The Impact of Fecal Incontinence on Mental Health and Quality of Life

A Literature Review

Presented to

To The Faculty of the Adler Graduate School

In Partial Fulfillment of the Requirements for

The Degree of Master of Arts in

Adlerian Counseling and Psychotherapy

By

Julie King

Chair: Louise Ferry, PhD, LP, LMFT

Reader: Jill Sisk, PhD

April, 2017
Abstract

Treating people with fecal incontinence as an individual, not as a medical disease or mental health condition, can increase quality of life in terms of decreased depression and anxiety. This in turn will increase an individual’s social activities and vocational success. Teaching individuals with fecal incontinence coping and lifestyle skills can increase their ability to be involved in their social community. The actual percentage of individuals who suffer from fecal incontinence is difficult to determine because individuals do not volunteer this information to their primary medical physicians. It is also thought that most general medical practitioners do not ask about fecal incontinence due to lack of knowledge about the condition. This paper will also address additional emotions related to an individual’s perception of fecal incontinence and how these emotions could play a part in social isolation. Future education for physicians on how to bring up the topic of fecal incontinence could be beneficial and making the topic part of routine medical and obstetrical care could make individuals less embarrassed about bringing up the subject. Using the Adlerian approach of community this writer believes more peer related groups and information could increase the quality of life of those suffering from fecal incontinence.
# Table of Contents

Abstract ........................................................................................................................................... 2  
Introduction ...................................................................................................................................... 4  
Incontinence .................................................................................................................................... 5  
  Causes of Incontinence .................................................................................................................. 5  
  Type of Incontinence ..................................................................................................................... 6  
  Incontinence Severity .................................................................................................................... 7  
  Duration of Symptoms .................................................................................................................... 8  
Emotions Related to Fecal Incontinence ......................................................................................... 9  
  Disgust ........................................................................................................................................... 9  
  Embarrassment ............................................................................................................................. 13  
  Shame .......................................................................................................................................... 16  
  Physician Inspired Shame ............................................................................................................ 19  
  Loneliness .................................................................................................................................... 21  
Impact on Mental Health ............................................................................................................... 22  
  Anxiety .......................................................................................................................................... 22  
  Depression ..................................................................................................................................... 23  
Decreased Quality of Life .............................................................................................................. 24  
  Social Isolation .............................................................................................................................. 25  
  Perceived Social Isolation .............................................................................................................. 28  
  Social Disconnectedness ............................................................................................................... 29  
  Social Support ............................................................................................................................... 30  
  Lifestyle and Coping Skills .......................................................................................................... 32  
Adler’s Connection .......................................................................................................................... 33  
  Social Interest ............................................................................................................................... 33  
  Private Logic .................................................................................................................................. 36  
  Inferiority ..................................................................................................................................... 37  
Future Research .............................................................................................................................. 37  
Final Summary ................................................................................................................................. 38  
References ......................................................................................................................................... 42
The Impact of Fecal Incontinence on Mental Health and Quality of Life

Introduction

Fecal incontinence is one of the last remaining taboos in the medical profession today. Fecal incontinence is defined as the involuntary loss of fecal material more than two times per month. Fecal incontinence is thought to affect 8 to 15% of the world’s population however it is difficult to come up with an exact number since there are few studies done on the data of incontinence cases (Koloski, Jones, Kalantar, Weltman, Zaguirre, & Talle, 2012). One study estimated about 7% of U.S. adults over the age of 50 had some sort of fecal incontinence, although there was no information available about the younger population (Rey, Rok Seon, Schlek, Zinsmeister, Locke, & Talley, 2010). Rey et al. (2010) were not sure if the information was indicative of the younger population since they had no other population based studies with which to compare their results. This could be from the lack of reporting from patients due to embarrassment and the stigma attached to the term. It could also be due to general medical practitioners not knowing how to ask about fecal incontinence or not asking patients about fecal incontinence, assuming if the patient had a problem they would address it with the practitioner. This writer will address the connection between fecal incontinence, mental health, and decreased quality of life. This paper will address how the physical symptoms of fecal incontinence and its stigma impact social relationships, emotions, self-esteem, anxiety levels, depression, and overall quality of life. It will also address Alfred Adler’s connection and future research ideas. This writer will review current research available regarding mental health and fecal incontinence as well as research available information regarding quality of life in relation to an individual’s fecal incontinence. Along with the above this writer will also review research regarding emotions that may relate to fecal incontinence and the possible social implication for an individual.
Incontinence

What is fecal incontinence and how is it defined? Fecal incontinence is the involuntary loss of mucus, liquid or solid stool (Koloski et al., 2012). It can also be defined as recurrent uncontrolled loss of fecal material at an inappropriate time or inappropriate place (Deutekom et al., 2004). If these uncontrolled or involuntary losses occur more than twice a month a person is considered to have fecal incontinence. The volume of stool and the sensation related to the incontinence helps pinpoint the cause of the fecal incontinence.

Causes of Incontinence

There are several causes of fecal incontinence, some more prevalent than others. The most commonly reported reasons for fecal incontinence are diarrheal symptoms, constipation overflow, obstetrical injury (traumatic vaginal delivery), previous anorectal surgery, radiation therapy (rectal, anal or prostate cancer), co-morbid conditions and advanced age (over the age of 50; Koloski et al., 2012). There are other, not as common reasons for reporting fecal incontinence such as diabetes mellitus, neurological diseases, spinal cord injury, anal trauma, pelvic floor muscle failure and sacral nerve injury (Miner, 2004). Other risk factors include: urinary incontinence, stroke, physical limitations, female sex, obesity, peri-anal injury, peri-anal surgery, gynecological surgery, hypertension, poor general health, and other bowel-related factors such as feelings of incomplete defecation and straining at bowel movements (Miner, 2004). Although female sex is given by many as a risk factor, some studies have found that fecal incontinence is as much a problem in men as it is in women (Goode et al., 2005). In one study, fecal incontinence was associated with advancing age in men but not in women (Goode et al., 2005).
Along with the causes of fecal incontinence, the question of gender and age are brought up as factors. One study indicated men are more reluctant to report issues with fecal incontinence than women, which means men were less likely to receive treatment or participate in a study for fecal incontinence (Maesa, Vaizey, Hollington, Stern, & Kamm, 2009).

**Type of Incontinence**

Fecal incontinence can be divided into four separate categories (Pares et al., 2011). A person can have one or all types of fecal incontinence. In each category there is a subset of severity which will be addressed in the following section. First the types of fecal incontinence will be described in each category in the fecal incontinence scale.

The first category is leakage or inability to control flatulence or gas (Parès et al., 2011). This is the least severe of the categories but that does not mean it is any less embarrassing. Leaking of gas is qualified by the person as not being able to hold back gas at an unwanted time or place. The gas is released unannounced to the person or the person is not able to stop the gas when they feel it coming.

The second category is the leaking of mucus (Parès et al., 2011). Mucus is leaked unbeknownst to the person into their undergarments or onto a pad. Mucus leakage tends to be an issue when a person has diarrheal symptoms or has a condition called rectal prolapse (the rectum prolapsing out of the anal canal).

