National Institute for Health and Care Excellence

Final

Pelvic Floor Dysfunction: prevention and non-surgical management

[O] Psychological therapy for women with pelvic floor dysfunction

NICE guideline number NG210
Evidence review underpinning recommendations 1.6.28, 1.6.29 and a research recommendation in the NICE guideline

Evidence reviews

December 2021

Final

These evidence reviews were developed by the National Guideline Alliance which is a part of the Royal College of Obstetricians and Gynaecologists

Disclaimer

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The recommendations in this guideline are not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Local commissioners and/or providers have a responsibility to enable the guideline to be applied when individual health professionals and their patients or service users wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with compliance with those duties.

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Contents

Psychological therapy for pelvic floor dysfunction

Review question

What is the effectiveness of psychological interventions for women with symptoms associated with pelvic floor dysfunction?

Introduction

Women who have pelvic floor dysfunction can also have high levels of depression and anxiety, and experience low mood, and emotional distress, impacting on their quality of life. There is evidence that the presence of these psychological conditions reduces the likelihood that women will attend for PFMT, and, if they do attend, the presence of these disorders will reduce the outcomes of that intervention. Given this, it seemed to the committee important to explore the extent to which psychological interventions would improve pelvic floor symptoms.

Summary of the protocol

See Table 1 for a summary of the Population, Intervention, Comparison and Outcome (PICO) characteristics of this review.

Table 1: Summary of the protocol (PICO table)

Population	Women and young women (aged 12 years and older) with symptoms associated with pelvic floor dysfunction
Intervention	Any psychological intervention, including but not exclusively those listed will be considered (examples provided below – see full list in the full protocol in appendix A): • Acceptance and commitment therapy • Cognitive behavioural therapy • Counselling • Dialectical behaviour therapy • Guided self-help therapy • Mindfulness-based cognitive therapy • Motivational interviewing • Psychodynamic psychotherapy • Psychosexual treatment • Pure self-help • Pharmacological treatment in combination with one of the above interventions
Comparison	• Any of those listed above (in isolation or in combination) • Waiting list • Usual care • Pharmacological treatment (only in comparison to pharmacological treatments given in combination to psychological interventions)
Outcomes	**Critical** • Subjective measure of change in the following symptoms: ○ urinary incontinence ○ emptying disorders of the bladder

	○ faecal incontinence ○ emptying disorders of the bowel ○ pelvic organ prolapse ○ sexual dysfunction ○ chronic pelvic pain **Important** • Health related quality of life • Satisfaction with the intervention • Adherence (attendance) • Change in psychological symptoms (for example anxiety, depression)

PFMT: Pelvic floor muscle training

For further details, see the review protocol in appendix A.

Declarations of interest were recorded according to NICE's 2019 conflicts of interest policy.

Methods and process

This evidence review was developed using the methods and process described in Developing NICE guidelines: the manual. Methods specific to this review question are described in the review protocol in appendix A and the methods document (supplementary document 1).

Declarations of interest were recorded according to NICE's conflicts of interest policy.

Clinical evidence

Included studies

Seven publications were included for this review, (Carty 2018, Felsted 2019, Komesu 2011, Osborne 2016, Ter kuile 2013, van Lankveld 2006 and Zarski 2017), all were randomised controlled trials (RCTs).

The included studies are summarised in Table 3 (studies specifically referring to pelvic floor dysfunction) and Table 2 (studies specifically addressing vaginismus)

One study compared a life stress emotional awareness and expression interview to control in women with chronic urogenital pain (Carty 2018).

One feasibility study compared a mindfulness based stress reduction program to a health enhancement program in women with urge urinary incontinence (UUI) (Felsted 2019).

One study compared hypnotherapy to standard care (behavioural therapy) in women with OAB (Komesu 2011)

One study compared having a motivational interview prior to pelvic floor muscle training (PFMT) to standard care in women with PFD (Osborne 2016)

Three of the studies investigated the effects of psychological therapy on vaginismus (Ter Kuile 2103, van Lankveld 2006, Zarski 2017).

No evidence was found for other symptoms associated with PFD (faecal incontinence, emptying disorders of the bowel or pelvic organ prolapse)

See the literature search strategy in appendix B and study selection flow chart in appendix C.

Excluded studies

Studies not included in this review are listed, and reasons for their exclusion are provided in appendix K.

Summary of studies included in the evidence review

Summaries of the studies that were included in this review are presented in Table 3 and Table 2

Table 2: Summary of included studies: Psychological therapies for women with PFD or symptoms associated with PFD

Study	Population	Intervention	Comparison	Outcomes
Carty 2018 RCT US	N = 70 Women with chronic urogenital pain Mean age (SD) Interview group: 44.89 years (15.34) Control: 47.72 years (14.88)	Interview n=45 (37 included in analysis) 90 minute interviews based on life stress emotional awareness and expression	Control n=25 Treatment as usual (no further information provided)	• Pain severity / pain interference • Pelvic floor symptoms (PFD-20) • Depression • Anxiety
Felsted 2019 Feasibility RCT US	N = 25 Postmenopausal women with UUI Mean age (SD)	Mindfulness-based stress reduction n=13 2 hour weekly sessions over 8 weeks. Standard protocol based on mindfulness	Health enhancement program n=12 2 hour weekly sessions over 8 weeks. Standardised protocol based on functional movement, nutrition, physical activity and music therapy.	• Retention
Komesu 2011 RCT US	N = 22 Women with OAB (women with and without UI were included) Mean age (SD)	Hypnotherapy n=11 Three 60 minute sessions (6-8 weeks) with a certified hypnotherapist	Behavioural therapy n=11 Three 60 minute counselling sessions (6 to 8 weeks)	• OAB questionnaire (Distress and quality of life scores) • Number of voids • Global impression of improvement

