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RESEARCH PAPER

Exploring older peoples’ experiences of nocturia: A poorly recognised urinary condition that limits participation

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Abstract

Purpose. This study sought to understand the experience of living and coping with nocturia, from the perspective of community-living older men and women.

Method. Individual semi-structured interviews were undertaken with 32 older people with self-reported nocturia of twice nightly or more.

Results. Four key characteristics of nocturia were identified. Nocturia was described as simultaneously debilitating, frustrating, distressing and puzzling. It impacted on sleep patterns and quality, personal relationships and increased the fear of falling among older people when rising to use the toilet at night. Previously unrecognised variability and unpredictability in the condition were highlighted features. Nocturia was not prioritised for health intervention. There were gender differences in initial help-seeking however once prostate disease was eliminated, self-management strategies to cope with the effects of nocturia were the norm.

Conclusions. This study indicates that nocturia has a widespread and profound influence on older people’s quality of life and participation, despite being regarded as a relatively benign condition by both older people and health professionals. Several features of the condition, which have the potential for great impact, are poorly recognised in particular its variability and unpredictability.

Keywords: Nocturia, elderly, participation

Introduction

Nocturia is defined as ‘the number of urinary voids recorded during a night’s sleep, each void being preceded and followed by sleep’ [1]. It has only been recently recognised as a urinary syndrome in its own right, where previously it was regarded as a lower urinary tract symptom (LUTS) associated with prostatic disease in men and urinary incontinence in women [2,3]. Epidemiological studies have shown nocturia to be common [4,5] and one of the most bothersome of urinary conditions [6,7], particularly among older people where the prevalence is highest [8,9]. Specific consequences of nocturia have been reported including poor sleep quality, daytime sleepiness, depression and increased mortality [10,11], increased risk of falls and fracture [12], raised likelihood of institutionalisation [13] and negative impact on well-being, productivity and quality of life [7,14–16].

Research in populations attending specialist urology clinics [17,18] provides further details on the features of nocturia and potential aetiological explanations; however generalisability to the wider population is limited. Understanding of the specific effects and impact of nocturia is hindered by the lack of research exploring the condition from the perspective of those living with it. In addition, the strategies used by older people to cope with nocturia are currently unclear and despite being widespread the consequences are thought to be grossly underestimated [19]. This article reports a qualitative study designed to address this gap in the evidence base and shed light on hitherto unexplored aspects of...
the condition. A qualitative method was used, as the aim was to elucidate older peoples’ experiences of living and coping with nocturia and achieve a better understanding from the perspective of community-living older men and women. This enquiry was one element in a mixed methods study designed to examine how nocturia in community-living older people is detected and managed and the role of community nursing in this process.

Methods

In January/February 2007, a structured postal questionnaire on Nocturia and Urinary Symptoms was sent to all individuals aged 60 and above, registered with one of two General Medical Practices in Scotland. These two practices had been selected because they serve communities with diverse demographic profiles. Practice 1 serves an affluent, rural population; Practice 2 serves a deprived, urban community. Respondents who experienced nocturia and were willing to participate in a face-to-face interview to explore the condition in greater depth were asked to provide their contact details on the questionnaire. The research protocol specified a sample of 32 interview participants (eight men and women from each practice). However 508 (46%) respondents supplied their contact details; a much larger number than anticipated. To select from this unexpectedly large number of volunteers and to ensure maximum variability within the sample, a sampling framework was developed incorporating key criteria (Table I). Applying this framework identified 51 potential participants, who were telephoned to provide them with information about the interview, answer any questions and determine whether they were willing to participate. One female respondent had died and a further 18 people declined to take part for a variety of reasons including ill health and resolution of nocturic symptoms. The final sample included eight males and eight females from each of the two study sites, a total of 32 participants. Table II provides details of the demographic characteristics of the participants.

Interviews were carried out by a single research assistant (ML). A suitable date and time for the interview was agreed with each participant and an information sheet and consent form posted to the participants prior to the interview. All interviews were conducted in participants’ own homes. Before the start of each interview any further questions about the research were answered and two copies of the consent form were signed, with one being retained by the participant. The interviews lasted between 15 min and 1 h and were digitally recorded.

A semi-structured interview schedule (Appendix 1), designed to ascertain older adults’ understanding of their nocturia, perceptions of the impact on their physical, social and psychological functioning, quality of life, wellbeing and relationships was used to guide the interview process. Additional questions sought to determine the older adults’ coping strategies, help-seeking behaviours and self-management techniques.