The next group is leakage of liquid stool (Parès et al., 2011). Liquid stool is related to gastroenterology symptoms such as diet or diarrheal symptoms due to a comorbid condition. Liquid stool is the most difficult to control since it is usually accompanied by an increased sense of urgency which in turn leaves the individual little time to get to a bathroom. Liquid stool tends to make the largest problem for people with incontinence.
The fourth and final category is loss of solid stool (Parès et al., 2011). The loss of solid stool can be accompanied by a person not having the sensation from the rectum that the bowel movement is ready to be released. Another reason for loss of solid stool can be the rectum does not have the sensation of being full and therefore the normal sensation that triggers an individual to have a bowel movement is absent. These reasons can leave the person not knowing when an accident may occur.

**Incontinence Severity**

Fecal incontinence severity is measured by the number of times an incident happens. The Fecal Incontinence Severity Scale (FISI) was developed by colorectal surgeons and patients to give a weighted number to a person with fecal incontinence (Northwood, 2013). The scale is separated into the above mentioned categories: gas, mucus, liquid stool and solid stool and then into a grid of the following groups: 2 or more times a day, once a day, 2 or more times a week, once a week, 1-3 times a month, and never. The person then relates each type of incontinence with a severity giving them a weighted scale number. The severity scores range from 0 to 61; the higher the score equals the higher the severity of the fecal incontinence (Rockwood, 2004).

There is another scale that is used to determine the severity of fecal incontinence called the Wexner scale (Rockwood, 2004). The Wexner scale is a non-weighted scale that separates fecal incontinence into solid stool, liquid stool, and gas, but then also adds in two quality of life measures: wears a pad and lifestyle alteration. It scores fecal incontinence and the quality of life measures on a scale of never, rarely, sometimes, usually, and always. This instrument is easier to score since it is on a Likert 5 point scale however this instrument cannot give as much detail into severity as a numeric weighted scale like the FISI.
Duration of Symptoms

The onset of fecal incontinence can start slowly over time or be the result of a traumatic injury. The question this writer asked was “Does the duration of the symptoms have a greater effect on mental health and quality of life?” Most of the research this writer could find did not address duration as a factor in fecal incontinence and quality of life. One item found was coping skills and adaptation correlated with an individual’s perception of self and quality of life (Wilson, 2013).

Although there are many reasons for fecal incontinence, the most common are diarrheal symptoms, obstetrical injury, radiation therapy and advanced age (Koloski et al., 2012). Along with the causes of incontinence there are four separate categories of fecal incontinence. Each of the four categories: gas, mucus, liquid stool and solid stool has a subset of severity of that category of fecal incontinence (Parès et al., 2011). The severity scale is rated on how many “accidents” a person has within a specific time frame.

The FISI was developed by colorectal surgeons and patients to give practitioners a weighted scale to determine severity of fecal incontinence. The Wexner scale was also developed to determine severity using a non-weighted scale and it includes two quality of life questions (Rockwood, 2004). The FISI and the Wexner scale are the most commonly used questionnaires regarding fecal incontinence. There are several other questionnaires that may be used in conjunction with the FISI and Wexner scale to assess physical health, mental health, and quality of life.
Emotions Related to Fecal Incontinence

Disgust

Literature has mostly examined how emotions can lead decision making in regards to health and how those emotions play a part in those health related decisions. The literature has primarily focused on the emotions of embarrassment and fear leaving the emotion of disgust overlooked (Davey, 2011). Disgust is a natural human emotion that prevents us as individuals to exposing ourselves to health risks and contamination. The oversight of this emotion should be addressed in relation to fecal incontinence. How does this concept of disgust relate to fecal incontinence and one’s quality of life?

The questions this writer will address in this section of disgust are the following but not limited to: Does one’s disgust factor play a role in the anxiety of having fecal incontinence? Does one’s disgust factor relate to how one copes with fecal incontinence? Does the disgust factor relate to an individual’s perception of fecal incontinence? Does the fear of contamination of one’s self or the contamination of others play a role? Does self-disgust relate more to shame then an actual disgust factor or fear/anxiety?

Disgust is a factor that researchers have investigated over the past 20 years to see what role it may play in the disease-avoidance emotion in psychopathology (Davey, 2011). Disgust’s primary biological function is to protect the said person against illness, disease and contamination. According to Davey (2011) the emotions of disgust and anxiety or fear have great overlap and it is possible that experiencing one of them may trigger the other and the individual may become confused on which emotion they are feeling. Along with this both disgust and fear/anxiety have a dominant tendency which can be fear motivated of avoidance. Disgust based avoidance has to do with a fear of contamination versus perceived physical
danger. Some empirical studies have found that shame and disgust, especially self-disgust to be closely related and may represent one of the primary emotional substrates in avoidance behaviors (Davey, 2011). Davey (2011) states “Two possibilities are (1) the role of disgust in more complex human emotions such as shame and guilt and (2) the effect of disgust as a negative emotion on the processing of information and the generation of information processing biases” (p. 3460).

According to Reynolds, McCambridge, Bissett and Consedine (2014) there are two forms of disgust, trait and state disgust. Trait disgust is the stable tendency to experience disgust and state disgust is the current emotional experience. They are relevant to decisions across immediate versus anticipated timeframes. In addition to the two types of disgust there is also disgust sensitivity which Reynolds et al. (2014) state women tend to score higher on the sensitivity scale than their male counterparts.

Reynolds, Consedine, Pizarro and Bissett (2013) note that the actual experience of disgust that is relevant to colorectal cancer is also related to the disgust one may have in themselves or in the way they feel others see them. This writer understands this to mean it is not only the individual’s disgust sensitivity but the perception of others around the individual’s level or sensitivity to disgust. This could possibly lead an individual with a high sensitivity to disgust to perceive that family, friends, medical staff and their community be disgusted by their fecal incontinence at the equal or even increased level of disgust they feel internally.

In relation to disgust and fecal incontinence, Reynolds et al. (2014) found that persons low in disgust sensitivity reported a higher quality of life when symptom severity was low, but those with high disgust sensitivity had a low quality of life regardless of symptom severity. That leads this writer to believe emotional factors such as disgust appear to have a role in an
individual’s quality of life. Anal incontinence is an abundant area for disgust-inducing stimuli. The exposure to feces, unpleasant odors and the insertion of medical instruments into the anal canal are well-established causes of disgust and anxiety, but despite its obvious relevance disgust has been essentially overlooked in the context of fecal incontinence. Other than a few recent studies investigating the role of disgust in bowel cancer screening, one study investigating disgust among stoma patients and some emerging experimental work, there is little research in this area (Reynolds et al., 2014). An individual’s disgust sensitivity may be the factor related to how well incontinent patients adapt to their symptoms and perhaps patients who are more disgust sensitive may struggle more with bowel symptoms than those who are less prone to disgust.

Reynolds et al. (2013) reviewed nine studies relating to colorectal cancer screening tests which included fecal occult blood testing. This test requires the individual to collect their own feces, place it in a given container and deliver it back to their healthcare facility. The commonly cited reason for not completing the test was “disgust at the idea of handling stool” (Reynolds et al., 2013, p.124). Other participants cited reason for non-compliance with the screening because they simply did not like the idea of handling fecal material and others refused because “it’s just not nice”, “too unpleasant”, the test itself was “pretty disgusting” or the individual felt the test was “gross or repugnant” (Reynolds et al., 2013, p.124).