Study	Population	Intervention	Comparison	Outcomes
	Hypnotherapy group: 51.1 years (14.0) Behavioural group: 56 years (7.4)			
Osborne 2016 RCT UK	N=31 Women with PFD Mean age (SD) Motivation group: 50.33 years (11.56) Control: 49.12 years (10.76)	Motivational interviewing n=16 20-minute group sessions delivered by a psychologist directly following sessions 2, 3, 4 of 6 PFMT sessions. The sessions targeted health behaviours, self-efficacy and autonomy, and explored ambivalence to change.	PFMT n=15 Six, 60-minute group sessions spaced over 6 months. To train women to perform PFM exercises, to identify correct muscle groups, and to provide education on anatomy and function of PFM.	• Adherence to the pelvic floor muscle training schedule (mean number of classes attended)

OAB: Overactive bladder; PFDI-20: pelvic floor distress inventory; PFD: Pelvic floor dysfunction; PFMT: Pelvic floor muscle training; PFPT: Pelvic floor physical therapy; UUI: Urge urinary incontinence

Table 3: Summary of included studies: Psychological therapy for vaginismus

Study	Population	Intervention	Comparison	Outcomes
Ter Kuile 2013 The Netherlands RCT	N = 70 Women with lifelong vaginismus Mean age (SD) Intervention: 28.54 years (7.83) Control: 29.29 years (6.92)	Exposure therapy n=35 Maximum of three 2-hour sessions within the first week. Followed by two follow up over the next five weeks. Session were with a female therapist and partner. Women were exposed to self-administered penetration objects and also completed exercises at home	Waitlist control n=35 No active treatment	• % achieving coitus • Sexual function (FSFI, • Sexual distress (FSDS) • Mean vaginismus score (GRISS)

Study	Population	Intervention	Comparison	Outcomes
Van Lankveld 2006 The Netherlands RCT	N = 117 Women with lifelong vaginismus Mean age (SD) Group CBT: 28.1 years (6.0) Bibliotherapy: 29.6 years (8.8) Control: 28.2 years (5.8)	Group CBT n=43 Ten 2 hour group sessions (6 to 9 participants) Manual based therapy including sex education, relaxation, exposure therapy, cognitive therapy, and sensate focus exercises. Included a CD-ROM and participants encouraged to practice daily	Bibliotherapy (information) n=38 Six biweekly telephone calls of 15 minutes Waiting list control n=36 No active treatment	• % achieving vaginal intercourse • adherence
Zarski 2017 Germany RCT	N = 77 Women with vaginismus Mean age (SD) Intervention: 25.83 years (6.46) Control: 28.95 years (8.92)	Internet based self-help n=40 Ten session of psychoeducation, relaxation, cognitive restructuring, body exposure, sensate focus exercises. Gradual insertion exercises	Waitlist control n=37 No active treatment	• % achieving penetration • Fear of sexuality • Sexual function (FSFI)

FSDS: Female sexual distress scale; FSFI: Female sexual function index; GRISS: Golombok Rust inventory for sexual satisfaction; SDQ: Sexual disgust questionnaire;

See the full evidence tables in appendix D. No meta-analysis was conducted (and so there are no forest plots in appendix E).

Quality assessment of studies included in the evidence review

See the evidence profiles in appendix F.

Economic evidence

Included studies

A single economic search was undertaken for all topics included in the scope of this guideline but no economic studies were identified which were applicable to this review question. See the literature search strategy in appendix B and economic study selection flow chart in appendix G.

Excluded studies

Economic studies not included in this review are listed, and reasons for their exclusion are provided in appendix K.

Economic model

No economic modelling was undertaken for this review because the committee agreed that other topics were higher priorities for economic evaluation because it was unlikely that recommendations would have a significant resource impact.

Brief summary of the evidence

Psychological therapy for vaginismus

- Very low to low quality evidence showed that exposure therapy as compared to wait list control showed improved outcomes for vaginismus, vaginal penetration, pain, fear of coitus and overall sexual functioning.
- Very low to low quality evidence showed group CBT and bibliotherapy both improved penetration as compared to waitlist control; however, the bibliotherapy appeared more effective than group CBT.
- Very low quality evidence showed a benefit of an internet based self-help program in terms of overall sexual functioning but showed no differences compared to control for penetration or fear of coitus.

Emotional expression and awareness interview versus treatment as usual of women with chronic urogenital pain

- Very low quality evidence showed a benefit for an emotional expression and awareness interview for pain severity and pelvic floor distress scores, but showed no effect on anxiety or depression.

Mindful based stress reduction versus embedded health programme for women with urge urinary incontinence

- Low quality evidence from a feasibility study showed more women no difference in retention in the intervention when receiving mindfulness based stress reduction as compared to an embedded health program.

Hypnotherapy versus behavioural therapy for women with overactive bladder

- Very low quality evidence showed no difference in outcomes between hypnotherapy and behavioural therapy.

Motivational interview versus pelvic floor muscle training alone for PFD

- Low quality evidence suggested a motivational interview before PFMT sessions improves the number of classes attended.

The committee's discussion of the evidence

Interpreting the evidence

The outcomes that matter most

The committee agreed that improvement in symptoms associated with pelvic floor dysfunction were the most critical outcomes as this is a review on management of symptoms, and therefore the intervention should improve these. The committee agreed that

important outcomes were health related quality of life and change in psychological factors (anxiety/depression) as these should be improved by a successful psychological intervention; additionally, and these are important outcomes as PFD often has a large impact on a woman's psychological state. Other important outcomes included adherence and satisfaction of the intervention, these outcomes likely influence the effect size of the outcome and should therefore be considered.

The quality of the evidence

The quality of the evidence for this review was assessed using GRADE and ranged from very low to low quality. All studies were downgraded due to risk of bias in the measurement of outcomes, as these were generally self-reported and as such open to influence from bias relating to assumptions about the effect of treatment. Additionally, the participants could not be blinded to the interventions due to the nature of treatment. Some outcomes were also downgraded due to imprecision in the data, which may be related to small study size.

No evidence was found for acceptance and commitment therapy, dialectical behaviour therapy, guided self-help therapy, pure self-help or combined pharmacological and psychological treatment.

