

BRIEF CLINICAL REPORT

Beyond exposure therapy: formulation-based therapy treating a fear of urinary incontinence – a case study

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Abstract

Background: The current literature on the specific phobia of urinary incontinence is limited, with no specific empirically established model or treatment protocol.

Aims: This article consists of a case study of formulation-driven cognitive behaviour therapy (CBT) for phobia of urinary incontinence.

Method: Martin attended a total of 12 treatment sessions. The treatment included the development of an idiosyncratic formulation, and the use of well-established cognitive and behavioural treatment strategies from other anxiety disorders.

Results: Both outcome measures and Martin's subjective report indicate that the treatment was effective.

Conclusion: This case study contributes to the current limited literature on this phobia, and emphasises the importance of formulation-driven CBT to map for idiosyncratic features and target cognitive and behavioural factors.

Keywords: behavioural experiments; CBT; empirically grounded interventions; urinary incontinence

Introduction

A specific phobia of urinary incontinence refers to a marked fear and anxiety of urinary incontinence in public settings that is out of proportion to the actual likelihood of its occurrence, and results in significant distress and impairment, usually leading to avoidance or the use of safety-seeking behaviours. Earlier published cases have described fear of urinary incontinence as variants of agoraphobia, panic disorder, obsessive compulsive disorder (OCD) or specific phobia, resulting in variety of suggested treatment approaches including bladder training, relaxation, exposure and response prevention (Kamboj *et al.*, 2015; Pajak and Kamboj, 2014; Tan and Lim, 2015). Kamboj *et al.* (2015), in a survey of non-treatment seekers, have explored the symptomatology and cognitive phenomenology of this disorder, identifying the role of mental imagery. Pajak and Kamboj (2014) have asserted that rescripting intrusive images can result in a reduction of fear associated with bladder sensations. Tan and Lim (2015) have suggested that cognitive behaviour therapy (CBT) grounded in exposure work may offer an effective treatment approach. Whilst it has been identified that both cognitive and behavioural factors may play a role when treating this phobia, there is no established treatment model. Salkovskis (2002) argues that CBT progresses through a multi-dimensional approach, where empirically grounded clinical interventions from other disorders may be used in the absence of adequate data for a new presentation. The case study aims to demonstrate the utility of this approach in treating this debilitating phobia, and to add to the current limited literature on this specific phobia.

Method

'Martin' (a pseudonym) presented with a phobia of urinary incontinence. Cognitive, physical, emotional and behavioural factors that played a part in the development and maintenance of the phobia were identified. Martin described a clear catastrophic misinterpretation of physical sensations, thus when collaboratively developing an idiosyncratic formulation, it was informed by Clark's (1986) established cognitive behavioural model of panic disorder, in the absence of an existing model for phobia of urinary incontinence. Clark (1986) established that catastrophic misinterpretation of physical sensations can result in the experience of severe anxiety, further causing the individual to change their behaviour to reduce or avoid the anxiety, reinforcing the catastrophic interpretation. Therapeutic interventions were driven by the collaborative formulation.

Measures

Martin completed validated self-report outcome measures on a weekly basis including functional impairment (Work and Social Adjustment Scale (WSAS); Mundt *et al.*, 2002), specific anxiety based cognitions (Fear Questionnaire (FQ); Marks and Mathews, 1979) and the Agoraphobic Cognitions Questionnaire (ACQ; Chambless *et al.*, 1984). At his first appointment Martin indicated substantial specific phobia symptomatology on the FQ.

Patient profile

Martin was a man in his early-30s who self-referred for treatment to his local Improving Access to Psychological Therapies (IAPT) service. Assessment indicated that Martin met the DSM-5 (American Psychiatric Association, 2013) diagnostic criteria for specific phobia. His fear of urinary incontinence began 9 months earlier, after he suddenly experienced a burning sensation in his urethra whilst travelling on public transport. The fear of public incontinence provoked severe anxiety, and he exited the public transport to use a nearby bathroom. However, the sensation persisted and he stopped to use bathrooms four more times over the next 15 minutes. Following this event, Martin experienced a marked perceived risk of urinary incontinence in public that resulted in severe anxiety when he believed he did not have immediate and easy access to a toilet. His fear and level of avoidance was persistent and had lasted more than 6 months. His anxiety caused significant distress and impairment, reduced his quality of life, and made it hard for him to focus on work-related tasks or engage in his relationship. He did not meet criteria for any other disorder.