Reynolds et al. (2013) found that unlike studies regarding screening of colorectal cancer the treatment of colorectal cancer had no obvious themes. The only two consistencies Reynolds et al. (2013) could find was most patients presented late with bowel symptoms and 13% declined remove of rectal tumors because it would result in a permanent colostomy. There was no mention of why or what the thought to late symptom presentation was, whether it was related to shame and embarrassment or access to healthcare, however an undetermined amount of the 13%
of individuals that declined treatment because the thought of a permanent colostomy was “repugnant”.

A final qualitative investigation of the above study conducted comparative analysis of interviews with anal healthcare workers and patients, finding that anal taboos and stigma permeated every aspect of anal healthcare delivery, with participants reporting shame, embarrassment, disgust and fear (Reynolds et al., 2013).

Reynolds et al. (2013) also investigated disgust and avoidance in post treatment of colorectal cancer adaptation. After colorectal cancer treatment there can be permanent changes to bodily functions and other long term adverse effects, includes but is not limited to fecal incontinence. This writer would link these to quality of life if the individual’s actual (or perceived) disgust response removes them from close relationships, intimate relationships and the surrounding community. Individuals that are diagnosed, treated and return to a normal life in social context create the possibility of real (or perceived) disgust responses from intimate partners, caregivers, nursing staff, other health professionals, and broader support networks. Disgust responses play a key role in the stigmatization (and avoidance) of “out-group” persons, particularly among those with a detectable disease or disability. Another work of research suggests that both patients and health professionals alike are affected by the stigma of anal disgust (Reynolds et al., 2013). Within closer relationships, the same disease cues may trigger a disgust response in the individual, their loved ones, friends and the outlying community. This could potentially impact the quality of life and intimate and relationship connections that the individual currently has or could create in the future.
Emarrassment

Embarrassment is characterized by feelings of awkwardness, foolishness, humiliation and a heightened self-awareness. Normative situations eliciting embarrassment include physical ineptness or inadequacy, cognitive shortcomings, loss of control or poise and failure at privacy regulation, typically in the presence of strangers (Consedine, Krivoshekova & Harris, 2007). Any or all of the above may be why an individual avoids medical situations that created those feelings and the medical setting that promotes those feelings.

Individuals do not always participate in certain health related appointment (preventative or diagnostic) and treatments based on one emotional state or interpretation of the health-related appointment. Researchers have begun to examine how embarrassment may influence one’s willingness to partake in health care behaviors and health care decisions. An individual’s level of medical embarrassment potentially relates to their willingness to engage or not to engage in medical examinations. Consedine et al. (2007) state that most research in this area has focused on dental care, incontinence and cancer screenings, testicles, cervix and colon; a small number of studies have shown the absence of embarrassment when talking to a physician about personal health care.

With fecal incontinence, there comes a feeling of insecurity and self-awareness of the condition. A person with a deeper self-awareness of their fecal incontinence can lead to a decrease in their self-perception and an increase in their embarrassment. People often describe the impact of their fecal incontinence in terms of shame and embarrassment which leads them to isolate themselves from family and friends (Miner, 2004). Qualitative analyses have shown that medical procedures that are intimate in nature (e.g. gynecological, urological or incontinence procedures) produce feelings of anxiety and embarrassment in patients (Shaw, Williams,
Assassa, & Jackson, 2000). For example in the context of treatment seeking (or avoidance) for dental issues, it has been suggested that poor dental health may create feelings of embarrassment which, in turn, creates anxiety in the patient and thus avoidance of dental appointments (Berggren, Carlsson, Gustafsson, & Hakeberg, 1995).

In a study done by Bartlett, Nowak, and Ho, (2009) fecal incontinence frequency and type had significantly affects embarrassment and depression with a $P$ factor of $< 0.05$. Yip, Dick, McPencow, Martin, Ciarleglio, and Erekson, (2013) had consistent findings that a person with fecal incontinence has a decreased overall concept of self-perception.

Emotions theory suggests that emotional states can be motivational in anticipation those emotions such as embarrassment, shame and guilt (Consedine et al., 2007). These emotions may serve as social regulators by motivating prosocial behaviors that prevent their occurrence. Basically, embarrassment may also lead individuals to engage in health behaviors in response to symptoms that are already embarrassing or because they fear being embarrassed for not having undertaken the behavior (Consedine et al., 2007).

In relation to colorectal symptoms or screening, researchers do not know whether individuals are simply embarrassed by the prospect of having something inserted into their rectum, whether it is about being touched, whether it relates to obesity or having poor skin, whether they worry about the thoughts the technician has during the procedure, about their response to possible pain or about other people seeing them. It could be any one of the above items individually or a combination of any of them together, the list is endless.

Consedine et al. (2007) did find in their research strong theoretical reasons to suspect that some aspects of embarrassment may actually promote a superior health behavior. In one study of urinary incontinence, for example, men who had severe and/or more frequent symptoms reported
greater embarrassment and men who were bothered by symptoms that could be observed by social others (e.g. wet pants, dribbling, frequent daytime urination) were more likely to visit a doctor than those less bothered. Among men who were not bothered by their symptoms, those who were more embarrassed were 17 times more likely to see a doctor than men who felt little embarrassment, although this ratio dropped to 8 times more likely after annual income was controlled (Consedine et al., 2007).

Consedine et al., (2007) stated in their data medical embarrassment has two distinct aspects: (1) Bodily embarrassment and (2) judgement concern, each may relate differently to health behaviors and engagement alone or in interaction with each other. Greater bodily embarrassment appear in the Consedine et al. (2007) study to act as a barrier to participation in general medical visits where a physical exam may be or is required of the individual and embarrassment may act as a barrier to participation in intimate examinations. Consedine et al. (2007) analyses found that greater bodily embarrassment was associated with fewer sexual and general (although not psychological) visits. Greater bodily embarrassment predicted less frequent sexual visits, although our data does suggest that this effect may be greater among women (Consedine et al., 2007).

Bodily embarrassment did not predict visit frequency in psychological visit frequency; this was a better predictor of judgmental embarrassment. Consedine et al. (2007) suggest that higher judgment concern may either promote greater psychological distress, or that the measure may index greater neuroticism; persons with greater neuroticism are more likely to receive mental health care whether or not they have an emotional disorder.
Shame

Shame and humiliation refer to painful feelings caused by the lowering of one's pride, self-respect, or self-concept. Although shame and humiliation are often used interchangeably, there are differences in their use. Shame may refer to distress concerning the state of the self the person regards as no good, not good enough, or defective. Humiliation, in contrast, refers to a temporary status of the self, usually caused by someone else the person regards as lowering or degrading. With the experience of shame an individual may feel or believe that they do not measure up to ideals or standards they have set for themselves (Lazare, 1987). An individual becomes aware that they are not the kind of person they think they are, wish to be, or need to be. This standard against which an individual judges themselves is discussed in psychodynamic circles, where it has been referred to as the self, ideal self, self-concept, self-representation, ego ideal, and ego identity (Lazare, 1987).

Although shame and guilt are often confused, they represent two distinct experiences. With shame, the precursor event is the sudden awareness of a deficiency of the self, a goal not reached (Lazare, 1987). Shame shields one’s self against further exposure. The reaction to shame is to hide or disappear or to shame the other person that caused the scorn, contempt, or ridicule. Shame is about the whole self, often calling into question one's total identity and an individual can be ashamed not only of himself, but feel shame for those close to him—a child, parent, or a friend (Lazare, 1987).