Benefits and harms

Overall, the evidence presented was limited and varied in quality. Due to the uncertainty in the evidence the committee could not use it to support their recommendations. The committee noted based on their experience that the symptoms of pelvic floor dysfunction can cause embarrassment and that women can feel stigmatised. They therefore decided that it is important to ask the woman about their psychological wellbeing and whether this is affected negatively by their symptoms. The committee discussed that this would allow women to talk about their feelings and help explore whether further psychological help may be need.

Evidence suggested that psychological interventions improved attendance and adherence to therapies such as pelvic floor muscle training. The committee agreed that in their clinical experience, adherence is important in the management of the symptoms associated with pelvic floor dysfunction. However, as the evidence did not address whether psychological interventions directly improve symptoms of pelvic floor dysfunction, the committee discussed whether a research recommendation is needed. They were conscious that the studies identified did not evaluate if psychological interventions improved the psychological distress experienced by the women. Due to this gap in research, the committee made a research recommendation to investigate this further.

Cost effectiveness and resource use

Although the clinical evidence was generally limited the committee noted that some evidence suggested that psychological therapies might improve adherence to treatment and therefore could potentially be cost-effective depending on the size of the effect. However, as there was no direct evidence that these psychological interventions improved the symptoms of pelvic floor dysfunction the committee limited themselves to a research recommendation. They also cross referenced the NICE guidelines on antenatal and postnatal mental health and depression in adults with a chronic physical health problem for cost-effective recommendations that could be related to women's pelvic floor dysfunction symptoms.

Other factors the committee took into account

They also agreed to refer to the NICE guideline on antenatal and postnatal mental health as this provides relevant advice on psychological wellbeing before and after giving birth and the NICE Depression in adults with a chronic physical health problem: recognition and management (2009) guideline because pelvic floor dysfunction can become a chronic condition which can lead to depression.

Recommendations supported by this evidence review

This evidence review supports recommendations 1.6.28, 1.6.29 and a research recommendation on psychological interventions in the NICE guideline.

References

Carty 2018
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Zarski 2017
Zarski, A. C., Berking, M., Fackiner, C., Rosenau, C., Ebert, D. D., Internet-Based Guided Self-Help for Vaginal Penetration Difficulties: Results of a Randomized Controlled Pilot Trial, Journal of sexual medicine, 14, 238-254, 2017

Appendices

Appendix A – Review protocol

Review protocol for review question: What is the effectiveness of psychological interventions for women with symptoms associated with pelvic floor dysfunction?

Table 4: Review protocol

ID	Field	Content
0.	PROSPERO registration number	CRD42019162297
1.	Review title	Psychological therapy
2.	Review question	What is the effectiveness of psychological interventions for women with symptoms associated with pelvic floor dysfunction?
3.	Objective	The objective of this review is to determine whether psychological interventions can effectively improve symptoms (including urinary incontinence, pelvic organ prolapse, emptying disorders of the bladder, faecal incontinence, emptying disorders of the bowel, sexual dysfunction and chronic pelvic pain syndromes) associated with pelvic floor dysfunction.
4.	Searches	The following databases will be searched: • Cochrane Database of Systematic Reviews (CDSR) • Cochrane Central Register of Controlled Trials (CENTRAL) • MEDLINE & Medline in Process • Embase • Cinahl or Emcare • PsycINFO Searches will be restricted by: • Date: 1980 onwards (see section 10 for justification) • Human studies • English language studies only Other searches: • Inclusion lists of potentially relevant systematic review

ID	Field	Content
		The full search strategies for MEDLINE database will be published in the final review. For each search, the principal database search strategy is quality assured by a second information scientist using an adaptation of the PRESS 2015 Guideline Evidence-Based Checklist.
5.	Condition or domain being studied	The following symptoms will be addressed as long as they are associated with pelvic floor dysfunction: urinary incontinence, emptying disorders of the bladder, faecal incontinence, emptying disorders of the bowel, pelvic organ prolapse, sexual dysfunction and chronic pelvic pain syndromes.
6.	Population	Inclusion Women and young women (aged 12 years and older) with symptoms associated with pelvic floor dysfunction Exclusion • Studies which include women with urinary incontinence, emptying disorders of the bladder, faecal incontinence, emptying disorders of the bowel, pelvic organ prolapse, sexual dysfunction and chronic pelvic pain syndromes which are not due to pelvic floor dysfunction will be excluded. For example, women who have urinary incontinence due to a neurological condition or pelvic cancer will be excluded. During the screening stage, the reported inclusion/exclusion criteria of studies will be examined carefully. We do not anticipate studies on urinary incontinence, emptying disorders of the bladder or pelvic organ prolapse will explicitly state "associated with pelvic floor dysfunction" therefore this will be a pragmatic decision based on the description of the condition provided by the study authors. Some of these symptoms (for example urinary incontinence) are most often due to a failure in the pelvic floor and therefore unless the exclusion criteria states a different cause, these studies are likely to be included. However, for studies on faecal incontinence, emptying disorders of the bowel, sexual dysfunction and pelvic pain the causes are more numerous. As such for these symptoms unless the study specifically states "associated with pelvic floor dysfunction" they will be excluded. If any ambiguity exists, at least two reviewers will make the final decision if to include or exclude the study. • Men • Babies and children (younger than 12 years)
7.	Intervention	Any psychological intervention, including but not exclusively those listed will be considered: • Acceptance and commitment therapy • Adjuvant therapies (for example pelvic floor muscle training, pharmacological interventions, physical devices) • Applied behaviour analysis • Behavioural therapy (BT) (excluding bladder drill or lifestyle modifications) • Cognitive analytical therapy • Cognitive behavioural therapy (CBT)

