

# Overactive Bladder in Middle Age Women: The Frustration of Baby Boomers with OAB Symptoms

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## ABSTRACT

In 2009, NAFC sponsored a nationwide survey of women aged 40 to 65 with overactive bladder (OAB). The purpose was to learn more about what drives women to seek treatment for OAB symptoms and what factors might precipitate stopping or changing treatment. Using a nonexperimental correlational design, descriptive demographic data were collected on respondents to examine correlations with their self-reported symptoms, behavior, attitudes, and feelings about OAB. The most salient findings of the primary research were: (1) women are significantly more likely to express feeling annoyed and frustrated about their symptoms of OAB than they are embarrassed or stigmatized and (2) frustration abounds among those in treatment. More research is needed to support the suggestion that female baby boomers are not necessarily obstructed by embarrassment or stigma associated with bladder control in seeking solutions to conditions such as OAB. Practitioners are encouraged to be more interactive and instructional with patients by offering a combination therapy approach to managing symptoms. Greater public health education is warranted to make more people aware of their treatment options.

**Keywords:** overactive bladder, stigmatization, quality of life, urinary incontinence, help-seeking behavior

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## INTRODUCTION

Throughout the first decade of the 21st century, the National Association for Continence (NAFC) has periodically undertaken nationwide consumer surveys to gain a better understanding of how bladder control problems affect the daily lives of those living with the condition. In 2009, NAFC undertook a survey of women aged 40 to 65 with symptoms of overactive bladder (OAB), comparing subgroups in or out of treatment according to their self-described, emotional well-being. The purpose of the research was to learn more about what initially drives patients to seek treatment, how wed women are to their current treatment for OAB, and what might influence them to change the treatment they are currently receiving. In analyzing elements of help-seeking behavior, we also sought to quantify the extent that feelings of embarrassment associated with bladder control symptoms, as a measure of stigma, may present an obstacle for middle age women with OAB in pursuing treatment. This paper represents one of several being submitted for publication intended to report separately on how OAB impacts a woman's sense of normalcy and the issues and hurdles they confront related to OAB treatment based on survey findings.

NAFC is a 501 (c) 3 corporation whose national, nonprofit mission is to provide public health education and to advocate on behalf of people with bladder and bowel control problems, voiding dysfunction including retention, and related pelvic floor disorders such as organ prolapse. It is broadly supported by consumers, health care professionals, and industry largely through donations, dues, and grants. This study represents

the fifth such nationwide, population-based survey conducted by an independent professional research firm for NAFC as primary research.

The online survey was independently conducted by Kelton Research, a California-based consumer research and marketing services firm working in a variety of industries. Survey results were unveiled in a news release during the American Urological Association Annual Meeting held April 25 through April 30 in Chicago. Findings from this primary research have not otherwise been published to date. The survey was executed during the first quarter of 2009 by Kelton on behalf of NAFC.

## REVIEW OF THE LITERATURE

OAB is defined jointly by the International Urogynecological Association and the International Continence Society as "urinary urgency, with or without urgency urinary incontinence, usually accompanied by frequency and nocturia, in the absence of urinary tract infection or other obvious pathology." Typical symptoms include: urinating eight or more times per day (increased daytime urinary frequency), one or more times at night being interrupted of sleep (nocturia) because of the need to micturate, and complaint of a sudden, compelling desire to pass urine that is difficult to defer (urinary urgency) [1]. About 17% of women and 16% of men over the age of 18 years in the United States have OAB. This translates into an estimated 33 million adult Americans with symptoms of OAB, of which an estimated 12.2 million adults have urge incontinence [2].

OAB, inclusive of urge incontinence, is associated with significant reductions in health-related quality of life [3]. The emotional toll of OAB on patients' lives can be serious. People with urinary control problems often struggle with simple everyday activities, such as working, shopping, or traveling for fear of a public accident or lack of timely access to a toilet. The social costs of urinary incontinence are high, and even mild symptoms affect sexual, interpersonal, and professional function [4]. Instruments that measure patient reported outcomes concerning health-related quality of life improvements are valuable in assessing the efficacy of treatment for OAB, and epidemiological studies such as cross-sectional surveys enhance the understanding by clinicians, policymakers, and public health educators of how sufferers are impacted and the association of factors correlated with such self-reported experiences and beliefs [5].

