International Journal of Osteopathic Medicine (2016) 21, 51—57

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International Journal of Osteopathic Medicine

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COMMENTARY

Factors affecting help-seeking behaviour of women with urinary incontinence; a commentary providing insights for osteopaths

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Received 30 July 2015; revised 14 March 2016; accepted 13 April 2016

KEYWORDS
Adult women;
Barriers;
Help-seeking behaviour;
Osteopath;
Triggers;
Urinary incontinence (UI)

Abstract Urinary incontinence (UI) is a common condition, affecting approximately one third of women over the age of forty. Recommended first-line management in the majority of cases consists of simple, conservative, self-help measures, and the condition is often highly preventable and treatable. Despite this, many affected by symptoms do not seek help from healthcare providers and do not mention their symptoms when attending for appointments. Rather than seeking help, women will often adopt coping strategies, sometimes to the detriment of their health and wellbeing. Osteopaths are likely to encounter a large proportion of women experiencing symptoms of UI, but may be unaware that their patients are affected by the condition. An extensive body of literature examining the factors that may affect the help-seeking behaviour of women experiencing UI exists and an exploration of this was undertaken in order to consider these factors in the context of osteopathic practice. The factors affecting whether an individual would seek help for urinary symptoms can be described in terms of the triggers that prompt an individual to seek help and also in terms of the barriers that might prevent or delay this. An appreciation of these, along with the risk factors and treatment options may be considerations for osteopaths when treating their female patients. The implications for providing advice to patients should be considered in light of this.

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http://dx.doi.org/10.1016/j.ijosm.2016.04.005
1746-0689/

Implications for practice

- No published literature was identified that specifically assessed women's help-seeking behaviour for UI from osteopaths.
- This paper is the first to consider factors affecting help-seeking behaviour in the context of osteopathic practice in the UK.
- It is not known whether osteopaths routinely ask about urinary symptoms and whether advice, education and exercises are provided.
- Research into current practice and osteopaths' and their patients' perceptions of urinary incontinence is needed.

Background

Urinary incontinence (UI) may be defined as a storage symptom of the lower urinary tract and "the complaint of any involuntary loss of urine".[1] The most common categorisations of UI are:

- Stress urinary incontinence (SUI) — involuntary leakage of urine on effort or exertion, or on sneezing or coughing.
- Urge urinary incontinence (UUI) — the involuntary leakage of urine accompanied or immediately preceded by urgency.
- Mixed urinary incontinence (MUI) — involuntary leakage associated with urgency and also with exertion, effort, sneezing or coughing.[2]

UI may affect females of all ages and at all stages of life and may be experienced at specific times, or associated with specific activities. Risk factors for developing UI include: pregnancy, childbirth, menopause, hyper-mobility syndromes, gynaecological surgery, constipation, coughing, having low-back pain and participating in sporting activities such as gymnastics, weight-lifting and running.[3] Females are generally affected more than males[4,5] and diagnostic and management strategies are targeted with a gender specific strategy.[6] For these reasons, this article will focus on UI in women.

Adult women are commonly affected by UI; estimations of prevalence rates vary across the literature and have been reported as ranging anywhere from 5% to 72%.[4] The Medical Research Council (MRC) Incontinence Study Team reported a mean prevalence rate of 34.2% for some degree of UI (from minimal to profound), for women aged over 40.[7,8] Individuals may be affected by a wide variety of symptoms and level of severity.[9] The peak prevalence is reported by some authors to depend upon the type of UI, with a peak for SUI at age 30—49 years, MUI between 50 and 59 and UUI steadily increasing with age.[10]

UI is a condition that in many cases will respond well to conservative management. Current National Institute for Health and Care Excellence (NICE) Guidelines[11] recommend initial assessment of UI category along with completion of a bladder diary.[11] Pelvic floor muscle training is the first-line approach for SUI (following digital assessment to confirm pelvic floor muscle contraction) and bladder training is the initial approach for those with UUI.[11] In cases of MUI, the treatment is directed towards the predominant symptom.[11] Other conservative interventions for the management of UI may include life-style advice (such as advising weight loss, smoking cessation and reducing caffeine intake).[11]

Despite UI being a commonly experienced condition, the number of women consulting a healthcare professional about urinary symptoms is relatively low, with varying rates reported in the literature. It is suggested by Minassian et al.,[12] that approximately 25% of women seek help from healthcare professionals, those seeking help tending to be individuals with the most severe symptoms and with at least a two-year history.[12] It has been noted that UI may not be given an "illness label" by individuals and that lack of awareness of the cause and treatment options result in those affected adopting coping or self-care strategies rather than seeking help.[13] Healthcare professionals similarly may not routinely screen for this condition and in many cases are likely to be unaware that their patients are affected by it.[14] Whilst it is widely accepted that GPs would be the healthcare professional that most affected individuals would approach regarding symptoms of UI,[5] it has been suggested that GPs receive only limited training regarding UI issues and may not be fully aware of treatment options and services,[10] and may consider their training in continence/incontinence as inadequate.[15]

Osteopaths in the UK are consulted for a range of health complaints and in many instances patients may have co-existing conditions,[16] which are likely to be important considerations for overall care. In the study by Fawkes et al.,[16] that profiled osteopathic care in private practices in the UK, it was reported that over 70% of participants were aged between 30 and 69, and the proportion of female: male was 56%: 43%. The prevalence of UI in adult women and the increased incidence with