ID	Field	Content
		• Cognitive remediation therapy (CRT) • Combination social support groups • Counselling • Dialectical behaviour therapy (DBT) • Dynamic (interpersonal (IPT), Psychodynamic General) • E-therapies • Guided Self Help with therapist guidance • Guided self-help therapy • Humanistic therapy • Hypnotherapy • Interpersonal psychotherapy • Mindfulness-based cognitive therapy • Motivational interviewing • Psychodynamic psychotherapy • Psychosexual treatment • Psychosocial treatment • Pure self-help • Values intervention therapy • Pharmacological treatment in combination with one of the above interventions
8.	Comparator	Any of the above (in isolation or in combination) • Waiting list • Usual care • Pharmacological treatment (particularly for pain and sexual dysfunction) only in comparison to pharmacological treatments given in combination to psychological interventions
9.	Types of study to be included	Systematic reviews of RCTs RCTs Non-randomised or quasi-randomised controlled trials Note: For further details, see the algorithm in appendix H, Developing NICE guidelines: the manual.
10.	Other exclusion criteria	Studies with a mixed population (that is women with symptoms such as urinary incontinence which are associated with pelvic floor dysfunction and women with symptoms that are not associated with pelvic floor dysfunction) will be excluded, unless subgroup analysis for those women with symptoms associated with pelvic floor dysfunction has been reported.

ID	Field	Content
		Studies will only be included if they include one of the primary outcomes listed. We will not include studies which only measure psychological outcomes. For example, a study must measure a change in urinary incontinence in addition to a change in anxiety, not simply measure anxiety in a population of women with urinary incontinence. Any psychological therapies aiming to change lifestyle/well-being will be excluded (psychological interventions should only target pelvic floor dysfunction itself) Conference abstracts will be excluded because these do not typically provide sufficient information to fully assess risk of bias. Only articles published after 1980 will be included. This was agreed by the committee as this is the date that the condition "pelvic floor dysfunction" was recognised to include agreed terminology on symptoms. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2815805/
11.	Context	Studies which explicitly demonstrate a change in outcomes for symptoms associated with pelvic floor dysfunction will be prioritised for decision making in regards to recommendations, and these recommendations will apply to those receiving care in any healthcare settings (for example community, primary, secondary care). However, the context of recommendations is likely broader than just the health care setting itself. Women who are not currently accessing services may benefit from the recommendations in order to make lifestyle changes which could improve symptoms they are experiencing. Specific recommendations for groups listed in the Equality Considerations section of the scope may be also be made as appropriate.
12.	Primary outcomes (critical outcomes)	• Subjective measure of change in the following symptoms: ○ urinary incontinence ○ emptying disorders of the bladder ○ faecal incontinence ○ emptying disorders of the bowel ○ pelvic organ prolapse ○ sexual dysfunction ○ chronic pelvic pain syndromes For the above outcomes, only validated tools will be included (for example: ICIQ-UI, ICIQ-VS, BFLUTS, KHQ, UDI, ISI, ePAQ, POPSS, PISQ, POPQ, FISI, FIQL, GIQLI, PAC-QM, PAC –SYM, PDI, BPI)
13.	Secondary outcomes (important outcomes)	• Health-related quality of life (only validated scales will be included) • Satisfaction with intervention • Adherence (attendance) to intervention • Change in psychological symptoms (for example anxiety, depression; only validated tools will be included)

ID	Field	Content
		• Outcomes are in line with those described in the core outcome set …..
14.	Data extraction (selection and coding)	All references identified by the searches and from other sources will be uploaded into STAR and de-duplicated. Titles and abstracts of the retrieved citations will be screened to identify studies that potentially meet the inclusion criteria outlined in the review protocol. Duplicate screening will not be undertaken for this question. Full versions of the selected studies will be obtained for assessment. Studies that fail to meet the inclusion criteria once the full version has been checked will be excluded at this stage. Each study excluded after checking the full version will be listed, along with the reason for its exclusion. A standardised form will be used to extract data from studies. One reviewer will extract relevant data into a standardised form, and this will be quality assessed by a senior reviewer. Information to be extracted from studies includes: study type, study dates, location of study, funding, inclusion and exclusion criteria, participant characteristics, and details of the intervention and comparator.
15.	Risk of bias (quality) assessment	Quality assessment of individual studies will be performed using the following checklists • ROBIS tool for systematic reviews • Cochrane RoB tool v.2 for RCTs • ROBINS for non-randomised trials The quality assessment will be performed by one reviewer and this will be quality assessed by a senior reviewer.
16.	Strategy for data synthesis	Depending on the availability of the evidence, the findings will be summarised narratively or quantitatively. Data Synthesis Where possible, pair wise meta-analyses will be conducted using Cochrane Review Manager software. A fixed effect meta-analysis will be conducted and data will be presented as risk ratios for dichotomous outcomes. Peto odds ratio will be used for outcomes with zero events Mean differences or standardised mean differences will be calculated for continuous outcomes. Heterogeneity Heterogeneity in the effect estimates of the individual studies will be assessed using the I2 statistic. I2 values of greater than 50% and 80% will be considered as significant and very significant heterogeneity, respectively. In the presence of heterogeneity sub-group analysis will be conducted • According to risk of bias of individual studies • According to socioeconomic status of population included • By ethnicity of included populations

ID	Field	Content
		Exact subgroup analysis may vary depending on differences identified within included studies. If heterogeneity cannot be explained through subgroup analysis, then a random effects model will be used for meta-analysis. If heterogeneity remains above 80% reviewers will consider if meta-analysis is appropriate given the characteristics of included Minimal important differences (MIDs) Default MIDs will be used for risk ratios and continuous outcomes only, unless the committee pre-specifies published or other MIDs for specific outcomes • For risk ratios: 0.8 and 1.25. • For continuous outcomes: ○ For one study: the MID is calculated as +/-0.5 times the baseline SD of the control arm. ○ For two studies: the MID is calculated as +/-0.5 times the mean of the SDs of the control arms at baseline. If baseline SD is not available, then SD at follow up will be used. ○ For three or more studies (meta-analysed): the MID is calculated by ranking the studies in order of SD in the control arms. The MID is calculated as +/- 0.5 times median SD. ○ For studies that have been pooled using SMD (meta-analysed): +0.5 and -0.5 in the SMD scale are used as MID boundaries. Validity The confidence in the findings across all available evidence will be evaluated for each outcome using an adaptation of the 'Grading of Recommendations Assessment, Development and Evaluation (GRADE) toolbox' developed by the international GRADE working group: http://www.gradeworkinggroup.org/
17.	Analysis of sub-groups	Stratification If data is available, separate analysis will be conducted on: • Women who are pregnant • Women before and after gynaecological surgery • Women aged 65 or older • Women with physical disabilities • Women with cognitive impairment • According to those who do not identify themselves as women, but who have female pelvic organs • Women who have difficulties reading, speaking or understanding English Recommendations will apply to all those with pelvic floor dysfunction unless there is evidence of a difference in these stratified groups
18.		☒ Intervention