Despite the widespread prevalence of OAB and its potential for impacting quality of life, only a minor portion of those with symptoms seek and remain in treatment. Such documentation is drawn largely from cross-sectional, community-based surveys, although some studies have utilized validated instruments such as the ICIQ-SF King's Health Questionnaire or similar structured and pretested questionnaires to survey patient populations whose medical records are accessible. From the published research, less than half of community-dwelling adult US women with symptoms of urinary incontinence have talked with a physician about their symptoms [6]. A significant proportion (39%–53%) of women, even those in a prepaid managed care health plan whose concept is to facilitate access to health care, remain undiagnosed despite the documented record of bothersome incontinence symptoms [7, 8].

While numerous studies have examined the help-seeking behaviors of women with urinary incontinence, there are mixed results regarding whether embarrassment is significantly related [9]. Instead, the most common themes to emerge are a lack of knowledge of the condition and available treatment options [10, 11]. Interestingly, help-seeking in women for the condition may be slightly different from that of men. Research indicates the initiative by elderly women to seek diagnosis and treatment is significantly related to duration of the symptoms, the presence of concomitant complaints, and the severity of incontinence, whereas in older men it is mostly related to the distress experienced in daily life [12]. In fact, in still another community-based study, women juried on the subject of incontinence named "research making seeking help easier" as their highest priority for improving the lives of women with symptoms, after, in subsequent priority order: (a) research making day-to-day life more manageable, (b) research finding out total costs, (c) research for more knowledge about causes, and (d) research on the effects of lifestyle [13]. With such high percentages of women undiagnosed and undertreated for symptoms and so little explored on the topic of help-seeking behaviors, specifically among women with OAB, there is ample support for additional research to learn more about what obstructs or drives women to seek treatment for

symptoms of OAB and what factors might precipitate stopping or changing treatment.

Much has been written associating incontinence with highly stigmatizing conditions. Nurses, in particular, have researched ways to break the cycle of stigmatization, as stigma is believed to be among the chief obstacles to seeking diagnosis and treatment due to the self-esteem decrements that people lacking bladder control experience [14]. Depression and decreed quality of life have been found to co-occur in the person struggling with incontinence [15]. Just as the definition of stigma itself suggests, as an identifying mark of shame or discredit, toileting accidents have long been associated with feelings of embarrassment and social isolation. They are the brunt of jokes, teasing, and ridicule, among youth and adults.

Further compromising an informed and mature approach to the topic of bladder control by the general public are the widespread myths and misunderstandings of the subject. Two in five or 38% of Americans believe incontinence is simply a natural part of aging, when those reporting symptoms in the same survey reveal their own loss of control first surfaced around the age of 40 [16]. There is, however, little research on whether there are demographic differences in attitudes of women specifically about embarrassment surrounding the stigma associated with experiencing symptoms of OAB and to what extent stigma itself is specifically an obstacle for middle age women in the baby boomer generation to pursuing treatment.

## SURVEY METHODS AND PROCEDURES

The design of this study was a descriptive, cross-sectional survey in which all measurements were made on a single occasion. This design is considered well-suited to the research goal of describing variables and their distribution patterns. Kelton Research, a leading national public opinion company, administered online interviews between March 18 and March 31, 2009, with a total of 1111 female American Internet users, of whom 500 constituted a nationally representative sample between the ages of 40 to 65. This constituted the norm, or control group, for a baseline view of American women's beliefs about the role of health for achieving a sense of balance in life. The demographic quotas for the 500 nonOAB audience approximated US Census figures. By comparison, a sample of 611 women in the same age bracket with self-reported symptoms of OAB was surveyed online during the same time interval in 2009. Based on responses, women with OAB were further categorized into three subgroups: those who had never been treated, those who were currently in treatment, and those who had discontinued treatment. The study was intentionally structured in this manner to mirror similar, but not identical, consumer research among women with OAB commissioned by NAFC, also employing online methodology, and completed in early 2003.

On a self-reported basis, the survey respondents classified themselves as either having OAB or representing a nonOAB

audience. This was based on the definition of OAB provided by the International Continence Society, housed on the NAFC web site, accessed on November 13, 2008, and reflecting symptoms of “urgency, with or without urge incontinence, usually with frequency and nocturia.” Kelton Research, as a third party research firm, made no attempt to medically validate this diagnosis in respondents.