Ethics

Approval to undertake the study was granted by the Multi Centre Research Ethics committee for Scotland.

Analysis

Prior to the analysis of the interview data the voice files were listened to, corrected for any errors or gaps in the transcription and imported into qualitative analysis software (QSR NVIVO v.7). To promote rigour in the analysis two researchers independently analysed the data. This involved listening to the digital recordings whilst reading the interview transcripts and inductively identifying a number of common and recurrent analytic codes. During the second stage of analysis, consensus on the codes was reached between the two researchers (ML, JB) including the identification of redundant themes, the merging of duplicated themes, the generation of initial hypotheses and examples of deviant cases [20]. In total 45 codes were identified of which eight were redundant, two additional codes were identified by JB and agreed by both researchers, and 20 codes were merged into five, resulting in 24 agreed codes. In the third stage of analysis, an extended ‘challenge meeting’ was held between three members of the research team (JB, ML, LM). During this meeting, the researchers made statements and were challenged to demonstrate that these were supported by the study data. This process, in which themes and hypotheses were further examined and interpreted, facilitated the development of a thematic framework.
that illustrated the experience of nocturia as a debilitating, frustrating, distressing and puzzling condition.

The findings are presented later, in accordance with these four key themes. The help seeking behaviours and self-management strategies are then described, and the findings section closes with a consideration of the impact of nocturia on family relationships and broader social participation.

### Findings

**Nocturia: a debilitating condition**

Nocturia is a debilitating condition that has a consistently negative impact on the lives of individuals and their families. The debilitating effects reported included: sleep disturbances and restless nights, increased awareness of the risk of falling,
feeling slow and sluggish on wakening in the morning, irritability, reduced concentration and mental acuity and the need to sleep during the day. The effects of nocturia on sleep patterns and quality were profound with the inability to fall back to sleep after rising to pass urine described as having the greatest impact.

I generally find that when I get up, it’s about 1 or 3 o’clock in the morning, it might take a couple of hours to get back to sleep, and if I’m up more than twice at night I tend to find I don’t really go back to sleep, I sort of doze slightly, but I don’t really get a proper sleep.

(2022, male, Practice 2)

If I could go 3 or 4 hours without the toilet I’d be quite satisfied . . .. Its one and a half to two hours and then it takes me over half an hour to get to sleep again, and then by the time I fall asleep again its time to get up and go to the toilet again

(2027 female, Practice 1)

Variability in the ability to resume sleep was described and seen as problematic:

When you get up to the toilet twice, maybe three times, during the night you lie and you can’t get to sleep again and that’s the problem, and other times I go straight back to sleep

(525, female, Practice 2)

Sleep disturbances associated with nocturia, especially prolonged periods of sleeplessness, were described as having a negative impact on mood:

Och! I don’t know, it’s just sometimes you - you get fed up going up and down all night, you know. There’s nothing you can do about it, you know.

(1062, female, Practice 2)

Nocturia: a frustrating condition

In addition to its debilitating features nocturia was perceived as a frustrating condition that was difficult to live with, largely because of its variable and unpredictable nature. The experience was unpredictable with regard to the number of times an individual might have to get up during a single night:

What is true is it’s not consistent in that it’s not always twice or three times, whatever . . . there’s no regularity about it

(138, male, Practice 2)

Oh the number of times varies – there’s the odd night I’m not up

(456 female, Practice 2)

This night-to-night variability was commonly compounded by periods where the condition was discernibly different for unpredictable, and apparently uncontrollable, durations:

About 4 or 5, then it goes away, and then it comes back, then it goes away . . . Now? I’m up all the time, 5 times, I don’t know, I don’t sleep at all . . .

(609, female, Practice 1)

P: I’m not too bad the now, I’m only up twice

R: So at the moment you’re up two times in a night, is it worse than that sometimes?

P: Oh aye a lot worse! We’re talking 6 or 8 times

(993 male, Practice 1)

The volume of urine passed at each episode was another variable feature of nocturia, commonly differing from one ‘visit’ to the next:

When I go, I’m lucky if - a wee eggcup full. And then maybe the next time when I go, I could fill a bottle, you know what I mean?

(2017, female, Practice 1)

Participants found that prior to voiding they were unable to assess whether they needed to pass large or small volumes and thus determine the real need for a visit to the toilet. This was frustrating because often the volumes passed were small (dribbles) and the individual did not have the satisfaction that derives from a ‘proper pee’. The disruption caused by the nocturia was often reported to be disproportionate to the amount of urine that resulted from repeated visits to the bathroom.

