

# Women with urinary incontinence: self-perceived worries and general practitioners' knowledge of problem

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**SUMMARY.** *In the context of a large scale survey of health problems in women aged 50 to 65 years, a study was undertaken on the effects of incontinence on daily life. For this purpose 1442 women randomly selected from the practice files of 75 general practitioners in the eastern part of the Netherlands were interviewed at home (response rate 60%). In cases of moderate or severe incontinence the general practitioner of the woman concerned was asked whether this problem had been diagnosed in general practice. Incontinence was reported in 22.5% of the women. Overall, 77.8% of the women did not feel worried about it and 75.4% did not feel restricted in their activities; even for women with severe incontinence (daily frequency and needing protective pads) only 15.6% experienced much worry and 15.7% much restriction. About a third of the women with incontinence (32.0%) had been identified by their general practitioner. The greater the worries and restrictions owing to incontinence, the greater the chance that the incontinence was known to the general practitioner concerned. Only a small minority of the women who felt severely restricted were not identified by their general practitioner. There was a positive relation between recognized incontinence and a history of hysterectomy. This study contradicts the image of the incontinent woman as isolated and helpless; most women in this study seemed able to cope.*

## Introduction

URINARY incontinence is common in the general population; in patients aged under 65 years it is a typically female problem.<sup>1-10</sup> Although not a life threatening condition it can interfere with daily life and consequently influence the quality of life for sufferers. It is generally assumed that a large number of patients suffer in silence, and that shame and low expectations of the benefits from treatment are obstacles to seeking medical advice.<sup>4,5,11</sup> Strengthened by the images of pharmaceutical advertisers, a psychological profile has been created of an anxious and depressed woman. Loss of self-esteem, feelings of helplessness, somatization, and deprivation have also been mentioned as likely outcomes of incontinence.<sup>12-16</sup> Patients often have to cope with relational and social problems.<sup>13</sup> They also feel mentally and physically unhealthy and reluctant to engage in outdoor activities.<sup>17</sup>

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Yet most of the studies are based on small and unrepresentative samples.<sup>7</sup> It has not been established that this profile is similar in the population at large. The study reported here is of a less selected population. The aim was to assess the consequences of incontinence in terms of amount of perceived worry and restrictions in activities and the differences in psychological profile of women with and without incontinence. At the same time this study examined the number of women whose incontinence was known to the general practitioner and compared them with those whose incontinence was not known about.

## Method

The material for this study was collected in the context of a large scale survey of the health status of women aged 50 to 65 years. For this purpose 2400 women were randomly selected from the practice files of 75 general practitioners in the eastern part of the Netherlands. Fourteen hundred and forty two consented to take part (60% response). All respondents were interviewed at home by trained interviewers.

The following data were collected. Sociodemographic background was noted (age, marital status, parity, education, employment). Psychosocial characteristics were established using the following questionnaires: the health locus of control,<sup>18</sup> which measures the extent to which people perceive responsibility for their health; the expectancy list,<sup>11</sup> which measures the expected beneficial effect of self-care and professional care; the social support list,<sup>19</sup> which measures the amount of social support respondents experienced from their environment. Perceived health status was measured by means of a psychometric test, the Nottingham health profile.<sup>20</sup> The presence of chronic disease was noted (for example, incontinence, hypertension, diabetes mellitus, chronic obstructive pulmonary disease, obesity, varicose veins, congestive cardiac failure, symptoms of the locomotor system). A history of hysterectomy was noted.

All patients reporting incontinence of urine were asked additional information on the frequency of incontinence (categorized as: three to four times a month, a few times a week, or daily). In addition, the women were asked whether they wore protective pads or garments because of the incontinence (no, on occasion, most of the time). To gain insight into the consequences of incontinence that respondents experienced, the following two questions were asked:<sup>18</sup> How much have you worried about your loss of urine over the past three months? (not at all, a little, quite a lot, very much); Have your activities been restricted by your voiding problems over the past three months compared with other people of your age? (not at all; a little; most of the time; all the time).

Urinary incontinence was defined as involuntary loss of urine more than twice a month. No attempt was made to distinguish between different types of incontinence as a questionnaire is not suitable for this purpose.<sup>3</sup> The degree of incontinence was subdivided into three categories, on the basis of the frequency of urine loss and the use of protective pads or garments: mild (either three to four times a month or a few times per week but requiring no protective pads); moderate (either a few times per week or daily but requiring protective pads on occasion/not at all);

severe (daily and requiring protective pads most of the time).