An email invitation was used, and quotas were set to ensure reliable and accurate representation of the US female population ages 40 to 65. Descriptive demographic data were collected about all subjects in both sample groups. Characteristics regarding age, geographic region of the country, ethnicity, marital status, employment status, household income, education, area of living, and parental status were captured for each respondent. The four standard regions of the country (Northeast, Midwest, South, and West) as designated by the US Census Bureau were utilized in classifying each respondent’s state of residence by region [17]. The identity and answers of respondents were maintained confidentially and anonymously, and all survey responses were reported in the aggregate only. No commercial products or services were involved in the questions. Respondents were not incentivized to participate in this or the earlier survey. While ethical issues may be present in studies of help-seeking behaviors, particularly those involving sensitive or personal health topics such as bladder control, the anonymity allowed by private, online participation minimizes risk of violating ethical research standards and thus optimizes freedom of participation and liberty in responses to questions. There was no Institutional Review Board approval sought for the survey methods employed. Demographic profiles of the two datasets of women surveyed are depicted in **Table 1**.

The 500 women representing the norm were asked seven questions, primarily related to feelings of normalcy and disruptions in their lives. Questions were also asked of respondents about their attitudes toward personal health. The 611 respondents self-reporting symptoms of OAB were asked the same seven questions, as well as 16 additional questions specifically regarding their search for treatment, satisfaction with current treatment, and reasons for stopping treatment for OAB if treated in the past but having elected to discontinue treatment. Some questions used dichotomous, binary measures, for example: “If you had to choose one, what would you be more comfortable talking to a doctor about, OAB or menopause?” Other questions used a Likert scale of 1 to 5 commonly used to quantify attitudes, behaviors, and domains of health-related quality of life to measure abstract variables. For this question, an ordinal, categorical variable served as response choices, although due to employment of a Likert scale their ordered categories lacked intervals that are quantifiable. An example of such a question in the survey is: “How strongly do you agree or disagree with the following statements: I am proactive about treating my OAB?” Still other questions were framed with only a single response selection allowed, represented by a nominal, categorical variable, from a multiple list of options. An example of this question in the survey is: “Which of the

following best describes how having OAB makes you feel?” A response had to be selected from one of the following choices: Annoyed, Embarrassed, Anxious, Insecure, Depressed, Inhibited, Disabled, Indifferent, Abnormal, Afraid, and Other. In this case, nominal, unordered categories were represented by the choice made as a discrete variable. It is recognized by this researcher that the choice of measurement scale influences the information content of the measurement, with continuous variables generally preferred over categorical variables for reasons of improved precision.

Results of any sample are subject to sampling variation. For the sample of 500 nationally representative women ages 40 to 65, the chances are 95 in 100 that a survey result does not vary, plus or minus, by more than 4.4 percentage points from the result that would be obtained if interviews had been conducted with all persons in the universe represented by the sample. In other words, the confidence interval for interpreting results is  $\pm 4.4\%$ . For the sample of 611 nationally representative women ages 40 to 65, the chances are 95 in 100 that a survey result does not vary, plus or minus, by more than 4.4 percentage points from the result that would be obtained if interviews had been conducted with all persons in the universe represented by the sample [18]. For each of the three subgroups of women at various treatment stages for their OAB symptoms, the individual margin of error is 6.9 percentage points [18]. Quantum version 5.8 by SPSS, Inc. was the software used to analyze the data. To interpret the statistical significance of difference between any two subgroups, a t test was applied to the data. A chi-squared test was not utilized because it is typically used to compare the proportion of subjects in each of two groups who have a dichotomous outcome, more typical of randomized clinical trials comparing a treatment group to a placebo group. No statistics are quoted for comparative data among findings with a base too small to be eligible for significance testing. Only those results meeting a significance test of  $P < .05$  are reported among findings.

## FINDINGS

### Triggers to seeking treatment: frustration more than embarrassment

Middle age women are significantly more likely to express feeling annoyed and frustrated about their symptoms of OAB than embarrassed or stigmatized. This is true regardless of whether they have sought treatment or whether they have continued treatment. Of the 611 respondents, 39% ( $n = 236$ ) with OAB reported they were annoyed by the symptoms, compared to only 24% ( $n = 146$ ) who described feeling embarrassed. Only 3% ( $n = 17$ ) selected the word “abnormal” to describe how OAB symptoms made them feel. Such feelings persisted despite the fact that more than two-thirds ( $n = 416$ ; 68%) of the 611 total respondents revealed that they currently experience urinary leakage by not making it to the toilet in time. Among those no longer in treatment, the percentage was higher at 78% ( $n = 155$  of 200). Findings are summarized in **Table 2**.