Lazare (1987) states attempts have been made to categorize issues which may be vulnerable to shame and may include the following but is not limited to: need to be loved and taken care of, not rejected; to be strong and powerful, not weak; to succeed or win, not fail or lose; to be clean and tidy, not messy and disgusting; to be good, not bad; to be whole and
complete in physical and mental makeup, not defective; to be in control of bodily functions and feelings, not incontinent and out of control. When we look at this list we see the words “not messy” and “disgusting” are mentioned along with control of our bodily functions which are both related to the issue of fecal incontinence.

The last factor Lazare (1987) discusses in the experience of shame is the social context. This includes the nature of the relationship to the person or people perceived as doing the shaming, the nature of the communication, and the nature of the social event. The more the person matters to the subject and the more public the exposure, the more intense the shaming experience “The perceived humiliating communication may take the form of a facial expression, a gesture, a verbal intonation, innuendo, an explicit criticism” (Lazare, 1987, p. 1655).

Lazare (1987) explains shame in a medical setting with a descriptive play by play of how each step through the process of the medical experience can induce or create shame

In the medical setting, the shame-inducing event and the individual vulnerability ultimately interact with a social context once the patient seeks professional help. Patients brave unfamiliar traffic, search frantically for parking space and search for the doctor's office. They hope they do not meet any acquaintances they are not quite sure what preoccupies them most, their disease, their insignificance, or arriving late. In the waiting room are labeled as people who belong in this office. Once in the examining room, patients must reveal personal information often about their weaknesses, expose their bodies, place themselves in undignified postures, and accept handling of their bodies including intrusions into orifices …. This can lead to intense shame over not being strong and in control. Confidentiality and privacy is most often a matter of protection from
exposure to the shame that others know what one personally regards as an inadequacy. (p. 1655)

When discussing shame there are different reactions and defenses it can produce which this writer thinks could lead to issues with quality of life and one’s mental health. Laughter is an adaptive response to minor embarrassments or shameful events and humor can be a powerful healer of humiliation. When the disrespect is perceived as more meaningful, the person may assume the hiding responses, increased protectiveness, lying, or the avoidance of social situations in which the person might be found vulnerable (Lazare, 1987). The hiding response can have an adaptive function, and shame acts as an emotional wall or boundary around a person serving as a protection against violations, assaults, or incursions against the self. A breach of this boundary signals the person to maintain distance, move away, hide, and protect himself (Lazare, 1987). A common maladaptive hiding response seen in shame-prone individuals is the unnecessary distancing from others, thereby depriving themselves of normal intimacy. The most extreme maladaptive hiding response is suicide (Lazare, 1987).

Related to a medical disease individuals who feel ashamed of their illness may use one of several hiding maneuvers; it may include avoiding going to the doctor or keeping a return appointment, or the individual may tell themselves they will return when they can appear more presentable. Others may seek care away from their local community, avoid telling friends or relatives about their illness, and/or refuse to receive visitors. Some individuals may lie to their physicians or withhold information if they think it will make them look bad to the physician such as self-treatment based on personal health beliefs. The individual may just deny the illness as a hiding technique.
Physician Inspired Shame

Another area of shame is how the physician may shame a patient during their interactions and how and what this can mean for an individual’s medical care and\or willingness to discuss health concerns with the physician. If shame is induced, what consequences does it have for the patients’ health and the patient doctor relationship? According to Lazare (1987) a physician should assume that any disease and treatment can be a shame-inducing event which can interact with that individual’s vulnerability. To decrease a shame event physicians need to attend to three interrelated tasks: (1) diminishing the patient's shame and humiliation; (2) avoiding exacerbating the patient's shame and humiliation; and (3) recognizing and managing their own shame and humiliation (Lazare, 1987). Harris and Darby (2009) ask the question whether shame provoking interactions, should they occur, always represent regrettable disruptions of patient-physician relationship or alternatively sometimes prompt behavioral change. The patients who feel shame primarily condemn themselves, not the behavior, and they will react negatively.

Harris and Darby (2009) found in their research that shame and guilt are common in patient-physician interaction, roughly one-fourth of their younger sample and half of their more mature sample reported having shaming experiences with their physicians. Harris and Darby’s (2009) research suggests that behavior condemnation, self-condemnation and perceptions of intentionality may play an important role in patient experience, which relates back to whether an individual will follow up with appointments and treatment. Both studies done by Harris and Darby (2009) found if an individual has the perception that the physician was intentionally trying to shame or guilt them it was related exclusively to negative outcomes and there was not perceived benefit to such an encounter. Now this negative outcome is based on the individual’s
perception of the physician shaming them, whether or not the physician actually did display shaming behaviors.

In a study conducted by Harris and Darby (2009) they stated about twenty percent of those who reported shame experiences with a physician stopped seeing that physician, eighteen percent avoided seeing the certain physician to some degree and fifteen percent lied to that physician about health related behaviors to avoid being embarrassed or shamed again. In relation to gender, Harris and Darby (2009) state women reported more negative and men more positive consequences for feeling shamed by a physician. A sizable proportion of individuals who reported experiences of shame in a medical context attribute highly undesirable consequences to the interaction, including persisting distress, cessation of treatment and lying to the physician to avoid embarrassment (Harris & Darby, 2014).

The question that this writer then began to think about is how this relates to fecal incontinence. Shame may come from the physician’s manner or reaction when the individual brings their concerns about incontinence, since this can be considered a delicate or shameful topic. If the physician is not comfortable with the subject due to their own understanding or embarrassment of a disease or disorder, does that effect how the patient perceives their reaction to them? It may also be that the individual has perceptions of being judged by the physician. The perception of being judged can then lead to maladaptive behaviors. The other factor that should be considered is the individual’s relationship with that physician. Does a long term relationship with the physician change the perception the individual will have or does the gender of the physician in relation to their own gender play a role and does the physician’s age or experience play a role in the perception an individual?
Loneliness

Loneliness is a negative feeling related to the person’s own experience of lacking social relations. The factors of loneliness are most often defined on the basis of two models (Singh & Misra, 2009). The first examines the external factors, which are absent in the social network, as the root of the loneliness; the second refers to the internal factors, such as personality and psychological factors (Singh & Misra, 2009).

Loneliness may lead to serious health-related consequences. It is one of the three main factors leading to depression and an important cause of suicide and suicide attempts, and loneliness is related to poor psychological adjustment, dissatisfaction with family and social relationships (Singh & Misra, 2009). Loneliness is not necessarily about being alone, instead it is the perception of being alone and isolated that matters most as it is “a state of mind”. It can be an inability to find meaning in one's life, a feeling of negative and unpleasantness and a subjective negative feeling related to the deficient social relation and a feeling of disconnectedness or isolation for people or the community.