Last night, I must have got up about ten times, and I was hardly doing anything, but I still had to get up, in case you know

(006, male, Practice 1)

There appeared to be no perceived correlation between the volume or type of fluid consumed and the frequency with which the participants had to get up to micturate through the night although, as reported later, this did not prevent the participants from modifying their fluid intake in their attempts to control the condition. Nocturia was experienced as a nuisance and an annoyance:

Well, when I got to bed yesterday, within three quarters of an hour I’d got to get up and go to the toilet. It then goes on to like, every hour up to about 3 o’clock and then it goes on till about two hours after that. Through the day I seldom go to the toilet, eh, so it’s only when I lie down it seems to affect me. It’s just a nuisance because you never get a decent night’s sleep, because you’re always up and down all night, you know. And it’s every night as well, it doesn’t matter if you drink a lot or drink a little, I seem to still be annoyed with it

(122, male, Practice 2)
Nocturia: a distressing condition

Pain and urgency were also predominant features of the experience of nocturia. Participants described being wakened by a painful bladder and awareness of an urgent need to pass urine.

It’s the pain that wakes me, um, and I have to get up and go then  
(369, female, Practice 2)

Yes, but only when you’re waking up, there’s no pain at other times. No pain in my bladder through the day, it’s only when I’m bursting for the toilet through the night, irrespective of how much urine I pass,  
(122 male, Practice 2)

See the minute I feel it and I’ve got to get up, the minute I put my feet on the ground it’ll just- that’s why I keep a pad, you know? Because it just comes before you even get there.  
(1062 female, Practice 1)

Fears of being incontinent were expressed, adding to the anxiety associated with the sudden need to get out of bed and go to the toilet.

You’re terrified you’ll pee the bed – when you need to go, you need to go. It sets off an ache in there [indicates bladder] and the minute you feel that twinge you go  
(2017, female, Practice 1)

Urgency associated with nocturia also created problems with individuals being aware that they were at risk of stumbles and falls. They were conscious of the need to balance their risk of falling against the fear of being incontinent.

It just comes on like that, but it’s disturbing, it’s terrible, truthfully, because sometimes it makes you up and you run to the loo, as you get older you get a wee bit more off balance, I think. There’s times I go [demonstrates being dizzy]  
(157 female, Practice 1)

Nocturia: a puzzling condition

Participants questioned themselves regarding their experience of nocturia; they expressed a need for greater understanding of the condition. For example participants were puzzled by their body’s apparent ability to produce urine despite their self-imposed fluid restrictions.

I don’t know what’s causing it, I really don’t, you know?  
(1062 female, Practice 2)

But there’s no rhyme nor reason to how much fluid either, it gets to– how much fluid I release in the toilet through the night, I don’t understand how I could have to go so often  
(122 male, Practice 2)

Help seeking behaviour

Despite the many deleterious effects of nocturia described by these participants, and their expressed lack of understanding, the ongoing condition experienced was not perceived to be debilitating. Nocturia was not prioritised as a health issue, possibly because it was understood, erroneously, as a consequence of ageing for which there was no ‘cure’ or effective treatment. However on becoming aware of their symptoms there was a discernable gender difference in help-seeking behaviour by participants. In general, male participants appeared to be well informed about the increased risk of prostate disease including cancer in older age. Consequently, an early response to nocturia was to eliminate this possibility so they visited their general medical practitioner (GP).

I’ve been at the GP and I’ve been diagnosed, I think he’s called it benign prostate enlargement . . . I’ve had quite a few tests and he says it’s nothing to worry about  
(476, male, Practice 1)

In contrast, none of the older women sought assistance from health professionals; rather they consulted with their peers and were reassured regarding the ‘normality’ of the condition and its effects.

I met a woman who told me she was up seven times, I says, ‘oh dear!’ Sometimes I’m just up once or twice, it all depends, everybody’s the same  
(1521 female, Practice 2)

we find there’s so many other people, neighbours, of the same age, get up, we’re all in the same boat  
(143 female, Practice 2)

I found that a lot of my friends at a certain age are, you know, having problems  
(2027 female, Practice 2)

Once the status of their prostate health had been determined, and if the symptoms of nocturia persisted, the men too consulted with their peers.