Table 1. Demographic Profiles of Surveyed Respondents with OAB

| Characteristic         | Number of respondents | Percentage | Memo: national sample, N = 500 |
|------------------------|-----------------------|------------|--------------------------------|
| <b>Age</b>             |                       |            |                                |
| 40-49                  | N = 210 of 611        | 34%        | 38%                            |
| 50-59                  | N = 318 of 611        | 52%        | 38%                            |
| 60-65                  | N = 83 of 611         | 14%        | 24%                            |
| <b>Region</b>          |                       |            |                                |
| Northeast <sup>a</sup> | N = 105 of 611        | 17%        | 21%                            |
| Midwest <sup>b</sup>   | N = 161 of 611        | 26%        | 23%                            |
| South <sup>c</sup>     | N = 239 of 611        | 39%        | 34%                            |
| West <sup>d</sup>      | N = 106 of 611        | 17%        | 22%                            |
| <b>Ethnicity</b>       |                       |            |                                |
| Caucasian              | N = 559 of 611        | 91%        | 71%                            |
| African American       | N = 27 of 611         | 4%         | 15%                            |
| Hispanic               | N = 10 of 611         | 2%         | 9%                             |
| Asian                  | N = 3 of 611          | –          | 2%                             |
| Other                  | N = 12 of 611         | 3%         | 3%                             |
| <b>Marital status</b>  |                       |            |                                |
| Married                | N = 386 of 611        | 63%        | 60%                            |
| Not married            | N = 225 of 611        | 37%        | 40%                            |
| <b>Employment</b>      |                       |            |                                |
| STATUS                 | N = 175 of 611        | 29%        | 34%                            |
| Full time              | N = 97 of 611         | 16%        | 18%                            |
| Part time              | N = 207 of 611        | 34%        | 28%                            |
| Unemployed Retired     | N = 132 of 611        | 21%        | 20%                            |
| <b>Income</b>          |                       |            |                                |
| <US\$50,000            | N = 358 of 611        | 59%        | 58%                            |
| US\$50,000+            | N = 253 of 611        | 41%        | 42%                            |
| <b>Education</b>       |                       |            |                                |
| Some college or less   | N = 409 of 611        | 67%        | 64%                            |
| College degree or more | N = 202 of 611        | 33%        | 36%                            |
| <b>Area</b>            |                       |            |                                |
| Rural                  | 218 of 611            | 35%        | 32%                            |
| Suburban               | 292 of 611            | 48%        | 43%                            |
| Urban                  | 101 of 611            | 17%        | 25%                            |
| <b>Parent</b>          |                       |            |                                |
| Yes                    | 146 of 611            | 24%        | 25%                            |
| No                     | 465 of 611            | 76%        | 75%                            |

<sup>a</sup>Northeast includes ME, VT, NH, NY, NJ, CT, RI, MA, and PA.<sup>b</sup>Midwest includes OH, IL, IN, WI, MI, MN, ND, SD, IA, KS, MO, and NE.<sup>c</sup>South includes AR, OK, TX, LA, MS, AL, GA, SC, FL, NC, VA, TN, WV, TN, MD, DE, and DC.<sup>d</sup>West includes AK, HI, CA, NV, OR, WA, ID, MT, UT, AZ, NM, CO, and WY.