Loneliness can create depression and anxiety; lonely people may exhibit more signs of physical stress. Loneliness is also related to alcohol consumption and decreased social activities and lastly there is research available that lonely people are more susceptible to physical illness (Singh & Misra, 2009). We know that fecal incontinence is not a disease that is brought on by stress, although it can be exacerbated by stress, this writer imagines that an individual’s fecal incontinence could lead them to isolate themselves from their community, family and friends. Loneliness can become a big issue and the three above mentioned physical signs may be increased which in turn leads to a higher rate of incontinence. It appears it could become a cycle for the individual that would take a large effort to break. A study by Tanskanen and Anttila,
(2016) found that those who reported having poor health also reported the highest levels of loneliness. It is possible that poor health might lead to loneliness, but there is strong evidence showing loneliness causes poor health.

**Impact on Mental Health**

Fecal incontinence is a stressor in life and is becoming increasingly recognized as not only a physical disease but a psychological co-morbidity. The effects of fecal incontinence vary from person to person. What one might find restrictive another will find it to be a social problem (Cotterill, 2011). Fecal incontinence is not discussed freely in groups of people and this can leave an individual feeling out of place. The feeling of being out of place can increase a person’s anxiety in social situations, which can in turn lead to an increase in a person’s depressive symptoms and social isolation.

**Anxiety**

An anxiety disorder can control and alter a person’s life when it is a diagnosis alone, but pairing it up with a medical condition that is not easily understood and not visible to the public can create greater effect on an individual’s mental health.

Loss of control is a key issue related to anxiety with fecal incontinence; it is the unpredictable nature of fecal incontinence. An individual does not know when an accident may occur which leaves a person with increased anxiety when leaving the comfort of their home. It was shown that women with weekly fecal incontinence had higher anxiety scores on the Hospital Anxiety and Depression Scale (HADS) than women who did not have weekly occurrences of fecal incontinence (Yip et al., 2013).

Severe anxiety actually turns off a part of the brain that controls urine and defecation (Perry, McGrother & Turner, 2006). That is why during periods of extreme anxiety, it is not
uncommon to feel the need to go to the bathroom. It is fairly rare to go without controlling it (except in the cases of extreme fear, like facing a life or death situation), but it is known that anxiety can turn off this part of the brain. If this is the case, when an individual who suffers from fecal incontinence has an increased level of anxiety, it would increase their level of incontinence.

### Depression

Bartlett, Nowak, and Ho (2009) found that people with fecal incontinence that were less able to cope with their fecal incontinence were more depressed. Koloski et al. (2012) found that people who reported fecal incontinence were significantly more depressed and anxious on a 12 year follow up study than people that no longer had issues with fecal incontinence. Koloski et al. (2012), however, did not report how they determined significance in numbers. Koloski et al. (2012) also found in this study that women between the ages of 30-90 years had higher levels of depression than the other study participants.

Smith, Menees, Xu, Saad, Chey, and Fenner (2012) conducted a survey of 225 women from a multidisciplinary clinic in Michigan by having them fill out the Fecal Incontinence Quality of Life (FIQOL), the FISI, and Patient Health Questionnaire (PHQ) for assessment of depression. This study showed worsening depression scores on the PHQ predicted worse scores in overall quality of life category on the FIQOL. By using the PHQ, Smith et al. (2012) found depression was a major factor contributing to decreased quality of life. This study did not find a correlation between depression and frequency of fecal incontinence events.

Yip et al. (2013) found that women with weekly fecal incontinence scored higher on the depression scales than women who did not have weekly issues with fecal incontinence. Maesa et al. (2009) found no difference between men and women, when using the Hospital Anxiety and Depression Scale (HADS) questionnaire, in the levels of depression or anxiety. Both of the
studies are showing that gender does not have a large effect on depression and anxiety when correlating the scores on the depression scales with fecal incontinence scales.

While there is not a lot of research available about fecal incontinence in relation to depression and anxiety, the information this writer found seemed to correlate with each other. The research available to this writer shows individuals with fecal incontinence can have higher depression and anxiety scores on multiple different health questionnaires. These questionnaires also have shown higher levels of anxiety among individuals with fecal incontinence on a weekly basis (Meyer & Richter, 2015). Yip et al. (2013) concluded in their study that women with fecal incontinence have increased loneliness, depressive symptoms, and anxiety symptoms when compared to women in their community without fecal incontinence.

An interesting point the Smith et al. (2013) article brought up that treatment of fecal incontinence requires cooperation and dedication to a plan, which someone with major depression may not be able to follow. This then increases the depression and decreases quality of life perception of the individual which leads the individual to not put effort into the treatment. It becomes a circle of disappointment and lack of motivation from the individual.

**Decreased Quality of Life**

People with fecal incontinence live in a restricted world, often describing it as being in a prison (Crowell et al., 2007). Quality of life is a personal construct and is different to every person at any given time. To understand a person’s quality of life in relation to fecal incontinence, a clinician or practitioner must look at it from the individual’s perspective. Quality of life is defined by the World Health Organization (WHO) as “a broad ranging concept, incorporating in a complex way individuals’ physical health, psychological state, level of independence, social relationships, personal beliefs, and their relationships to salient features of
Several studies have shown that fecal incontinence has a strong effect on a person’s quality of life (Parès et al., 2011). The functional status of patients with anal incontinence explains some but not all of the variation in quality of life.

The Fecal Incontinence Quality of Life (FIQOL) is used along with the Fecal Incontinence Severity Index (FISI) in evaluating quality of life outcomes of patients suffering from fecal incontinence (Bols, Hendriks, Berghamns, Baeten, & de Bie, 2013). FIQOL is a questionnaire that includes 4 scales to determine the person’s perceived quality of life. The subscales are lifestyle, coping behavior, depression/self-perception, and embarrassment. The higher the score, the higher quality of life the patient perceives of themselves. The questionnaires are used in conjunction with other health questionnaires to determine overall physical health and mental health. The questionnaires are not gender specific, although Bharucha, Zinmeister, Locke, Schlek, and McKeon (2006) found that fecal incontinence has a negative effect on a woman’s quality of life. It is not known why fecal incontinence has a greater effect on a woman’s quality of life rather than a man’s quality of life. It is unclear whether men report less problems due to embarrassment or if men are less emotional about their situation (Maesa et al., 2008).

Parès et al. (2011) found that lack of bowel control clearly impairs quality of life and the likelihood of depression. Altered levels of neurotransmitters in patients with depression may influence bowel function, thus whether the relationship is one of cause and effect it is difficult to determine.

**Social Isolation**

Social isolation is defined as the lack of social relationships and has often been interchangeable with loneliness. Social isolation can be defined as small social networks,
infrequent social contact, living alone and lack of participating in social events and/or activities (Tanskanen & Anttila, 2016). Loneliness is described as a feeling of being without the types or type of relationship an individual desires or the deficit between the actual and desired quality and quantity of social engagements. The definition and understanding of social isolation is an objective finding related to restriction of an individual’s relationships that are being upheld and creating new relationships. Loneliness is subjective in nature to an individual since one can have few social relationships and interactions and not be lonely but another individual can have numerous social relationships and interactions and still feel lonely. Individuals that have higher levels education are found to have larger and more diverse confidante networks than less-well-educated individuals (Tanskanen & Anttila, 2016). Those in higher socioeconomic groups are more likely to be married, to have more friends, and to enjoy higher levels of social support. Socioeconomic differences in health outcomes of social isolation may vary between men and women. With respect to men, one study showed that being in the lowest socioeconomic category increased the association between social isolation and death compared with belonging to the highest category (Tanskanen & Anttila 2016).

