Diabetes	7/21(33%)
Irritable Bowel Syndrome	4/21(19%)
Length of time with FI	
1-5 years	15/21(71%)
>5 years	6/21(29%)
Frequency of FI	
Daily	5/21(24%)
Couple of times/week	8/21(38%)
Couple of times/month	8/21(38%)

FI: Fecal Incontinence

Table 2:

Themes and Representative quotes

Themes	Representative quotes
Discovery of relationship of FI to diet	"I don't know, I think it had to happen a number of times because first you think, "Well maybe it just didn't agree with me," but when it consistently keeps happening and happening and happening, then you mess up enough underwear and then you've washed enough clothes." "…so I just started putting two and two together." I've eliminated lots of foods from my diet and sometimes it helps and sometimes it doesn't.
Dietary Triggers for FI	
Foods and Food groups	"I have one word. Coffee." "Well coffee's the problem" "Too much coffee" "Every time I ate ice cream it happened." "I think what triggers it, if I have spinach and kale, I know I may have [it]."
Methods of food preparation	"But it seems whenever I have something fried, I might have issues because of that." "I really think mine comes from the spicy foods. We like the spicy foods and we do eat it a lot, but I can't eat it anymore."
Size and frequency of Food	"I think for me, instead of what it is I'm eating, I think it's the volume of food that I'm eating." "Well, with me it's not really a specific food or at least I haven't figured it out if it is a particular food. To me, I think it's the fact that I just eat too much. I should for many, many reasons, I should cut down. But I find that hard because I like food." "I think this is very dangerous, the big meals…If I eat a big meal, I'm gonna be going."
Modifications/Strategies Used	
Modification to specific foods or food groups	"I try to avoid chocolate because I know I may have a problem." "I still want it. I like mangoes. I just go on and eat it and have to pay for it." "I've modified my caffeine intake a lot. I used to drink two hefty cups of coffee in the morning. And now I drink less than half a cup. I still have it, but not nearly as much." "Oh, I avoid the fat. I throw away the chicken skin all the time, if I'm gonna cook it." "I think I overdosed on roughage. So I had to cut back." "Well, you're talking about increasing, I had to decrease fiber. I think I was consuming too much. So I have moderated it. Because i thought it was good for me so I just went haywire. I found out that it was too much."
Modifications to preparation methods	"I try not to fry too many foods. I don't know, sometimes I have to, but most of the times I don't, we don't eat fried foods" "No, it's the way I prepare it. I don't fry things, I bake them because I know if I eat fried foods what's going to happen." "With the baking, I bake it and I have to be careful what I put on it… I can't put a lot of oil or butter or anything on it… I've learned to use a lot of sprays that you spray the can on the food to bake it with." "It's very difficult to eat out. I do all my … Most of my food preparation at home because I can control it." "I think it's sometimes just the restaurants and the way they prepare food differently than you do at home. I would find that after I ate out somewhere, within a half an hour I would have some kind of urgency that …"
Modifications to timing and amount of food	"I try not to eat that voluminous amount of food, I try to eat smaller portions." "If I eat small amounts more frequently, I'm okay."
Suggestions for Dietary Modifications for FI Management	
Importance of health care provider input	"I think it's the duty of a primary care doctor to bring the subject up, because it's **really not fair if** somebody feels too embarrassed to say anything and they just go on year after year." "Yes. What's missing, for me, is interaction between physicians. It's the GI person just does GI. And I'm like "Well, isn't the rectum part of the GI system?" "One of the things that I've found out when I asked my primary about diets and that kind of thing, she referred me to a dietitian, okay? The dietitian want to be paid… I had to make a choice between am I going to the dietitian or am I going to my cardiologist, and you know who won, the cardiologist."
Importance of a balanced approach	"I think the fact that it doesn't work, like, within in a week. That is annoying to me. Like if I'm going to this effort I want to see some [results]." "It's not easy giving up the foods. A piece of chocolate, oh my God. You know I sneak and eat it anyway, but I make sure I'm home. Certain things that I won't eat in the street I will eat at home because the bathroom is right there." "Well, we discussed diet quite a bit. This is my attitude, there's very little in life to enjoy anymore. Should I drastically adjust my diet to totally eliminate this? Maybe it will and maybe it won't. I enjoy food. There's not much left in life, you know? So, I struggle with that because I do enjoy different types of foods. I do enjoy dining out, occasionally. Am I gonna eliminate that? I don't know. I struggle."

Themes	Representative quotes
Sharing the individual experience	"Yeah, you know, older people the same as myself and then they, you know, they tell me about different things and so you try this, or do I need that." "So, I've looked up things online, also. But then, I'm thinking "Well, let me just speak to actual, real people who have experience and can guide me here and there." "Well, what I've found is that in talking to people you find a whole lot of people like yourself, you know, they have the same problem, so they don't have a problem talking about it, you know what I mean? Those are the people that you gravitate to…"

Table 3:

Diet Modifications/Strategies used by women with FI

- Identify food triggers using a system of “trial and error”
- Common triggers include ice cream, coffee, chocolate, spicy foods, fried foods
- Decrease caffeine intake
- Decrease fat intake
- Modify fiber intake and consume in moderation
- Eat small amounts more frequently instead of larger amounts in one sitting
- Avoid frying food; consider baking or boiling instead
- Seek information from other women and online
- Avoid eating out