In cases where the interview revealed moderate or severe incontinence, the general practitioner of the woman concerned was asked if he or she knew about the incontinence. Mild incontinence was excluded in this part of the study as it is of less clinical relevance. Incontinence was classified as 'unrecognized' after the general practitioner had explicitly checked the patients' files and had found no documented evidence of incontinence.

The study was approved by the medical ethics committee of the University of Nijmegen. The women were informed about the study design and agreed on the terms of the study.

## Results

Almost a quarter of the 1442 women aged 50 to 65 years complained of urinary incontinence (Table 1). There was a relation between the degree of incontinence, and the experienced worries and restrictions in activities (Table 2). The majority of the women experienced hardly any restrictions, even in the cases of severe incontinence.

A comparison of the women with and without incontinence showed that the sociodemographic background of both groups was similar and both groups were similar in terms of perceived responsibility for their own health, in the amount of social support received, and in their appreciation of self-care and professional care. The women with urinary incontinence had a

significantly poorer perceived state of health than the women without this symptom, except for the item on social isolation (Table 3). The women with urinary incontinence more frequently reported the following chronic diseases: congestive cardiac failure, chronic obstructive pulmonary disease, obesity, and symptoms of the locomotor system (Table 4). There was a positive correlation ( $P < 0.01$ ,  $\chi^2$  test) between the presence of incontinence and a history of hysterectomy: 40.2% of the women with severe urinary incontinence had undergone hysterectomy, 32.7% of those with moderate incontinence, 26.5% of those with mild incontinence and 24.3% of the women without incontinence.

For about a third of the women with a moderate or severe incontinence (32.0%) the general practitioner knew about the condition. The group with severe incontinence were more likely to have been recognized than those with moderate incontinence (39.2% versus 26.7%). When the 66 women with recognized incontinence were compared with the 140 women with unrecognized incontinence there was no difference in sociodemographic background; both groups were similar with regard to psychosocial characteristics; there were no differences in the perceived health status; and there was no differences in the number of reported chronic diseases. However, there was a larger proportion of hysterectomized women among those women with recognized incontinence (47.0%) than among those with it not recognized (31.4%). More women experiencing restrictions and/or worry because of their incontinence had been diagnosed by the general practitioner (Table 5).

**Table 1.** Degree of urinary incontinence in women aged 50 to 65 years.

| Degree of incontinence | Number (%) of women reporting incontinence (n = 1442) |
|------------------------|---|
| None                   | 1117 (77.5)   |
| Mild                   | 115 (8.0)   |
| Moderate               | 113 (7.8)   |
| Severe                 | 97 (6.7)  |

n = total number of women.

## Discussion

Urinary incontinence is a common condition in women; in this study 22.5% of women aged 50–65 years experienced the problem. Studies based on population samples<sup>1,2,5</sup> reported prevalences of regular incontinence according to the same definition of 12 to 20% in women in the age group 45–64 years. More selected studies have reported higher prevalences; 57% of the women aged 45–64 years in the study of Brocklehurst,<sup>6</sup> whereas Jolleys<sup>4</sup> showed a prevalence of 60% in women aged 45–54 years and 39% in those aged 55–64 years.

**Table 2.** Worries about incontinence and restrictions in activities perceived by women with incontinence according to the degree of incontinence.

| Degree of incontinence | Percentage of women        |          |             |           |                          |          |             |           |
|------------------------|----------------------------|----------|-------------|-----------|--------------------------|----------|-------------|-----------|
|                        | Worried about incontinence |          |             |           | Restricted in activities |          |             |           |
|                        | Not at all                 | A little | Quite a lot | Very much | Not at all               | A little | Quite a lot | Very much |
| Mild (n = 115)         | 85.8                       | 13.3     | 0.9         | 0.0       | 87.6                     | 12.4     | 0.0         | 0.0       |
| Moderate (n = 113)     | 75.9                       | 19.6     | 4.5         | 0.0       | 68.8                     | 26.8     | 4.5         | 0.0       |
| Severe (n = 97)        | 70.8                       | 13.5     | 10.4        | 5.2       | 68.8                     | 15.6     | 9.4         | 6.3       |
| Total (n = 325)        | 77.8                       | 15.6     | 5.0         | 1.6       | 75.4                     | 18.4     | 4.4         | 1.9       |

n = total number of women.  $\chi^2$  test: for worries  $P < 0.01$ , for restrictions  $P < 0.01$ .

