CRD summary
This review summarised the effects of psychosocial interventions in women with gynaecological cancers on their quality of life outcomes. Cognitive-behavioural therapy had some positive benefits and counselling interventions were the most promising. Despite some minor omissions in the reporting of the review methods, it was generally well conducted and the authors’ conclusions are likely to be reliable.

Authors’ objectives
To summarise the evidence of the effectiveness of psychosocial interventions in women with gynaecological cancers on their quality of life outcomes.

Searching
MEDLINE, CINAHL, and PsycINFO were searched for articles from 1980 to June 2008 and the search terms were reported. The reference lists of retrieved articles and reviews, and the CRISP database were searched for additional studies. The reviewers contacted two senior practising gynaecological oncologists to help identify new or unpublished studies and several authors for data from unpublished studies.

Study selection
Comparative studies with concurrent controls were eligible for inclusion if they evaluated quality of life outcomes after psychosocial interventions in women diagnosed with gynaecological cancer of the cervix, uterus, ovaries, vulva, or vagina. Studies of patients with breast cancer were also included if at least one third of the patient sample had gynaecological cancer.

Most of the studies had multiple-component interventions, with the primary features being cognitive-behavioural therapy, counselling, psychotherapy, information giving, or healing touch. Interventions were delivered by doctors, clinical psychologists, specialist nurses, psychotherapists, social workers (including some who had recovered from cancer), or providers of healing-touch therapy, via home or clinic visits, telephone contacts, individual or group counselling, behavioural skills training, or instructional videotapes. Several studies included breast and gynaecological cancers, but most of them included only gynaecological cancers. Cancer stage was mixed in most studies, but early-stage cancer (stage I and II) predominated. The mean age of the participants ranged from 43 to 69 years. The quality of life outcomes included psychological distress, depression, anxiety, self-esteem, body image and attitudes to medical care, social and sexual functioning, physical and vocational functioning, and physical symptoms. A range of questionnaires and scales were used to measure these quality of life outcomes.

The authors did not state how many reviewers performed the selection, but any ambiguities were resolved through consultation among the authors.

Assessment of study quality
The levels of evidence were independently rated by two reviewers according to the Australian National Health and Medical Research hierarchical rating system ranging from Level I evidence (systematic reviews of RCTs) to Level III-3 evidence (comparative studies with historical controls and two or more single arms, or interrupted time-series studies without parallel control groups).

The quality of the studies’ methods of randomisation, blinding, and losses to follow-up was summarised, but the authors did not state the criteria used nor how many reviewers performed this assessment.

Data extraction
The data were extracted independently by two reviewers using a review template. They included the study design, participant and intervention characteristics, comparator group, outcome measures, and findings for quality of life outcomes. Any discrepancies were resolved by discussion.

**Methods of synthesis**
Because of the clinical heterogeneity between studies in their interventions, outcomes, and participants, the outcome data was analysed qualitatively.

**Results of the review**
Twenty-two studies (n=1,926 participants) were included and 18 were RCTs, two were cohort studies, one study was described as quasi-experimental pre/post intervention, and one was a trial with pseudo-random allocation. The sample sizes ranged from 17 to 353 participants, with only five studies having more than 100 participants. Follow-up ranged from one month to two years after the intervention. Of the 18 RCTs, 12 reported adequate randomisation; the remaining six claimed randomisation, but failed either to describe an appropriate technique or to document group similarities at baseline. Blinding was generally not possible due to the nature of the intervention for most studies. Three studies failed to state the loss to follow-up and losses to follow-up were more than 20% in some studies.

**Psychological distress**: Single RCTs showed benefits for: healing touch on limitations in usual activities; symptom education on symptom distress; information provision about cancer and sexuality on mood; thematic counselling on distress; specialist nursing interventions on patients' sense of uncertainty; coping training on psychological distress; and relaxation training and guided imagery on emotional status. Four RCTs found no benefits of counselling interventions on distress, and three RCTs did not find any evidence of beneficial effects from cognitive-behavioural therapy.

**Depression and anxiety**: Symptoms of depression were reduced in two RCTs of counselling interventions, one provided by a senior doctor, and in a third RCT of supportive counselling. Three RCTs and one pseudo-RCT showed cognitive-behavioural therapy could provide significant benefits in depression and anxiety; four other trials found no effect.

**Self-esteem**: One RCT found that patients’ attitudes towards their health care improved after individual and group counselling sessions. Two cohort studies of cognitive-behavioural therapy found significant improvements in self-esteem and body image. Three RCTs found no benefits on self-esteem or body image from counselling or cognitive-behavioural therapy. Two further studies (one RCT) found no evidence that information-based interventions improved self-esteem or body image.

**Social and sexual functioning**: Ten studies evaluated social functioning and one RCT found that patients who experienced individual or group thematic counselling experienced fewer disruptions to leisure activities and their social environments. Two studies found Level II evidence of benefits in sexual functioning or satisfaction from counselling interventions. Four studies examined sexual functioning outcomes and two reported beneficial effects of cognitive-behavioural therapy; one of these included the women’s partners.

**Physical and vocational functioning**: One of seven studies reported an improvement in physical functioning after the intervention. Three studies of cognitive-behavioural therapy did not find any benefit in vocational functioning.

**Physical symptoms**: Five studies reported no benefits of any intervention type on the physical symptoms of cancer or side-effects of treatment. One study of relaxation techniques and guided imagery found reductions in symptom-related body discomfort.

**Authors' conclusions**
Information-based interventions were not proven to provide meaningful benefits, while there was limited evidence in support of healing touch. Cognitive-behavioural therapy and counselling were the most promising for improving quality of life in women with gynaecological cancers.

**CRD commentary**
This review addressed a clear broad question and the inclusion criteria were stated. The search was adequate and attempts were made to search for unpublished studies. Steps were reported to minimise bias and error for some parts of the review process, but not explicitly reported for study selection and quality assessment. Study details were provided in...
tables and further details on study quality were provided in the text. The authors’ decision not to pool the data was justified given the clinical heterogeneity of the interventions and outcome measures in the included studies. The authors correctly outlined possible limitations to the external validity, due to small study sizes, low consent rates leading to potential selection bias, and high losses to follow-up reported in some studies.

Despite some minor omissions in the reporting of the review methods, it was generally well conducted and the authors’ conclusions are likely to be reliable.

**Implications of the review for practice and research**

**Practice**: The authors stated that the main implications for clinical practice were that counselling interventions might be useful for women with gynaecological cancers, for sexual functioning, symptoms of depression, anxiety, psychological distress, and their attitudes to health care.

**Research**: The authors stated that future studies should use screening to target participants with unmet needs, psychological distress and/or lower quality of life.

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