It’s a bother to get up, aye. But unlike you [addresses his wife] I can’t hold on. I mean you feel you’ve got to, you’re bursting, you want to go, and this is it and I’ve spoken to one or two other people and they - they say the same thing, it’s the pressure there and you’ve got to get rid of it, not much you can do about it  
(1521 male, Practice 1)

These older people described many diseases such as cancer, heart disease, hypertension, chronic
obstructive pulmonary disease, diabetes, gastrointestinal disorders and renal disease. They associated these with a hierarchy of physical symptoms including chronic pain, depression and anxiety, among which nocturia was not prioritised. Participants described ‘forgetting’ to tell their GP because they had more urgent health matters that required attention. They felt that nocturia was too trivial to bother a busy doctor:

I don’t think it’s so much of a problem that I should mention it [nocturia] they’re so busy, you know, and when there’s anything really wrong with you, that’s the only time I go to the doctor

(2027, female, Practice 1)

Nocturia was not seen as a ‘real’ health problem. For a few, this perception was reinforced by their GP’s response when the topic was raised during a consultation:

Well, I mentioned to him once about it, but he didn’t seem very concerned to be honest . . . I had other problems as well, so I suppose he probably didn’t see that as being a major problem

(122, male, Practice 2)

The interview participants perceived nocturia and its impact on daily life as an expected and normal consequence of ageing.

I’m getting older and I don’t expect things to work in quite the same way as they did, so I mean, I just take it as one of those things I am going to have to live with

(138, male, Practice 2)

We don’t worry about it, I think we sort of accept the fact it’s part of the growing old process

(143, female, Practice 2)

Self-management

Providing that nocturia was not caused by prostate disease, the participants believed that nothing could be done to ‘cure’ the condition and so did not seek professional help.

I’ve never gone [to see my GP] with a view to doing anything about it, because I assumed there was nothing you could do about it

(138, male, Practice 2)

Rather than bother the GP, the participants self-managed the symptoms in an effort to minimise the impact of nocturia on daily life. All of the study participants had instigated at least one self-management strategy; usually it seemed, without the desired effect.

Practical strategies included manipulating the timing of fluid intake. For example, commonly a time in the evening was arbitrarily selected after which no drinks were to be consumed. For some individuals, this cut off point was as early as 6 o’clock, which constituted a considerable restriction of fluid intake:

I don’t drink after about 6 or 7 o’clock at night, I don’t drink at all, if I can avoid it

(678, female, Practice 2)

The type of fluids consumed was also managed. For example, caffeinated drinks were replaced with decaffeinated coffee and tea and herbal teas and participants also reported reducing their alcohol intake.

It’s got better with me not drinking so much [alcohol]

(754, male, Practice 2)

It is of note that the majority of participants continued to adhere to these restrictive self-management strategies even though they were judged to be ineffective with regard to controlling the unwanted symptoms of nocturia.

It’s every night . . . it doesn’t matter if you drink a lot or drink a little . . . Och! I’ve tried drinking less after tea time . . . but it doesn’t seem to make any difference . . . it doesn’t matter how much I drink, alcoholic or otherwise, I still have to get up

(122, male, Practice 2)

I’ll say [to my daughter] ‘Listen, I’ll need to get off this phone, I’m due my cup of tea, it’s getting near 9 o’clock’ and if I don’t have it before [9]I’m up through the night, you know. I’m up through the night anyway, you know, it’s just a force of habit now.

(1062 female, Practice 2)

Use of incontinence aids, such as urinals, commodes and incontinence pads were management strategies described by a number of participants. Urinals and commodes were obtained from the GP or practice nurse. However, the female participants who used ‘pads’ bought sanitary towels or ‘off the shelf’ incontinence pads rather than obtaining them on prescription. No one liked wearing a pad but their use was considered essential if the individual was to avoid embarrassing ‘accidents’, i.e. being incontinent:

I wear a pad during the night and then I wear another one during the day . . . they’re horrible, horrible!

(609, female, Practice 2)

I use a towel pad all the time you know um but I tried cutting down [fluids] but having a stone in the kidney I can’t manage without taking water

(1062 female, Practice 1)
Several participants described using the technique of ‘double voiding’, which had been recommended by a health professional or was self-discovered:

I feel as if I’ve not emptied it [my bladder] right and I sit down again and then I [pass] some more and then I’m finished

(2017, female, Practice 1)

Some participants tried using sleep and comfort promoting measures as a means of controlling their nocturia. This included use of analgesia:

I’ve taken painkillers because I thought, well, if I’m restless and turning over, you know, my knees get sore, so that’s bound to waken me. Well, I thought it worked quite good at first, you know but then I thought, I’m on these and it’s not any better, you know, I’m still getting up, you know, it maybe works for a night or two you know, and then it reverts back