**Table 2.** Survey Questions Responses

|   |  |
|---|--|
| 1. Which do you feel more insecure about, managing your OAB or having enough savings for retirement?              | a. Having enough savings for retirement (n = 451 of 611; 74%)<br>b. My OAB symptoms or condition (n = 160 of 611; 26%)   |
| 2. How strongly do you feel about this statement: I don't think I will ever be able to completely control my OAB. | a. Strongly agree (n = 107 of 611; 18%)<br>b. Somewhat agree (n = 194 of 611; 32%)<br>c. Neither agree nor disagree (n = 124 of 611; 20%)<br>d. Somewhat disagree (n = 117 of 611; 19%)<br>e. Strongly disagree (n = 69 of 611; 11%)   |
| 3. Which of the following best describes how having OAB makes you feel.   | a. Annoyed (n = 236 of 611; 39%)<br>b. Embarrassed (n = 146 of 611; 24%)<br>c. Anxious (n = 52 of 611; 9%)<br>d. Insecure (n = 42 of 611; 7%)<br>e. Depressed (n = 25 of 611; 4%)<br>f. Inhibited (n = 21 of 611; 3%)<br>g. Disabled (n = 20 of 611; 3%)<br>h. Indifferent (n = 20 of 611; 3%)<br>i. Abnormal (n = 17 of 611; 3%)<br>j. Afraid (n = 5 of 611; 1%)<br>k. Other (n = 27 of 611; 4%)  |
| 4. Which of the following, if any, has your OAB ever made you do?<br>Choose all that apply.                       | a. Alter my behavior in social situations (n = 208 of 611; 34%)<br>b. Refrain from intense physical activity such as biking or running (n = 188 of 611; 31%)<br>c. Refrain from normal physical activity, such as walking or doing chores (n = 170 of 611; 28%)<br>d. Refrain from physical intimacy (n = 148 of 611; 24%)<br>e. Cancel social plans, such as dinner or dancing (n = 91 of 611; 15%)<br>f. Perform poorly at work (n = 52 of 611; 9%)<br>g. Cancel family plans, such as holiday dinners or family reunions (n = 48 of 611; 8%)<br>h. Take a sick day from work (n = 40 of 611; 7%)<br>i. Call off a date (n = 36 of 611; 6%)<br>j. Miss an important event or meeting such as a job interview (n = 35 of 611; 6%)<br>k. Cancel a vacation (n = 13 of 611; 2%)<br>l. Other (n = 32 of 611; 5%)<br>m. None of these (215 of 611; 35%) |
| 5. If you had to choose one, what would you be more comfortable talking to a doctor about, OAB or menopause?      | a. Menopause (n = 365 of 611; 60%)<br>b. OAB (n = 246 of 611; 40%)   |
| 6. Which of the following caused you to seek treatment for your OAB?<br>Choose all that apply.                    | a. Frustration from living with the symptoms (n = 313 of 400; 78%)<br>b. Embarrassment (n = 166 of 400; 42%)<br>c. Physical discomfort (n = 152 of 400; 38%)<br>d. Advice from someone else (n = 36 of 400; 9%)<br>e. Other (n = 27 of 400; 7%)  |
| 7. Which of the following have you ever done to treat your OAB?<br>Choose all that apply.                         | a. Taken medication (n = 351 of 400; 88%)<br>b. Strengthened pelvic muscles through exercises (n = 204 of 400; 51%)<br>c. Bladder retraining (n = 75 of 400; 19%)<br>d. Had bladder augmentation surgery (n = 50 of 400; 13%)<br>e. Had a nerve stimulator implant for bladder control (n = 13 of 400; 3%)<br>f. Other (n = 21 of 400; 5%)   |
| 8. How strongly do you feel about this statement: I am proactive about treating my OAB.                           | a. Strongly agree (n = 118 of 400; 30%)<br>b. Somewhat agree (n = 120 of 400; 30%)<br>c. Neither agree nor disagree (n = 96 of 400; 24%)<br>d. Somewhat disagree (n = 41 of 400; 10%)<br>e. Strongly disagree (n = 25 of 400; 6%)  |
| 9. How strongly do you feel about this statement: I am satisfied with the way I currently manage my OAB.          | a. Strongly agree (n = 106 of 611; 17%)<br>b. Somewhat agree (n = 179 of 611; 29%)<br>c. Neither agree nor disagree (n = 125 of 611; 20%)<br>d. Somewhat disagree (n = 126 of 611; 21%)<br>e. Strongly disagree (n = 75 of 611; 12%)   |

Table 2 (continued)