ID	Field	Content		
	Type and method of review	☐	Diagnostic	
		☐	Prognostic	
		☐	Qualitative	
		☐	Epidemiologic	
		☐	Service Delivery	
		☐	Other (please specify)	
19.	Language	English		
20.	Country	England		
21.	Anticipated or actual start date	TBC		
22.	Anticipated completion date	August 2021		
23.	Stage of review at time of this submission	Review stage	Started	Completed
		Preliminary searches	x	x
		Piloting of the study selection process	x	x
		Formal screening of search results against eligibility criteria	x	x
		Data extraction	x	x
		Risk of bias (quality) assessment	x	x
		Data analysis	x	x
24.	Named contact	5a. Named contact National Guideline Alliance 5b Named contact e-mail PreventionofPOP@nice.org.uk		

ID	Field	Content
		5e Organisational affiliation of the review National Institute for Health and Care Excellence (NICE) and the National Guideline Alliance
25.	Review team members	NGA technical team
26.	Funding sources/sponsor	This systematic review is being completed by the National Guideline Alliance, which is funded by NICE and hosted by the Royal College of Obstetricians and Gynaecologists. NICE funds the National Guideline Alliance to develop guidelines for those working in the NHS, public health, and social care in England.
27.	Conflicts of interest	All guideline committee members and anyone who has direct input into NICE guidelines (including the evidence review team and expert witnesses) must declare any potential conflicts of interest in line with NICE's code of practice for declaring and dealing with conflicts of interest. Any relevant interests, or changes to interests, will also be declared publicly at the start of each guideline committee meeting. Before each meeting, any potential conflicts of interest will be considered by the guideline committee Chair and a senior member of the development team. Any decisions to exclude a person from all or part of a meeting will be documented. Any changes to a member's declaration of interests will be recorded in the minutes of the meeting. Declarations of interests will be published with the final guideline.
28.	Collaborators	Development of this systematic review will be overseen by an advisory committee who will use the review to inform the development of evidence-based recommendations in line with section 3 of Developing NICE guidelines: the manual. Members of the guideline committee are available on the NICE website: https://www.nice.org.uk/guidance/indevelopment/gid-ng10123/
29.	Other registration details	Not applicable
30.	Reference/URL for published protocol	https://www.crd.york.ac.uk/PROSPERO/display_record.php?RecordID=162297
31.	Dissemination plans	NICE may use a range of different methods to raise awareness of the guideline. These include standard approaches such as: notifying registered stakeholders of publication publicising the guideline through NICE's newsletter and alerts issuing a press release or briefing as appropriate, posting news articles on the NICE website, using social media channels, and publicising the guideline within NICE.
32.	Keywords	Physiological therapy Pelvic floor dysfunction
33.	Details of existing review of same topic	Not applicable

ID	Field	Content	
	by same authors		
34.	Current review status	☒	Ongoing
		☐	Completed but not published
		☐	Completed and published
		☐	Completed, published and being updated
		☐	Discontinued
35. .	Additional information	Not applicable	
36.	Details of final publication	www.nice.org.uk	

CDSR: Cochrane Database of Systematic Reviews; CENTRAL: Cochrane Central Register of Controlled Trials; DARE: Database of Abstracts of Reviews of Effects; GRADE: Grading of Recommendations Assessment, Development and Evaluation; HTA: Health Technology Assessment; MID: minimally important difference; NGA: National Guideline Alliance; NHS: National health service; NICE: National Institute for Health and Care Excellence; RCT: randomised controlled trial; RoB: risk of bias; SD: standard deviation

Appendix B – Literature search strategies

Literature search strategies for review question: What is the effectiveness of psychological interventions for women with symptoms associated with pelvic floor dysfunction?

Clinical Search

Database(s): Medline & Embase (Multifile) – OVID interface
Embase Classic+Embase 1947 to 2020 January 08; **Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily** 1946 to January 07, 2020
Date of last search: 9 January 2020

Multifile database codes: emczd = Embase Classic+Embase; ppez= MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily

#	Searches
1	Pelvic Floor/ use ppez
2	Pelvic Floor Disorders/ use ppez
3	pelvis floor/ use emczd
4	pelvic floor disorder/ use emczd
5	(pelvi$ adj (floor$ or diaphragm$) adj3 (dysfunction$ or disorder$ or fail$ or impair$ or incompeten$ or insufficien$ or dyssynerg$ or symptom$ or laxity or change$ or care$ or health$ or wellbeing$ or well-being$ or prevent$ or rehabilitat$ or weak$ or hypertonic$ or overactiv$ or over activ$ or over-activ$)).tw.
6	(pelvi$ adj (dysfunction$ or disorder$ or fail$ or impair$ or incompeten$ or insufficien$ or dyssynerg$ or symptom$ or laxity or care$ or health$ or wellbeing$ or well-being$ or prevent$ or rehabilitat$ or weak$ or hypertonic$ or overactiv$ or over activ$ or over-activ$)).tw.
7	or/1-6
8	exp *Urinary Incontinence/ use ppez
9	*Urinary Bladder, Overactive/ use ppez
10	exp *urine incontinence/ use emczd
11	*overactive bladder/ use emczd
12	*bladder instability/ use emczd
13	((stress$ or mix$ or urg$ or urin$) adj5 incontinen$).ti.
14	(bladder$ adj5 (overactiv$ or over activ$ or over-activ$ or instabilit$ or hyper-reflex$ or hyperreflex$ or hyper reflex$ or incontinen$)).ti.
15	(detrusor$ adj5 (overactiv$ or over activ$ or over-activ$ or instabilit$ or hyper-reflex$ or hyperreflex$ or hyper reflex$)).ti.
16	((urgency adj2 frequency) or (frequency adj2 urgency)).ti.
17	((urin$ or bladder$) adj2 (urg$ or frequen$)).ti.
18	(SUI or OAB).ti.
19	or/8-18
20	exp *Pelvic Organ Prolapse/ use ppez
21	exp *pelvic organ prolapse/ use emczd
22	*Rectocele/ use ppez
23	*rectocele/ use emczd
24	(pelvic$ adj3 organ$ adj3 prolaps$).ti.
25	(urinary adj3 bladder adj3 prolaps$).ti.
26	((vagin$ or urogenital$ or genit$ or uter$ or viscer$ or anterior$ or posterior$ or apical or pelvi$ or vault$ or urethr$ or bladder$ or cervi$ or rectal or rectum) adj3 prolaps$).ti.
27	(splanchnoptos$ or visceroptos$).ti.
28	(hernia$ adj3 (pelvi$ or vagin$ or urogenital$ or uter$ or bladder$ or urethr$ or viscer$)).ti.
29	(urethroc?ele$ or enteroc?ele$ or sigmoidoc?ele$ or proctoc?ele$ or rectoc?ele$ or cystoc?ele$ or rectoenteroc?ele$ or cystourethroc?ele$).ti.
30	or/0-29
31	*Fecal Incontinence/ use ppez
32	*feces incontinence/ use emczd
33	((faecal or fecal or faeces or feces or fecally or faecally or anal or anally or stool or stools or bowel or double or defecat$ or defaecat$) adj5 (incontinence or incontinent or urge$ or leak or leaking or leakage or soiling or seeping or seepage or impacted or impaction)).ti.
34	or/31-33
35	Urinary Retention/ use ppez
36	urine retention/ use emczd
37	(urin$ adj3 (retention$ or retain$)).tw.
38	(voiding adj (disorder$ or dysfunction$ or problem$)).tw.
39	(empty$ adj disorder$ adj3 (bowel$ or bladder$ or vesical$ or stool$)).tw.
40	((urogeni$ or anorec$ or ano-rec$ or ano rec$) adj3 dysfunction$).tw.

#	Searches
41	defecation disorder/ use emczd
42	Fecal Impaction/ use ppez
43	Feces Impaction/ use emczd
44	((difficult$ or delay$ or irregular$ or infrequen$ or pain$) adj3 (defecat$ or defaecat$ or stool$ or faeces or feces or bowel movement$)).tw.
45	(obstruct$ adj3 (defecat$ or defaecat$)).tw.
46	((defecat$ or defaecat$ or evacuat$) adj3 (disorder$ or dysfunction$)).tw.
47	outlet$ dysfunction$ constipa$.tw.
48	(dys?ynerg$ adj (defecat$ or defaecat$)).tw.
49	(pelvi$ adj3 dyskines$).tw.
50	pelvi$ outlet$ obstruct$.tw.
51	anismus$.tw.
52	puborectal$ contract$.tw.
53	((rectal or rectum) adj3 urge$).tw.
54	or/35-53
55	female sexual dysfunction/ use emczd
56	(female adj sex$ adj (dysfunct$ or satisf$ or problem$ or symptom$ or arous$ or activit$ or disorder$)).tw.
57	(obstruct$ adj3 intercourse).tw.
58	(vagin$ adj3 laxity$).tw.
59	(vagin$ adj wind).tw.
60	Vaginismus/ use ppez
61	vaginism/ use emczd
62	vaginismus$.tw.
63	(vagin$ adj penetrat$ adj disorder$).tw.
64	or/55-63
65	7 or 19 or 30 or 34 or 54 or 64
66	"Acceptance and Commitment Therapy"/ use ppez
67	"acceptance and commitment therapy"/ use emczd
68	((acceptance$ or commitment$) adj (therap$ or treatment$)).tw.
69	(applied$ adj (behavior$ or behaviour$) adj analy$).tw.
70	*Behavior Therapy/ use ppez
71	*behavior therapy/ use emczd
72	dialectical behavior therapy/ use emczd
73	((behavior$ or behaviour$) adj therap$).tw.
74	Cognitive Behavioral Therapy/ use ppez
75	cognitive behavioral therapy/ use emczd
76	cognitive therapy/ use emczd
77	(CBT$ adj3 (technique$ or strateg$ or process$ or treatment$ or therap$ or exercise$ or rehabilitation$ or session$)).tw.
78	(cogniti$ adj3 (therap$ or psychotherapy$ or psycho-therap$)).tw.
79	Cognitive Remediation/ use ppez
80	cognitive remediation therapy/ use emczd
81	(cognitiv$ adj3 remediat$).tw.
82	Social Support/ use ppez
83	*social support/ use emczd
84	Self-Help Groups/ use ppez
85	support group/ use emczd
86	((support or therapeutic$ or telephone$) adj group$).tw.
87	(group$ adj (therap$ or educat$)).tw.
88	Counseling/ use ppez
89	Directive Counseling/ use ppez
90	*counseling/ use emczd
91	*patient counseling/ use emczd
92	(counseling or counselling).ti.
93	Dialectical Behavior Therapy/ use ppez
94	dialectical behavior therapy/ use emczd
95	dialectical$.tw.
96	Psychotherapy/ use ppez
97	*psychotherapy/ use emczd
98	((interpersonal$ or inter-personal$ or dynamic$) adj (psychotherapy$ or psycho-therap$)).tw.
99	Psychotherapy, Psychodynamic/ use ppez
100	psychodynamic psychotherapy/ use emczd
101	((psychodynamic$ or psycho-dynamic$) adj3 (psychotherapy$ or psycho-therap$ or approach$ or intervention$ or support$ or group$ or therap$)).tw.
102	((behavior$ or behaviour$) adj (psychotherapy$ or psycho-therap$)).tw.
103	*Self Care/mt use ppez
104	*self help/ use emczd
105	(guide$ adj (selfhelp$ or self-help$)).tw.
106	((selfhelp$ or self-help$) adj (approach$ or intervention$ or support$ or group$ or therap$ or strateg$)).tw.
107	Humanism/ use ppez