**Table 3.** Nottingham health profile scores according to the degree of incontinence.

| Degree of incontinence | Mean percentage scores |            |            |            |                  |                   |
|------------------------|------------------------|------------|------------|------------|------------------|-------------------|
|                        | Energy                 | Pain       | Emotion    | Sleep      | Social isolation | Physical mobility |
| None (n = 1117)        | 17.1                   | 13.1       | 12.1       | 22.7       | 6.3              | 6.4               |
| Mild (n = 115)         | 23.9                   | 17.8       | 13.4       | 24.7       | 5.7              | 12.1              |
| Moderate (n = 113)     | 27.6                   | 22.2       | 17.0       | 32.4       | 7.8              | 12.4              |
| Severe (n = 97)        | 31.6                   | 23.8       | 17.6       | 31.5       | 9.0              | 15.5              |
| Kruskal-Wallis test:   | $P < 0.01$             | $P < 0.01$ | $P < 0.01$ | $P < 0.01$ | NS               | $P < 0.01$        |

n = total number of women.

Of more importance is our finding that only a minority of women worried about their incontinence or felt restricted in their activities. It is relevant to take into account the severity of the incontinence. Thomas<sup>1</sup> has defined severity according to the use of protective pads and restrictions on activities. Restrictions on activities formed one theme of the present study, and therefore different indicators of the degree of incontinence were used: frequency of involuntary voiding and use of protective material ('objective' aspects) and experienced worry and restrictions ('subjective' features). There was a strong correlation between the 'objective' and 'subjective' features. Nevertheless, even among the women losing urine daily and more or less continually in need of protective material, only a minority worried 'quite a lot' or 'very much' and few experienced 'quite a lot' or 'very much' restriction of activity.

The incontinent women in this study scored normal on the psychosocial scales; it seems as though the degree of incontinence rather than psychological factors are responsible for the experienced worries and restrictions. This is in our view an important finding for daily practice: so called 'subjective' aspects should be taken at their face value and there is no reason to interpret complaints in terms of illness behaviour. Nor were social isolation or lack of social support reported more often by incontinent women than by women without incontinence.

These results do not correspond to the often pictured profile of an incontinent patient as an isolated, anxious and helpless woman.<sup>12-17</sup> It should be noted that this picture is by and large based on studies with small numbers of patients or patients selected for medical specialist treatment and includes a high proportion of women with urge incontinence. Psychological disorders are described particularly in patients with urge incontinence<sup>14-16</sup> and this type of incontinence is much more prevalent in selected, and referred groups than in the general population.<sup>16</sup>

Approximately 66% of the women with a moderate or severe incontinence were not known to the general practitioner concerned. This is comparable with the study of Thomas<sup>1</sup> and Holst.<sup>5</sup> Why is there such a great discrepancy between the prevalence of incontinence in the community and the rate of

recognition of the condition in primary care? From our data it was not possible to distinguish between women never presenting and physicians ignoring or overlooking the problem. What we found was that only a minority of the women that suffered quite a lot (5-6%) or very much (1-2%) were not known to the general practitioner. Holst<sup>5</sup> came to the same conclusion: the severity (in Thomas<sup>1</sup> definition) was the main significant difference between women who sought help and those who did not. The identification of incontinence did not appear to be affected by the patient's psychosocial characteristics; nor by the generally expected benefit from medical treatment or by the perceived health status.

The high occurrence of incontinence in women who have had a hysterectomy is noteworthy. Hysterectomy and urinary incontinence are thought to be related: hysterectomy markedly enhances the chance of becoming (mainly stress) incontinent,<sup>22,23</sup> although Iosif<sup>24</sup> contradicts this conclusion. It is also known that the use of medical services by hysterectomized women significantly exceeds that of other women.<sup>25</sup> Hysterectomized women presented more problems of a harmless nature (minor ailments), were more often referred to a medical specialist and were more often hospitalized. Moreover they showed a greater tendency than other women to somatize.<sup>26</sup> Incontinence is possibly one of the many complaints of hysterectomized women and this may be why there had been a large number of hysterectomies among incontinent women. The poorer perceived state of health in women with incontinence was possibly also to do with the high occurrence of hysterectomy or may be due to the reported prevalence of chronic morbidity.