|  |  |
|--|--|
| 10. Which of the following best describes your level of satisfaction with your current OAB treatment?  | <ul style="list-style-type: none"> <li>a. Extremely satisfied (n = 40 of 200; 20%)</li> <li>b. Somewhat satisfied (n = 90 of 200; 45%)</li> <li>c. Neither satisfied nor dissatisfied (n = 27 of 200; 14%)</li> <li>d. Somewhat dissatisfied (n = 32 of 200; 16%)</li> <li>e. Extremely dissatisfied (n = 11 of 200; 6%)</li> </ul>  |
| 11. Which of the following are reasons you would consider changing your current OAB treatment?         | <ul style="list-style-type: none"> <li>a. Hearing positive things about a different treatment from a physician (n = 88 of 200; 44%)</li> <li>b. Experiencing no improvement in my OAB (n = 74 of 200; 37%)</li> <li>c. Experiencing side effects of current OAB medication (n = 70 of 200; 35%)</li> <li>d. Having an embarrassing moment due to OAB (n = 67 of 200; 34%)</li> <li>e. Hearing positive things about a different treatment from an OAB sufferer (n = 62 of 200; 31%)</li> <li>f. Experiencing only slight improvement in my OAB (n = 57 of 200; 29%)</li> <li>g. Developing other health problems in addition to OAB (n = 50 of 200; 25%)</li> <li>h. My current treatment having a negative effect on physical intimacy (n = 33 of 200; 17%)</li> <li>i. Other (n = 10 of 200; 5%)</li> <li>j. None of these—I wouldn't consider changing my current OAB treatment (n = 22 of 200; 11%)</li> </ul> |
| 12. Which of the following are reasons you never sought treatment for your OAB? Choose all that apply. | <ul style="list-style-type: none"> <li>a. I don't think I need any treatment (n = 87 of 211; 41%)</li> <li>b. I don't know much about available treatment options (n = 55 of 211; 26%)</li> <li>c. It's embarrassing to discuss my OAB (n = 48 of 211; 23%)</li> <li>d. Treatment options are too expensive (n = 39 of 211; 18%)</li> <li>e. I am afraid of the side effects (n = 35 of 211; 17%)</li> <li>f. I don't think the available treatment options are effective (n = 10 of 211; 5%)</li> <li>g. Other (n = 28 of 211; 13%)</li> </ul>  |
| 13. Which of the following are reasons you have stopped treatment for your OAB? Choose all that apply. | <ul style="list-style-type: none"> <li>a. The treatment options I tried weren't effective (n = 69 of 200; 35%)</li> <li>b. The treatment options I tried were too expensive (n = 55 of 200; 28%)</li> <li>c. The treatment options I tried produced side effects I didn't want to live with (n = 46 of 200; 23%)</li> <li>d. I wasn't made aware of other treatment options (n = 28 of 200; 14%)</li> <li>e. I meant to investigate other treatment options but never did (n = 21 of 200; 11%)</li> <li>f. It had a negative effect on physical intimacy (n = 7 of 200; 4%)</li> <li>g. I had trouble getting information about other treatment options (n = 5 of 200; 3%)</li> <li>h. Other (n = 41 of 200; 21%)</li> </ul>   |
| 14. Do you currently experience urinary leakage by not making it to the toilet in time?                | <ul style="list-style-type: none"> <li>a. Yes (n = 416 of 611; 68%)</li> <li>b. No (n = 195 of 611; 32%)</li> </ul>  |

Responses were consistent across all demographic segments of total respondents, although women in the South demonstrated slightly higher percentages of those expressing embarrassment (n = 64 of 239; 27%) than other regions (n = 82 of 372; 22%). Interestingly, respondents who are parents (n = 46 of 146; 32%) were significantly less likely than nonparents (n = 190 of 465; 41%) to express annoyance than embarrassment, suggesting that the potential impact of family concerns may be of greater weight and thus a source of embarrassment to women who are parents (n = 146; 29%) than those who are not parents (n = 465; 22%).

Still, an overwhelming majority (n = 313 of 400; 78%) of women with OAB who have sought treatment did so because they are frustrated living with the symptoms, far greater than those who express being motivated by physical discomfort (n = 152 of 400; 38%) or out of embarrassment (n = 166 of

400; 42%). This indicates that for many women with OAB, the symptoms are more than just a physical issue. In the age group of women studied, stigma does not appear to be the chief obstacle for not seeking treatment. Approximately one in four (n = 55 of 211; 26%) of those who have never sought treatment responded that it is because they do not know much about available treatment options. Only 23% (n = 48 of 211) offer the explanation that it is too embarrassing a topic to discuss.