Social connections can operate to influence health-related behaviors in three general ways: behavioral, psychosocial and physiological. Behavioral relates to future habits, information and the influence one may receive to create new norms (Tanskanen & Anttila, 2016). The physiological relates to one’s actual body systems’ function such as cardiovascular, immune and endocrine. Persons who are connected are found to have lower stress levels than those of socially isolated persons and all of the previous mentioned body systems engage in stress responses (Tanskanen & Anttila, 2016). Psychosocial behaviors relate to personal control, social network support and mental health.
Tanskanen and Anttila (2016) found that poor health, frequent heavy drinking, not working or studying, and low household incomes were connected to evaluated levels of loneliness and social isolation. Women and highly educated individuals experienced greater loneliness, whereas those less well educated suffered higher degrees of social isolation. Also, those who never engaged in physical exercise reported higher levels of social isolation. Young people and senior citizens were also particularly socially isolated. Tanskanen and Anttila (2016) found that previous studies have established a connection between social relationships and health. Specifically, social isolation has been connected to an impact on physical or general health whereas loneliness has an impact on mental health (Cornwell & Waite, 2009). There is low correlation between objective social isolation and the subjective feeling of loneliness indicating that loneliness does not depend on the quantity of social relationships, but rather on the quality and expectations of social relationships (Cornwell & Waite, 2009). Tanskanen and Anttila (2016) found their study and confirming with previous studies certain individuals are more at risk than others for social isolation, particularly young people, senior citizens and the less educated.

The elderly compile a high-risk population for social isolation and this group of individuals has the highest rate of fecal incontinence. According to Goode et al. (2005) the rate of fecal incontinence in adults over the age of 70 is 17%, which is higher than the average of all ages. This average may mean that since the elderly already have a smaller social network and may have a condition that produces embarrassment and shame within themselves, this may lead them to isolate themselves even more from their social group. Another thought on the elderly population is that a large number of elderly individuals live in a long-term care facility further decreasing their quality of life and social network.
Perceived Social Isolation

Social isolation can happen for numerous reasons. It can be due to location, loss of friends and family due to death, moving away from friends and family, or as in the elderly population being placed into a long-term care facility. Isolation can be a measured event but can also be a perceived event that one may feel when they are conscious of the loss of support or if they have or a hidden medical issue such as fecal incontinence that makes them withdraw from their social support. Perceived isolation is characterized by the subjective experience of a shortfall in one’s social resources such as companionship and support. For example, feelings of not belonging indicate a perceived inadequacy if the intimacy or companionship of interpersonal relationships compared to the relationship that that individual would like to have (Cornwell & Waite, 2009). Research has suggested a potential connection between perceived social isolation and mental health problems and physical health problems (Cornwell & Waite, 2009). Perceived social isolation may affect physical health through the effect that it has on one’s mental health just like one’s mental health may affect one’s physical health.

People with fecal incontinence describe the feeling of social isolation like living in a prison because they feel confined to be close to a bathroom at all times. This feeling decreases their confidence and courage to go out of the house (Parès et al., 2011). Individuals then are less likely to participate in social events and then have less social support. Less social support leads to isolation, disconnectedness and limits an individuals’ life situation

Yip et al. (2013) found in their study women with weekly fecal incontinence reported feeling isolated “often” and felt disconnected from their social network. The feeling of disconnect came from not participating in social activities, volunteering or group events. These women relied more on their spouse or partner for social support. The women also reported a
higher rating on the loneliness scale than women that did not have weekly problems with fecal incontinence (Yip et al., 2013).

Fecal incontinence can also influence a person’s economic status. An individual with fecal incontinence can miss work, have an impaired work performance and can have a change in their job status due to a person trying or not trying to accommodate to their situation (Miner, 2004). Miner (2004) reports that a person with a large volume of fecal incontinence misses, on average, 50 days of school or work related to their fecal incontinence. Edwards and Jones (2001) report that 59% of people with fecal incontinence report themselves as severely disabled compared to only 16% of individuals that do not suffer from fecal incontinence.

Social Disconnectedness

Social disconnectedness is defined as a lacking in social relationships and low levels of participation in social activities (Cornwell & Waite, 2009). Social connectedness can provide access to resources such as information, transportation, money and emotional support; with these networks it could lead an individual to a better outcome with physical and mental health. Cornwell and Waite (2009) found in their study that both perceived social isolation and social disconnectedness were associated with decreased physical and mental health. Although social disconnectedness is related to decreased physical health, it suggests that older adults have decreased mental health only to the extent they feel isolated (Cornwell & Waite, 2009). In relation to fecal incontinence there are no studies available that this writer could find about how incontinence and social isolation relate. This writer did find studies available that ask the question “Does group treatment of sensitive healthcare problems assist in the outcome of the treatment?” These are the studies this writer will use to support how social connection and
community support may assist in the treatment of fecal incontinence both from a physical standpoint and a mental health standpoint.

Social Support

Group treatment is a well known part of the mental health community from support groups for cancer and infertility to group sessions in addiction recovery. This writer poses the question, “Could group treatments for shameful or sensitive medical problems change the outcome of the physical part of the disease as well as the emotional, mental health, quality of life and social challenges?”

Lamb, Pepper, Lall, Jorstad-Stein, Clark, Hill and Fereday-Smith (2009) created a study with group biofeedback treatments for urinary incontinence for the hypothetical benefits of increased peer-support, mutual self-help, giving and sharing information, reduction of depression and isolation, increased motivation and compliance with the treatment. Besides the potential for the effectiveness related to quality of life this could be more cost effective for the individuals attending the group sessions along with more cost effective for the healthcare identity giving the group sessions. The Lamb et al. (2009) study included ten women who suffered from urinary incontinence. The women were given three weekly one hour sessions. The first session include information of normal bladder function, causes of stress incontinence and teaching and practice of pelvic floor exercise. The second sessions included causes of urge incontinence, discussion related to motivation and again practice of pelvic floor exercise. Finally, the third session included a bladder quiz to reinforce previously giving knowledge. Lamb et al. (2009) found that half of the women had no preference for individual or group treatment, and the remaining half would prefer individual sessions. The preference was weakly associated with severity of symptoms, women with milder symptoms preferred the group treatments (Lamb et al., 2009).
Lamb et al. (2009) concluded the study by stating there was no sustainable difference in symptoms, psychological or quality of life outcomes. The group sessions were no more effective in reducing the burden of psychological symptoms and distress than individual sessions.

Jones, Gosselink, Fourie and Lindsey (2014) investigated if group pelvic floor retraining for fecal incontinence provide positive peer support, increase compliance and change in behavior. Jones et al. (2014) stated pelvic floor retraining has shown to have significant improvement of symptoms and quality of life in fecal incontinence and obstructed defecation. In the Jones et al. (2014) study they compared patients who attended a one hour initial session followed by two 45 minute sessions three and six months later. With the group treatment, the initial one hour session was held as a group and the follow up sessions were held as individual sessions. The groups were made up of both male and female participants; the original thought was to have them separated by gender but there were not enough participants to have separate groups. In the group session, no individual’s details were discussed and they were given the same information regarding diet, medication, normal physiology, evacuation techniques and pelvic floor exercises the individuals were given in the private sessions.