Another finding is that the combination of urinary incontinence and hysterectomy more frequently coincides with professional recognition of the incontinence. This may be related to the tendency of the hysterectomized patient to present more complaints to her doctor and to the more explicit attention which physician and patient may pay to incontinence after hysterectomy. This was in contrast to the chronic morbidity. Although the prevalence of chronic morbidity was higher among incontinent women, there was no relationship with the identification of incontinence in general practice. This is an interesting find-

**Table 4.** Chronic diseases according to degree of urinary incontinence.

| Degree of incontinence | Percentage of women |                            |              |         |                |                    |                    |                   |        |
|------------------------|---------------------|----------------------------|--------------|---------|----------------|--------------------|--------------------|-------------------|--------|
|                        | Angina pectoris     | Congestive cardiac failure | Hypertension | Obesity | Varicose veins | Dyspeptic symptoms | Locomotor symptoms | Diabetes mellitus | COPD   |
| None (n = 1117)        | 10.0                | 5.3                        | 7.5          | 19.8    | 7.8            | 4.8                | 21.4               | 4.3               | 7.8    |
| Mild (n = 115)         | 13.4                | 8.8                        | 8.8          | 19.1    | 4.4            | 5.2                | 26.1               | 8.5               | 11.4   |
| Moderate (n = 113)     | 11.6                | 16.8                       | 7.1          | 33.6    | 12.4           | 8.0                | 34.8               | 4.9               | 6.2    |
| Severe (n = 97)        | 7.3                 | 19.6                       | 10.3         | 33.0    | 8.3            | 7.2                | 38.1               | 6.5               | 16.5   |
| $\chi^2$ test          | NS                  | P<0.01                     | NS           | P<0.01  | NS             | NS                 | P<0.01             | NS                | P<0.05 |

COPD = chronic obstructive pulmonary disease. NS = not significant. n = total number of women.

**Table 5.** Worries about incontinence and restrictions in activities perceived by women with incontinence according to whether condition known about by general practitioner.

| Condition known to GP | Percentage of women        |          |             |           |                          |          |             |           |
|-----------------------|----------------------------|----------|-------------|-----------|--------------------------|----------|-------------|-----------|
|                       | Worried about incontinence |          |             |           | Restricted in activities |          |             |           |
|                       | Not at all                 | A little | Quite a lot | Very much | Not at all               | A little | Quite a lot | Very much |
| Yes (n = 66)          | 62.5                       | 18.8     | 12.5        | 6.3       | 45.3                     | 39.1     | 9.4         | 6.3       |
| No (n = 140)          | 78.6                       | 15.7     | 5.0         | 0.7       | 78.6                     | 14.3     | 5.7         | 1.4       |

n = total number of women.  $\chi^2$  test: for worries P<0.05, for restrictions P<0.01.

ing: consultations for other reasons apparently do not put the general practitioner on the track of incontinence nor do they seem to facilitate presentation of incontinence by the patient. Only in the case of hysterectomy, where the patients' specific characteristics play an important role, does this seem to be a relevant factor.

We conclude that urinary incontinence is a common problem among women in the age group 50–65 years. Its prevalence is easily overlooked by the medical profession but from our data it can be seen that most women do not worry exceptionally about it and do not feel very much restricted in their activities. They seem to be able to cope adequately with their incontinence. Most of the women who experience 'quite a lot' to 'very much' worry and restriction are known to the general practitioner. At the same time, our findings do not support the hypothesis of severe, broad-based psychological effects of hidden incontinence. We believe that identification is less of a problem than providing proper treatment. Efforts should be focused on those women who experience their incontinence as problematic. It is therefore essential to improve the management of urinary incontinence in primary care.