### Frustration with treatment: a lack of engagement by providers

Frustration abounds with those in treatment. Whereas almost nine in ten (n = 351 of 400; 88%) of women have treated their OAB with medication, fewer than one in four (n = 43 of 200; 22%) in current treatment are satisfied with their

current OAB treatment. Twenty-eight percent ( $n = 55$  of 200; 28%) said the treatment options tried were too expensive. Almost one in four ( $n = 46$  of 200; 23%) claimed they stopped because of undesirable side effects. Sadly, there are clear signs that the prescribing practitioner is still not engaging with female OAB patients, as medication is overwhelmingly the sole means of therapy. Only 19% ( $n = 75$  of 400) among those ever treated were instructed in bladder retraining, proven in studies over the years to be successful for urge incontinence and OAB for both women and men. Medication, in combination with behavioral therapies, including good toileting habits, eliminating known bladder irritants from the diet, and using pelvic floor muscle contractions to help control sudden urges, has been demonstrated as more effective than any single intervention alone [19, 20].

## DISCUSSION AND CONCLUSIONS

Over the years, stigma has been frequently raised in connection with discussions of incontinence and OAB. However, the frustration level voiced in this study by American, women ages 40 to 65 with OAB, more so than their embarrassment associated with its symptoms, strongly suggests that baby boomers are not willing to forfeit quality of life freedoms robbed by symptoms of OAB. The NAFC's survey 6 years earlier of middle age women with OAB indicated that for most women the symptoms are a big "bother." In that earlier research, 77% of women who had never used OAB medication but who reported symptoms agreed with the statement describing the condition as a big bother [16]. In still another separate study, prevalence of bothersome incontinence symptoms among females in a prepaid health plan was also found to be high, with over half of the women reporting these symptoms bothered them [7].

While global initiatives are underway by such organizations as the Fogarty International Center and its partners at the US National Institutes of Health (NIH) to prevent or mitigate stigma and its adverse consequences on populations, the focus of such projects is considered appropriately placed on AIDS and/or infectious disease, neurological and psychiatric disorders, both in terms of care-seeking and provision of services [21]. More research is needed to support the suggestion that female baby boomers are not necessarily obstructed by embarrassment or stigma associated with bladder control in seeking solutions to conditions such as OAB to achieve quality of life improvements. More research is also needed in examining how different segments of the population are affected, particularly across cultural and racial differences, so as to improve our understanding of help-seeking behaviors.

Despite the fact there are now 11 different prescription drugs available for treating OAB in the United States (ditropan, ditropan XL, transdermal ditropan, gel ditropan, sanctura IR and ER, tolterodine IR and ER, fesoterodine, darifenacin, and solifenacin), more than one-third ( $n = 69$  of 200; 35%) of those who have stopped treatment opted out because they found the treatment they tried was not effective. While lack of effectiveness from medications is blamed by

one-third of patients as the reason for discontinuing treatment, patient dissatisfaction with current OAB treatment approaches could be due, in part, to the lack of engagement about the topic between patients and their providers. Far too few patients indicate they are instructed in helpful behavioral measures for a combination therapy approach to managing or reducing symptoms of OAB.

On the other hand, frustration with negative side effects may be lessening somewhat with a greater array of options and more extended release formulations smoothing the peaks of effects. The NAFC's earlier survey research in 2003 among women of the same age group documented frustration with side effects as reasons given for discontinuance of medication for OAB. In that earlier study, nearly one-third (31%) of those categorized as lapsed users of prescription drugs reported they were more likely to speak to their prescribing physician about their gastrointestinal problems than any other adverse side effect, including dry mouth. In addition, the most prevalent problem of lapsed users in the earlier study and associated by them with OAB medication was dry skin, self-reported by 58% of respondents [16].

Finally, the findings demonstrate the need for greater public health education so that people are made aware of what they can do for themselves, as well as their options for OAB treatment, beyond just taking daily medications.

The scope of this paper is not intended to cover the full extent of all possible findings and conclusions from this survey. This survey was not intended to diagnose or suggest treatment in any way to respondents. Nor was it intended to provide educational material to respondents. In addition, it was not designed to serve as a comparative study in any way to earlier studies and therefore was not intended to serve in any longitudinal capacity from a research perspective. Given the small sample size, the use of electronic invitations biased to those who were more computer literate, and the limitations of demographic data collected on each respondent in the sample of 611 women with OAB, it is recognized that this study's ability to be representative of the entire population of American women with OAB, whether diagnosed or not, is limited and therefore not necessarily generalizable to the entire US population. It should be considered preliminary in nature and therefore repeated in the future on a larger scale for a more meaningful, generalizable interpretation whose external validity cannot be so readily questioned.

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