(2027, female, Practice 1)

the doctor put me on some tablets, they were actually for epilepsy, but it is painkillers as well, and I’ve only to take one at night and I - since I’ve been taking these, I’ve slept better and I’ve only been up a couple of times

(369, female, Practice 2)

This strategy recognised night-time comfort in bed as a significant factor influencing the occurrence of nocturia.

a month ago I went off for a week to stay with an aunt, and I realised after I had come back that in fact I didn’t have to get up during the night at all while I was actually staying with her, and the only difference I could think other than being away, was that she - I felt warmer and more comfortable, and she had ... flannelette sheets on the bed, which I have not had for yonks, and that’s the only difference that I actually have thought, that the bed felt more comfortable and warmer,

(271 female, Practice 2)

Impact on personal relationships and social participation

Both the symptoms of nocturia and the self-management strategies had a negative impact on personal relationships and resulted in reduced social participation. For example, these older people were concerned that they would disturb others when they rose during the night to go to the toilet. Consequently, some people elected to sleep in separate beds or even in separate rooms.

I have my own bedroom downstairs, I’ve a toilet through there, so if I get up in the night I don’t have to affect [my wife], so that’s quite a consideration

(138 male, Practice 2)

The symptoms of nocturia and the potential for being incontinent caused such embarrassment to these older adults that some felt unable to disclose their problem even to their closest relatives. Instead, they opted to decline invitations to visit. As one woman described:

My oldest daughter’s just phoned me ... saying, ‘Do you want to come down?’ I do, and she’s got a room there and she says, ‘That’s yours, so just come down,’ ... but I feel if I go there, I’m frightened anything happens to me ... in case I wet ... oh, it’s terrible, and then you’re up, you just feel as if you’re disturbing people getting up and down to the bathroom, so I just stay here, I don’t tell them that right enough

(157, female, Practice 1)

This self-imposed limited participation was extended to family celebrations and other social occasions, including day trips and holidays:

I don’t let it stop me doing things if I can avoid it but, as I say, it has stopped me from going on holiday ... I wouldn’t go abroad or do things like that, really. It’s tiring, it makes you tired ... probably makes you miserable to be with

(369, female, Practice 2)

Discussion

To the authors’ knowledge, this is the first study to examine nocturia from the perspective of older people, asking them about their experiences and how the condition influences their lives. The rich data produced using this qualitative approach enabled a description of the experience of living with nocturia and the coping strategies used, aspects of the condition not previously described in the literature. However, as with all qualitative studies, caution should be exercised with regard to interpreting and transferring the findings as the interview sample was small and self-selected. Taking account of these limitations, nocturia was experienced as a multifaceted condition that could be simultaneously debilitating, frustrating, distressing and puzzling.

Primarily, older adults elected to self-manage the condition, as they perceived it as a condition to be ‘coped with’ rather than ‘cured’. The findings align closely with the results of population and specialised
clinical-based studies, confirming that nocturia is indeed bothersome to older people [7,21,22]. However, this study has revealed that older people often implement restrictive and ineffective self-management strategies in an attempt to minimise the negative impact of nocturia in daily life. The findings clearly demonstrate that this apparently benign condition is more complex than is generally understood, and, importantly, that the unresolved symptoms of nocturia have the potential to limit the social participation of older adults [19,23].

No descriptions of the personal distress and the many anxieties experienced by individuals who suffer from nocturia have been found in the literature. For example, whilst nocturia is known to be a risk factor for falls and fractures in the older population [12], this study is the first to demonstrate that older people have a heightened awareness of the personal risk associated with the fear of falling when they rise during the night to go to the toilet. Participants identified this risk as a source of anxiety, particularly when the fear of falling had to be weighed against the fear of incontinence, i.e. 'wetting the bed'. Similarly, localised bladder pain associated with nocturia is another facet of the experience absent from the literature. Such pain demands an immediate response of rising to use the toilet in order to relieve the pain and this is perceived as an additional risk.

The effects of variability in the nocturic condition and its unpredictability were unexpected findings to emerge from the study. Only one other study has been found which describes variability in association with nocturia and that was only with regard to fluctuations in frequency of voiding [24]. However in this study, variability was found in all aspects of the condition including volume, timing, frequency and duration. It is suggested that variability associated with nocturia may be a major factor affecting the older person’s ability to cope with the long-term consequences of the condition.