## References

1. Thomas TM, Plymat KR, Blannin J, Meade TW. Prevalence of urinary incontinence. *Br Med J* 1980; **281**: 1243-1245.
2. Yarnell JW, Voyle GJ, Richards CJ, Stephenson TP. Prevalence and severity of urinary incontinence in women. *J Epidemiol Community Health* 1981; **35**: 71-74.
3. Iosif S, Henriksson L, Ulmsten U. The frequency of disorders of the lower urinary tract, urinary incontinence in particular, as evaluated by a questionnaire survey in a gynecological health control population. *Acta Obstet Gynecol Scand* 1981; **60**: 71-76.
4. Jolleys JV. Reported prevalence of urinary incontinence in women in a general practice. *Br Med J* 1988; **296**: 1300-1302.
5. Holst K, Wilson PD. The prevalence of female urinary incontinence and reasons for not seeking treatment. *NZ Med J* 1988; **101**: 756-758.
6. Brocklehurst JC, Fry J, Griffith LL, Kalton G. Urinary infection and symptoms of dysuria in women aged 45-64 years: their relevance to similar findings in the elderly. *Age Ageing* 1972; **1**: 41-47.
7. Mohide EA. The prevalence and scope of urinary incontinence. *Clin Geriatr Med* 1986; **2**: 639-655.
8. Van den Hoogen HJM, Huygen FJA, Schellekens JW, et al (eds). *Morbidity figures from general practice. Data from four general practices 1978-82*. Nijmegen: University Department of General Medicine, 1985.
9. Lamberts H. *Morbidity in general practice. Diagnosis related information from the Monitoring Project*. Utrecht: Huisartsenpers, 1984.
10. Royal College of General Practitioners, Office of Population Censuses and Surveys and Department of Health and Social Security. *Morbidity statistics from general practice 1981-82. Third national study. Series MB5 no 1*. London: HMSO, 1988.
11. Van de Lisdonk E. *Ervaren en aangeboden morbiditeit in de huisartspraktijk [Perceived and presented morbidity in general practice]*. [Dissertation]. Nijmegen: Katholieke Universiteit Nijmegen, 1985.
12. Macaulay AJ, Stern RS, Holmes DM, Stanton SL. Micturition and the mind: psychological factors in the aetiology and treatment of urinary symptoms in women. *Br Med J* 1987; **294**: 540-543.
13. Stone GB, Judd GE. Psychogenetic aspects of urinary incontinence in women. *Clin Obstet Gynecol* 1978; **21**: 807-815.
14. Hafner RJ, Stanton SL, Guy J. A psychiatric study of women with urgency and urgency incontinence. *Br J Urol* 1977; **49**: 211-214.
15. Freeman RM, McPherson FM, Baxby K. Psychological features of women with idiopathic detrusor instability. *Urol Int* 1985; **40**: 257-259.
16. Dijkstra SJ, Mensink HJA, Janssens J. Urge-incontinentie, van medisch naar psychologisch model? [Urge incontinence, from a medical to a psychological model?] *Ned Tijdschr Geneesk* 1987; **131**: 814-817.
17. Wijman JF, Harkins SW, Choi SE, et al. Psychosocial impact of urinary incontinence in women. *Obstet Gynecol* 1987; **70**: 378-381.
18. Wallston KA, Wallston BS. Health locus of control scales. In: Lefcourt HM (ed). *Research with the locus of control construct. Vol. 1. Assessment methods*. New York: Academic Press, 1981.
19. Thoits P. Social support as coping assistance. *J Consult Clin Psychol* 1986; **54**: 416-423.
20. Hunt SM, McEwen J, McKenna SP. Measuring health status: a new tool for clinician and epidemiologist. *J R Coll Gen Pract* 1985; **35**: 185-188.
21. Brook RH, Lohr KN, Berman DM, et al. *Conceptualization and measurement of physiologic health for adults. R-2262-HHS*. Santa Monica: Rand Corporation, 1980-1983.
22. Smith P, Roberts M, Slade N. Urinary symptoms following hysterectomy. *Br J Urol* 1970; **42**: 3-9.
23. Mensink WFA. *Diagnostiek en therapie van stress- en urge-incontinentie bij de vrouw [Diagnosing and treating stress incontinence and urge incontinence in the female]*. [Dissertation]. Groningen: Groningen State University, 1980.
24. Iosif CS, Békássy Z, Rydhström H. Prevalence of urinary incontinence in middle-aged women. *Int J Gynecol Obstet* 1988; **26**: 255-259.
25. Lagro-Janssen T, Van Manen M. Alles weggehaald: een onderzoek naar de relatie tussen uterusxirpatie en medische consumptie [Everything out: a study of the relation between hysterectomy and medical consumption]. *Huisarts en Wetenschap* 1986; **29**: 137-140.
26. Lagro-Janssen T, Frénay J, Van Arendonk M. Alles weggehaald: een onderzoek naar enkele kenmerken van vrouwen die een uterusxirpatie hebben ondergaan [Everything out: a study of some data on hysterectomized women]. *Huisarts en Wetenschap* 1986; **28**: 168-171.
27. Jolleys JV. Diagnosis and management of female urinary incontinence in general practice. *J R Coll Gen Pract* 1989; **39**: 277-279.

## Acknowledgements

This study was supported by the Prevention Fund.

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