Jones et al. (2014) found that 91% were satisfied with their group experience and would recommend it to others. The comments ranged from informative to “I felt normal” and most patients experienced symptom improvement after the sessions. The study reported that patients liked the group sessions as it provided peer support and it was an opportunity to develop peer social support with others that suffer from fecal incontinence. This above information leads this writer to understand that peer support can influence one’s perception of social acceptance and decrease one’s social isolation perception when they discover they are “normal” and there are
others out in the community that suffer from the same hidden medical issue from which they suffer.

**Lifestyle and Coping Skills**

An individual with fecal incontinence must develop coping skills and change their current lifestyle to adjust to fecal incontinence. There are numerous coping skills that people use to deal with their incontinence. Coping strategies like restricting diet or sacrifice items from their diet can give a person the temporary sense of control over their incontinence and make them feel like other people around them (Rasmussen & Ringsber, 2010).

Along with coping skills, an individual must adjust to fecal incontinence with some lifestyle changes. Toilet mapping is knowing where all of the bathrooms are at any given location they frequent. This is one of the main lifestyle changes that a person with fecal incontinence to deal with the fear of not being able to make it to a bathroom. The idea of toilet mapping for an individual can lead to restriction with social activities. An individual may not attempt new situations or unfamiliar events because they do not know the layout of where the restrooms are located.

Wilson (2013) found that long-term stable relationships that were established before fecal incontinence help the adaptation and coping skills of the person with fecal incontinence. Bartlett et al. (2009) found a highly significant association between FIQL and quantity of fecal loss. Individuals that scored lowest in coping and embarrassment had the lowest FIQL scores. If an individual can learn to create coping skills, decreasing their embarrassment of their fecal incontinence, the person can have a slight increase in their perceived quality of life. No person wants to be stigmatized by their fecal incontinence, which could be why someone may remain silent or misrepresent their symptoms to medical professionals, family and friends.
In turn, the person has then begun to isolate themselves from their social support system, increasing their embarrassment and decreasing their overall quality of life. In a study done by Alsheik et al. (2012), they found that twenty-eight of 58 patients in their study with fecal incontinence reported a lower quality of life (FIQL<2.5), although the effect of fecal incontinence on quality of life does not seem to correlate with frequency of symptoms (Cotterill, 2011).

Failure to seek treatment for fecal incontinence diminishes a person’s quality of life over time (Bartlett et al. 2009). Bartlett et al. (2009) found that older women reported a lower quality of life than younger women but the thought is that this could be due to the delay in seeking treatment for their fecal incontinence.

**Adler’s Connection**

**Social Interest**

One of Adler’s key concepts is that of social interest. “Social interest” in German is *Gemeinschaftsgefühl*, which translates as “community feeling,” as opposed to one’s private interests or concerns (Ferguson, 1989). One’s “style of life” is the set of constructs and personal narratives one has devised in order to cope with being-in-the-world (Ferguson, 1989). If one has social interest then one endorses a “useful” style of life (Ferguson, 1989). If one does not have social interest then one is self-absorbed and is concerned only with one’s self. Such a style of life is “useless” in the eyes of Adler and Individual Psychology. Social interest works in conjunction with an individual’s need to belong; if an individual feels they are part of the group they will work to go from a felt minus to a felt plus. An individual making this horizontal move from negative to positive will in turn benefit the group and the larger community (Ferguson, 1989).
Need to Belong

As humans we are socially rooted and are motivated to find our place in our families, among our friends, at school, at work and in society. If we feel inadequate or inferior to others, then we doubt our place in the group. Instead of moving towards participation and co-operation, we defend ourselves against those individuals; simply all humans feel the need to belong. Adler wrote in 1938 “To be human is to recognize that one’s humanity rests in one’s identity as a social being, an equal among equals” (Adler, 1938, p. 22). The feeling of belonging is vital to one’s mental health and when this is elevated to the social level it is vital to all members of the community to feel the sense of belonging. Eva Dreikurs Ferguson (2010) wrote mental health increases when the individual feels belonging and all the individuals in the community feel belonging. This extends between social groups when they feel equal to one another. The well-being of the individuals in the groups then feels belonging to a larger circle of the human community. Psychological disturbances occur when individuals do not feel belonging and symptoms and difficulties emerge. An individual begins to direct behaviors towards self-protection rather than contributions to the community and this begins a cycle. This protective pattern can become set and this leads to more failures of support (Ferguson, 2010). The greater the sense of belonging the more likely the individual is to reach out to others, and in turn the more the individual reaches out to other the more that individual feels a sense of belonging (Ferguson, 1989).

This writer would like to give thoughts on how this need for belonging can affect one with fecal incontinence. As this writer stated above fecal incontinence can be accompanied by many negative emotions from depression and anxiety to embarrassment, shame and disgust.
Those emotions can lead an individual to become socially isolated due to physical symptom but also due to the effect the physical symptoms are having on one’s mental health.

A beginning point to help aid with the effects fecal incontinence can have on one’s mental health and quality of life could be to have the topic of fecal incontinence be brought up as a normal question at a physical exam appointment. As the research has shown the topic is not frequently brought up by physicians either due to their lack of knowledge or their own personal embarrassment to discuss the subject. It would also be important to be brought up as a normal part of obstetrical care since fecal incontinence is a risk of natural childbirth. This incontinence can start directly after the birth of a child due to a traumatic delivery or years later due to latent effects of birth trauma. By making the topic not taboo in the clinical setting it could possibly lead individuals that are suffering not as much strain and stress when needing to bring up the subject. Providing information regarding causes, treatment and outcomes more readily available could increase the quality of life of an individual with fecal incontinence and make that individual more active in their community. Coping skills and tools have shown in some research to be of assistance to an individual with fecal incontinence so again making these items more available could increase the quality of life of individuals. Another thought of this writer is if you give individuals the information and the ability to assist themselves with their fecal incontinence and it is not as taboo of a subject, they will want to share their knowledge and experiences with others. This can make individuals who suffer from fecal incontinence their own community and build strength within the group that could support the individual when they are among other social groups such as friends, co-workers or families.
**Private Logic**

Everything we do has the goal of making us feel better or safe, but our notion of the way the world works and what we must do this is called our private logic (Mitchell, 2015). Our private logic is often flawed and can lead an individual to becoming fixed and unhappy. Adler’s theory believes common to all individuals is a striving to overcome feelings of inferiority, which can make us aware of our weakness and need (Mitchell, 2015). This leads to a striving for superiority or in Adlerian terms, from a felt minus to a felt plus. Our individual ways of overcoming our feelings of inferiority will vary in many ways, whether it is to encourage or compete with others or whether it is to find the 'courage to be imperfect’ (Mitchell, 2015).

Private logic is usually formed in childhood and relates to how we see and interpret the world around us, and sometimes used along with common sense. Private logic assumes the person is acting "as if" the behavior was a rational response in the situation (Griffith & Powers, 1984). However, common sense is the understanding and evaluation of life which is shared by the community (Griffith & Powers, 1984). If this is the case then an individual suffering from fecal incontinence knows in their common sense that it is considered “disgusting, unclean, not normal” and those thoughts translate to how one’s private logic understands those thoughts. If an individual feels disgusting or unclean, their private logic could be telling them to hide away from the community. Hiding away from the community can lead to social isolation, decreased quality of life and a decrease in mental health. This process also leads us back to Adler’s social interest. The more the individual withdraws from the community, the larger effect on that individual’s social interest and sense of community.
**Inferiority**

Alfred Adler believed that inferiority complex is a condition where an individual feels inferior to others and is developed in childhood (Mitchell, 2015). Adler believed that children were taught that if they had organ inferiority (physical or mental), it makes them less worthy than others (Mitchell, 2015). Depending on the attitude one takes toward the individual’s defects, the compensation for disabilities or limitations will be satisfactory or unsatisfactory.