#	Searches
108	humanism/ use emczd
109	humanist$.tw.
110	(humanist$ adj3 therap$).tw.
111	Hypnosis/ use ppez
112	hypnosis/ use emczd
113	hypnotherapy/ use emczd
114	(hypnosis or hypnotherap$).tw.
115	Mindfulness/ use ppez
116	mindfulness/ use emczd
117	Meditation/ use ppez
118	meditation/ use emczd
119	psychoeducation/ use emczd
120	(mindfulness-based or mindfulnessbased).tw.
121	(mindfulness$ adj3 therap$).tw.
122	Motivational Interviewing/ use ppez
123	motivational interviewing/ use emczd
124	*interview/ use emczd
125	(motivational$ adj3 interview$).tw.
126	personal value/ use emczd
127	(value$ adj (intervention$ or therap$)).tw.
128	Psychoanalytic Therapy/ use ppez
129	sex therapy/ use emczd
130	((psychosexual$ or psycho-sexual$ or sexodynamic$ or sexological$) adj (approach$ or intervention$ or support$ or group$ or therap$ or treatment$ or service$ or gyn?ecolog$)).tw.
131	Psychosocial Support Systems/ use ppez
132	psychosocial care/ use emczd
133	psychosocial rehabilitation/ use emczd
134	((psychoeducat$ or psycho-educat$ or psychosocial$ or psycho-social$) adj (approach$ or intervention$ or support$ or group$ or therap$ or treatment$ or service$ or gyn?ecolog$)).tw.
135	(psycholog$ adj intervention$).tw.
136	Telemedicine/ use ppez
137	telemedicine/ use emczd
138	Telerehabilitation/ use ppez
139	telerehabilitation/ use emczd
140	telehealth/ use emczd
141	teletherapy/ use emczd
142	Distance Counseling/ use ppez
143	e-counseling/ use emczd
144	Remote Consultation/ use ppez
145	teleconsultation/ use emczd
146	(online adj therap$).tw.
147	(e-therap$ or etherap$).tw.
148	(helpline$ or help line$ or help-line$ or hotline$ or hot line$ or hot-line$).tw.
149	((telephone$ or phone$ or smartphone$) adj (support$ or counsel$)).tw.
150	((mobile$ or mHealth$ or eHealth$) adj (communicat$ or technolog$)).tw.
151	or/66-150
152	65 and 151
153	(controlled clinical trial or pragmatic clinical trial or randomized controlled trial).pt. or drug therapy.fs. or (groups or placebo or randomi#ed or randomly or trial).ab.
154	crossover procedure/ or double blind procedure/ or randomized controlled trial/ or single blind procedure/ or (assign* or allocat* or crossover* or cross over* or ((doubl* or singl*) adj blind*) or factorial* or placebo* or random* or volunteer*).ti,ab.
155	meta-analysis/
156	meta-analysis as topic/
157	systematic review/
158	meta-analysis/
159	(meta analy* or metanaly* or metaanaly*).ti,ab.
160	((systematic or evidence) adj2 (review* or overview*)).ti,ab.
161	((systematic* or evidence*) adj2 (review* or overview*)).ti,ab.
162	(reference list* or bibliograph* or hand search* or manual search* or relevant journals).ab.
163	(search strategy or search criteria or systematic search or study selection or data extraction).ab.
164	(search* adj4 literature).ab.
165	(medline or pubmed or cochrane or embase or psychlit or psyclit or psychinfo or psycinfo or cinahl or science citation index or bids or cancerlit).ab.
166	cochrane.jw.
167	((pool* or combined) adj2 (data or trials or studies or results)).ab.
168	letter/
169	editorial/
170	news/
171	exp historical article/
172	Anecdotes as Topic/

#	Searches
173	comment/
174	case report/
175	(letter or comment*).ti.
176	168 or 169 or 170 or 171 or 172 or 173 or 174 or 175
177	randomized controlled trial/ or random*.ti,ab.
178	176 not 177
179	animals/ not humans/
180	exp Animals, Laboratory/
181	exp Animal Experimentation/
182	exp Models, Animal/
183	exp Rodentia/
184	(rat or rats or mouse or mice).ti.
185	178 or 179 or 180 or 181 or 182 or 183 or 184
186	letter.pt. or letter/
187	note.pt.
188	editorial.pt.
189	case report/ or case study/
190	(letter or comment*).ti.
191	186 or 187 or 188 or 189 or 190
192	randomized controlled trial/ or random*.ti,ab.
193	191 not 192
194	animal/ not human/
195	nonhuman/
196	exp Animal Experiment/
197	exp Experimental Animal/
198	animal model/
199	exp Rodent/
200	(rat or rats or mouse or mice).ti.
201	193 or 194 or 195 or 196 or 197 or 198 or 199 or 200
202	185 use ppez
203	201 use emczd
204	202 or 203
205	153 use ppez
206	154 use emczd
207	205 or 206
208	(or/155-156,159,161-166) use ppez
209	(or/157-160,162-167) use emczd
210	208 or 209
211	152 and 204
212	152 not 211
213	limit 212 to english language
214	limit 213 to yr="1980 -Current"
215	207 or 210
216	214 and 215 [RCT/SR data]
217	214 not 216 [Non-RCT/SR data]

Database(s): Cochrane Library – Wiley interface
Cochrane Database of Systematic Reviews, Issue 1 of 12, January 2020; **Cochrane Central Register of Controlled Trials**, Issue 1 of 12, January 2020
Date of last search: 9 January 2020