Despite being experienced as debilitating, frustrating, distressing and puzzling nocturia was not regarded as a ‘proper’ health condition, amenable to intervention by healthcare professionals. The exception to this was the male participants; they acknowledged the possibility of prostate disease (specifically cancer) and acted accordingly. This finding demonstrates the successful promulgation of this particular health promotion message and supports the findings of Shaw et al. [25] who found that a key stimulus to seeking help from health professionals was fear of a serious disorder, i.e. a condition that is potentially life threatening. However, although nocturia is known to increase mortality in older people [26,27], it is not included in public health campaigns. Rather lay understanding that nocturia is an expected feature of the ageing process, holds sway amongst older people.

This erroneous expectation is coupled with a general lack of awareness of nocturia as a urinary condition amenable to intervention. Consequently, older people fail to seek help and access effective treatment [3], opting instead to, self-manage the condition, often with little or no reduction in symptoms. This may be due to the lack of a sustained urinary health promotion campaign that has targeted older people and older women in particular, a finding borne out by Chen et al. [28].

The participants described employing a range of problem-focused and emotion-focused coping strategies [29,30]. They all initiated problem-focused strategies, most commonly related to the management of fluid intake. All of the behavioural strategies described by the participants have been previously reported in the literature [3,23,28] although the efficacy of individual strategies has yet to be established. Indeed, the most common self-imposed strategy, i.e. fluid restriction has been claimed to be of little use physiologically, for the majority of older people [10,31]. Interestingly in this study, most participants reported that the strategies they initiated were not effective in terms of managing the symptoms, and yet despite acknowledging this, they continued with this self-limiting, and often socially limiting, strategy.

Problem-focused strategies that concentrated on promoting sleep rather than directly addressing the symptoms of nocturia indicated that some of these older people were querying whether wakening at night was the result of poor quality sleep rather than an effect of bladder-associated needs. This finding reflects recent evidence which suggests that the two conditions are closely linked and should be considered together [32]. One small study has reported significant improvements in older people’s nocturia symptoms when simple behavioural and comfort measures to promote sleep were introduced [33]; further research is required in this area.

The participants in this study described using a range of emotion-focused strategies to minimise and normalise the condition of nocturia, particularly the women, amongst whom peer affirmation was prevalent. The use of normalisation strategies in relation to LUTSs has been reported elsewhere and [3,34–36] much of this behaviour is thought to reflect a paucity of lay knowledge about function/dysfunction of the urinary tract [28,34]. Fear of disturbing others and daytime tiredness were cited as reasons that underpinned the emotion-focused strategy of self-imposed isolation. Although these differ from the reasons usually offered in relation to urinary incontinence, e.g. odour and visual signs of wetness, they are similar in that night-time rising represents an external sign of a urinary tract dysfunction, which is evident to others. Using a social isolation strategy
reduces the risk of detection of an older person’s nocturic condition by family members and members of wider social networks.

Conclusion

The experiences of nocturia as reported in this study indicate that nocturia has a widespread and profound influence on older people’s quality of life and participation, despite being regarded as a benign condition by both older people and health professionals. Several features of the condition, in particular its variability and unpredictability, are poorly recognised. Older people consider nocturia to be a normal consequence of ageing, for which there is no cure; therefore self-management is the most common yet often ineffectual response.

A better understanding of the condition, coping strategies used and effective interventions is essential. Crucially, improved public awareness of nocturia as a health condition amenable to treatment is needed, especially among older women.

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References

Appendix 1: Interview Schedule

During each interview, audio recorded with the participant’s permission, information and views of the older person will be sought on the perceived impact of nocturia. A number of areas will be explored, depending on the person’s experiences however specific information on the following will be recorded:

- Perceived impact on physical, social and psychological functioning.
- Perceived impact on quality of life and well-being.
- Perceived impact on relationships.
- Coping strategies used.
- Help-seeking behaviours and triggers.
- Self-management techniques.
- Knowledge of and access to formal and informal support.
- Use of health, social and voluntary services.

Examples of questions:

- Can you tell me more about your need to get up to pass urine during the night and how you find it affects you?
- Do you think nocturia affects your abilities to lead your normal daily life? In what ways?
- Do your experiences of nocturia have any effect on your relationships with others?
- Can you describe how you usually deal with your nocturia?
- Do you do anything in particular to try and improve your situation?
- Have you ever sought any help for your nocturia? Who from?
- How did you find out about this help?
- Was there anything in particular that made you ask for help?
- What sorts of help have you been offered? By whom?