We formulated a specific event when Martin attended a meeting at work and noticed that his bladder felt full. His interpretation of this physical sensation was 'I'm going to wet myself', which triggered anxiety. Martin's increased anxiety caused him to notice physical sensations, including pressure on his bladder, tense muscles, increased heart rate, agitation, and a sense that his trousers felt tighter. These physical sensations activated further catastrophic misinterpretations: 'I will lose control of my bladder and wet myself', 'It will be everywhere and form a big puddle', 'It will be everywhere, and everyone will notice' and 'It will stink, and others will be angry, disgusted and offended by me'. In an effort to prevent this happening, Martin would engage in thought suppression, distraction and reassurance seeking, and pre-plan excuses and exit routes. He would actively avoid social situations and travel on public transport, or any other situations where he might not be able to take himself away from others and have immediate access to a bathroom. When leaving his home, he would meticulously plan his journey, bring changes of clothes, wear dark clothing, and use male sanitary pads.

Table 1. Overview of behavioural experiments and predictions tested

Prediction to be tested and belief rating	Experiment	Outcome/learning
I will lose control of my bladder and wet myself (100%)	Martin drank a large amount of water before and during the session and then did jumping jacks in a crowded place to test his beliefs	Despite feeling like I was going to wet myself I did not. I can cope better than I think Re-rating of original belief: 0%
It will be everywhere and form a big puddle (100%)	Martin dressed in light coloured trousers and purposefully wet himself in his shower at home when he was alone	It is a lot harder than expected to wet myself when wearing trousers, and no puddle formed when I did wet myself Re-rating of original belief: 0%
It will be everywhere, and everyone will notice/it will stink, and others will be angry, disgusted and offended by me (100%)	Therapist modelling – the therapist walked around in public, stood by a crowded bus stop and entered a busy café with a visible wet patch on his trousers	Becoming incontinent in public is not as awful as predicted – most people don't notice and those who do don't seem to care Re-rating of original belief: 0%

Procedures and intervention

Martin attended an initial 2-hour assessment and a total of twelve 1-hour sessions of CBT. In between each session, Martin would complete the homework tasks, listen to his recording of the previous session and create a brief summary of key points from the session. The first two sessions focused on collaboratively developing a shared maintenance formulation and identifying treatment goals. Session 3 offered psychoeducation on the role of attention and bladder capacity and average urine output per hour. Subsequent sessions focused on behavioural experiments testing the impact of avoidance and the use of safety seeking behaviours in maintaining his beliefs about his incontinence, which required spontaneity and inventiveness by both client and therapist, use of survey data, and cognitive restructuring. To reduce self-focused attention, attention training was introduced towards the end of treatment, followed by a detailed therapy blueprint and relapse prevention plan. Table 1 below outlines examples of behavioural experiments conducted.

Results

Martin's scores on all outcome measures significantly reduced, indicating a significant reduction in distressing symptomatology and phobia cognitions. His WSAS score indicated subclinical functional impairment, whilst the phobia scales and the anxiety specific measures (FQ, ACQ) no longer indicated the presence of a phobia. He no longer met *DSM-5* diagnostic criteria for a specific phobia at discharge. Subjectively, Martin reported significant progress and said that therapy had allowed him to regain his old life. Martin identified the use of behavioural experiments and a survey to test his beliefs as particularly useful therapy interventions. Two particular behavioural experiments resulted in a significant change in Martin's scores: (1) therapist modelling to pretend to lose continence in public, and (2) Martin engaging in physical exercise for 20 minutes after drinking a sizeable quantity of water. His belief ratings rapidly shifted from 100% to 0% in these behavioural experiments; in the event of a lesser shift, the therapist and Martin would have planned and executed further behavioural experiments as in-session and self-directed tasks until he had achieved a 0% belief in these threat appraisals. At the end of therapy, Martin was regularly attending meetings, and was travelling on public

transport daily without pre-planning his trips or engaging in safety seeking behaviour. He had booked a long-haul flight, and reported no anxiety about the upcoming journey.

Discussion

Established cognitive models of anxiety disorders, e.g. panic (Clark, 1986) and social anxiety (Clark and Wells, 1995), are based on clear formulations that focus therapeutic interventions on key cognitions. This case study helps to address the ‘gap in the literature’ for specific phobia of urinary incontinence by illustrating how, in the absence of an empirically supported treatment protocol, an idiosyncratic formulation grounded in empirically supported and well-established models of therapy, can help guide treatment, determine treatment interventions and impact on the effectiveness of therapy. It shows how a multitude of cognitive strategies rather than exposure alone can help reduce anxiety in ‘viscerally centred’ phobias by challenging the catastrophic misinterpretation of physical sensations.

To establish an empirically valid model for this phobia that accurately outlines maintaining factors across individuals, further research is required using a larger population. This will give clients with this debilitating phobia confidence early on in therapy that treatment will be effective.

Supplementary material. To view supplementary material for this article, please visit: <https://doi.org/10.1017/S1352465821000333>

Data availability statement. The data from this study are available in the extended version online.

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Ethical statement. The authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS.

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