When translating this to fecal incontinence, this writer would relate it to an idea or process that one was taught and is inferior to others. A child at a young age is expected to learn control of their bladder and bowel habits. This transcends into adulthood, as adults we are expected to be able to control our bladder and bowel habits in public and at home. We are taught to be accepted into society and this is an expected ability that “normal” individuals can control. If one cannot control their bowels in public, they are less than normal intelligence or they are not socially acceptable.

**Future Research**

When thinking ahead to future research regarding fecal incontinence this writer believes there are several avenues that could and should be addressed. One of these areas of research that could benefit is a more in-depth look at an individual’s disgust factor related to “shameful” or socially embarrassing diseases. This writer could not find a large amount of research related to fecal incontinence and disgust, shame or embarrassment. There is more research available regarding urinary incontinence but not fecal incontinence. Creating specific tools that can examine one’s disgust sensitivity and fecal incontinence could be a strong tool in assessing an individual’s negative thoughts. Being able to assess the negative thoughts around feces one
could then know how to approach treatment of fecal incontinence and how to give support to the individual with fecal incontinence.

Group biofeedback treatment seemed to have a positive effect on the small study this writer encountered (Lamb et al., 2009). Further research with group treatment protocols could be warranted and beneficial to the fecal incontinence community and the healthcare community. This writer also suggests that physicians become more knowledgeable about fecal incontinence so they are able to assist their patients when they come to them with a complaint of incontinence. This writer would think that with the practitioner’s increase in knowledge that the practitioner would be more comfortable asking about fecal incontinence during a routine exam. Along the same lines would be using the knowledge of how fecal incontinence can happen with a normal or traumatic birth directly after delivery or many years after delivery. Research could potentially look at whether information is given at a routine medical exam and if that leads to more individuals discussing their own complaints of incontinence that they might not have just willing discussed.

From a mental health perspective, the area of future research related to fecal incontinence could look at how social isolation and embarrassing medical conditions relate. Most of the research available regarding social isolation and health is related to medical disease and not a medical condition. Since incontinence can be related to both a disease (Crohn’s or colitis) and a lack of bowel control due to numerous other reasons, it may correlate differently with isolation than heart disease or an immunosuppressant disease.

**Final Summary**

Fecal incontinence is a taboo subject among the general population and in the medical community. This can cause people living with the condition to feel stigmatized, embarrassed,
depressed, anxious and socially withdrawn. Only about one-third of people with fecal incontinence report their problems, the others suffer in silence (Bols et al., 2013). When people are directly asked by their medical practitioners about fecal incontinence, they are more likely to discuss the issue.

Fecal incontinence duration and how long the incontinence has been present, had a significant effect on lifestyle, depression, and embarrassment (all $P<0.05$) but not in coping skills ($P=0.103$) (Bartlett et al., 2009). People with fecal incontinence have a reduced quality of life mostly due to issues related to coping skills and embarrassment rather than depression and lifestyle issues (Alsheik et al., 2001). During this writer’s literature review it was stated numerous times with different researchers that the thought is the longer fecal incontinence was present the more negative lifestyle adaptations a person feels they must conform to.

People with loose stools or diarrheal symptoms had lower quality of life scores than people with alternating types of incontinence (Alsheik et al., 2011). This writer looked at the table supplied with these results above but the numbers were not entered correctly, the severity score was placed twice instead of the quality of life scores. Due to this error, this writer does not know the significance of the quality of life score or the exact numeric score of quality of life.

Barlett et al. (2009) concluded in their study: daily, solid, and large losses of stool to be significant factors for lifestyle ($P <0.05$); monthly and daily leakage, urgency, and large quantities of fecal incontinence to be significant in coping ($P <0.05$); frequent and perceived major accidents of solid and liquid stool were significant factors for depression ($P <0.05$); and frequent solid and liquid fecal incontinence significantly affected embarrassment ($P <0.05$). “Fecal incontinence severity average score was not significantly different between men and
women but women had a lower average quality of life than men (3.04 versus 2.51: \( P<0.03 \))” (Alsheik et al., 2011, p. 4).

One interesting fact this writer came across was the treatment of fecal incontinence and antidepressant therapy. The goal of antidepressant therapy is to raise the serotonin levels, which 95% of serotonin production is in the gastrointestinal tract (Bailey & Parès, 2010). Bailey and Pares (2010) questioned whether or not increasing an individual’s serotonin levels with antidepressant therapy could help since it is possible that a person with fecal incontinence may be losing serotonin at an increased rate which could be contributing to a person’s depressive feelings.

When individuals are going through treatment they should be offered skills to cope with the problem of incontinence in the beginning to decrease the risk of the individual feeling out of control which can in turn lead to an impact on the person mental health and quality of life (Yates, 2010). It is also a suggestion of this writer that the medical profession use a multidisciplinary approach to fecal incontinence. When an individual seeks treatment for their fecal incontinence, having available a specialized team of nurses, therapists and physiotherapist could address more than just the physical aspect of the person’s fecal incontinence. This can give the individual options and a social network available to them so they do not feel alone and embarrassed over their situation, feeling like they are the only person suffering with fecal incontinence.

Adlerian counseling emphasizes optimism and hope, resilience and growth, competence, social consciousness, and finding meaning and a sense of community in relationships. An Adlerian therapist focuses on encouragement not as technique, but as a way of being. Using encouragement can give an individual a sense of control over how they interpret their fecal incontinence in relation to their mental health and quality of life. Communicating self-
confidence in the individual’s strengths and abilities, including identifying past successes with a challenge can help move an individual through the challenges they are facing with fecal incontinence. This self-confidence can help individuals separate between who they are and who they perceive others perceive them in relation to their fecal incontinence. By concentrating on efforts and progression of coping skills and lifestyle changes, it allows the individual to create their own solutions. These solutions can give the individual the power to determine how fecal incontinence will affect their quality of life. These solutions then could create a desire to make lifestyle adjustment and to move forward with those changes.

The “question” is another Adlerian technique that may help a therapist direct the individual from letting fecal incontinence control their life and emotions. The therapist can use the question direct the individual to what they could do to help themselves. An assortment of ways a therapist could ask the question may include: "How would your life be different if, all of a sudden, you didn't have fecal incontinence problem anymore?" “Suppose there was a pill to make the incontinence go away or get better?” “What if you had a magic wand?” or “What if you woke up in the morning and the incontinence was cured?” These questions can allow the individual to reflect on the incontinence and give the individual a sense of how it affects their quality of life and how it affects their mental health. The individual can feel a sense of encouragement as they begin to understand they have the resources and abilities to overcome the problem.
References


Consedine, N. S., Krivoshekova, Y. S., & Harris, C. R. (2007). Bodily embarrassment and judgment concern as separable factors in the measurement of medical embarrassment:


http://doi.org/10.2217/whe.14.66


