

The continence paradigm

JO BOOTH: Before you think about any continence activities, it's essential that you consider the purpose of what it is you're trying to do, what are you trying to achieve with this person? What the paradigm of continence is that you're working with.

This slide shows a particular continence paradigm which is used to define incontinence and continence management across the age spectrum. The continence paradigm consists of three different types of continence and to help to understand this slide, I've over-laid three different models of healthcare over each part of the continence paradigm.

Firstly, on the right-hand side, there's *Contained Incontinence*, and this is what most people would describe as continence care, and it's actually a form of managing incontinence rather than continence promotion. It includes the use of absorbent pads, sheaths and catheters, different types of products where the overall purpose is to achieve social continence, in other words to ensure that the person will be socially acceptable, not smelling, not wet, and they will be able to take part in social activities, or if they are a hospital patient, they will be fit for discharge.

And then we have *Independent Continence*. The purpose of all our efforts with regard to Independent Continence is often not totally realistic for many people who live with a bladder and bowel disfunction in the longer term, however independent continence reflects the medical model, where the aim of what we do in our activities, is to cure the bladder and bowel disfunction. This would include the use of surgery, perhaps for a prostate problem or urogynaecological surgery for a prolapse or tension free vaginal tape insertion for a stress urinary incontinence problem.

In this situation, the person is not expected to do anything other than turn up for the intervention and they are not having to be supported to do things for themselves.

Being supported to do things for themselves is reflective of the third type of continence in the paradigm which is *Dependent* or *Controlled Continence*, where the person is enabled to achieve continence but relies on on-going assistance to do this and this may be from a range of different interventions, such as behavioural treatments, for example pelvic floor muscle exercises, or bladder training or alternatively, they may rely on drugs to be continent such as antimuscurinics, or Mirabegron.

They may also rely on assistance from another person or other equipment to reach and to use the toilet but in all cases, provided they have the support and the assistance that they need, they are continent. So, this reflects a rehabilitation model and involves the person or the patient taking an active part in maintaining their continence status. They cannot rely on others to do it for them and they must, themselves, make an effort to work at it. For instance, if we look at bladder training, bladder training is a very intensive form of activity undertaken by the person with the support of the continence advisor, who will enable them to understand what's happening with their bladder, to understand how to suppress the urgency that they are experiencing and to learn how to extend the period of time between their voids, in this way, regain and maintain control of their bladder.

Some of this will also involve positive feedback that they receive from their own bodies in the fact that they are recognising that they are actually holding on to their bladder and suppressing the urge successfully. But also they receive a lot of reinforcement from the continence advisor that they are working with who is able to demonstrate to them through the use of, for instance, bladder diaries and voiding programs to show how long they are achieving their delay in voiding and how they are improving with regard to the capacity of urine that they are able to hold, and their ability to suppress their urgency and reach the toilet in time.