#	Searches
#1	MeSH descriptor: [Pelvic Floor] this term only
#2	MeSH descriptor: [Pelvic Floor Disorders] this term only
#3	((pelvi* NEXT (floor* or diaphragm*) NEAR/3 (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or change* or care* or health* or wellbeing* or well-being* or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or over activ* or over-activ*))):ti,ab,kw
#4	((pelvi* NEXT (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or care* or health* or wellbeing* or well-being* or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or over activ* or over-activ*))):ti,ab,kw
#5	MeSH descriptor: [Urinary Incontinence] explode all trees
#6	MeSH descriptor: [Urinary Bladder, Overactive] this term only
#7	(((stress* or mix* or urg* or urin*) NEAR/5 incontinen*)):ti,ab,kw
#8	(((bladder* NEAR/5 (overactiv* or over activ* or over-activ* or instabilit* or hyper-reflex* or hyperreflex* or hyper reflex* or incontinen*)))):ti,ab,kw
#9	(((detrusor* NEAR/5 (overactiv* or over activ* or over-activ* or instabilit* or hyper-reflex* or hyperreflex* or hyper reflex*)))):ti,ab,kw
#10	((((urgency NEAR/2 frequency) or (frequency NEAR/2 urgency)))):ti,ab,kw
#11	((((urin* or bladder*) NEAR/2 (urg* or frequen*)))):ti,ab,kw
#12	(((SUI or OAB))):ti,ab,kw

#	Searches
#13	MeSH descriptor: [Pelvic Organ Prolapse] explode all trees
#14	MeSH descriptor: [Rectocele] this term only
#15	(((pelvic* NEAR/3 organ* NEAR/3 prolaps*))):ti,ab,kw
#16	(((urinary NEAR/3 bladder NEAR/3 prolaps*))):ti,ab,kw
#17	((((vagin* or urogenital* or genit* or uter* or viscer* or anterior* or posterior* or apical or pelvi* or vault* or urethr* or bladder* or cervi* or rectal or rectum) NEAR/3 prolaps*))):ti,ab,kw
#18	(((splanchnoptos* or visceroptos*))):ti,ab,kw
#19	(((hernia* NEAR/3 (pelvi* or vagin* or urogenital* or uter* or bladder* or urethr* or viscer*)))):ti,ab,kw
#20	(((urethroc?ele* or enteroc?ele* or sigmoidoc?ele* or proctoc?ele* or rectoc?ele* or cystoc?ele* or rectoenteroc?ele* or cystourethroc?ele*))):ti,ab,kw
#21	MeSH descriptor: [Fecal Incontinence] this term only
#22	((((faecal or fecal or faeces or feces or fecally or faecally or anal or anally or stool or stools or bowel or double or defecat* or defaecat*) NEAR/5 (incontinence or incontinent or urge* or leak or leaking or leakage or soiling or seeping or seepage or impacted or impaction)))):ti,ab,kw
#23	MeSH descriptor: [Urinary Retention] this term only
#24	(((urin* NEAR/3 (retention* or retain*)))):ti,ab,kw
#25	(((voiding NEXT (disorder* or dysfunction* or problem*)))):ti,ab,kw
#26	(((empty* NEXT disorder* NEAR/3 (bowel* or bladder* or vesical* or stool*)))):ti,ab,kw
#27	((((urogeni* or anorec* or ano-rec* or ano rec*) NEAR/3 dysfunction*))):ti,ab,kw
#28	MeSH descriptor: [Fecal Impaction] this term only
#29	((((difficult* or delay* or irregular* or infrequen* or pain*) NEAR/3 (defecat* or defaecat* or stool* or faecal or fecal or faeces or feces or fecally or faecally or bowel movement*)))):ti,ab,kw
#30	(((obstruct* NEAR/3 (defecat* or defaecat*)))):ti,ab,kw
#31	((((defecat* or defaecat* or evacuat*) NEAR/3 (disorder* or dysfunction*)))):ti,ab,kw
#32	((outlet* dysfunction* constipa*)):ti,ab,kw
#33	(((dys?ynerg* NEXT (defecat* or defaecat*)))):ti,ab,kw
#34	(((pelvi* NEAR/3 dyskines*))):ti,ab,kw
#35	((pelvi* outlet* obstruct*)):ti,ab,kw
#36	((anismus*)):ti,ab,kw
#37	((puborectal* contract*)):ti,ab,kw
#38	((((rectal or rectum) NEAR/3 urge*))):ti,ab,kw
#39	(((female NEXT sex* NEXT (dysfunct* or satisf* or problem* or symptom* or arous* or activit* or disorder*)))):ti,ab,kw
#40	(((obstruct* NEAR/3 intercourse))):ti,ab,kw
#41	(((vagin* NEAR/3 laxity*))):ti,ab,kw
#42	(((vagin* NEXT wind))):ti,ab,kw
#43	MeSH descriptor: [Vaginismus] this term only
#44	((vaginismus*)):ti,ab,kw
#45	(((vagin* NEXT penetrat* NEXT disorder*))):ti,ab,kw
#46	#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40 OR #41 OR #42 OR #43 OR #44 OR #45
#47	MeSH descriptor: [Acceptance and Commitment Therapy] this term only
#48	(((acceptance* or commitment*) NEXT (therap* or treatment*))):ti,ab,kw
#49	((applied* NEXT (behavior* or behaviour*) NEXT analy*)):ti,ab,kw
#50	MeSH descriptor: [Behavior Therapy] this term only
#51	(((behavior* or behaviour*) NEXT therap*)):ti,ab,kw
#52	MeSH descriptor: [Cognitive Behavioral Therapy] this term only
#53	((CBT* NEAR/3 (technique* or strateg* or process* or treatment* or therap* or exercise* or rehabilitation* or session*))):ti,ab,kw
#54	((cogniti* NEAR/3 (therap* or psychotherapy* or psycho-therap*))):ti,ab,kw
#55	MeSH descriptor: [Cognitive Remediation] this term only
#56	((cognitiv* NEAR/3 remediat*)):ti,ab,kw
#57	MeSH descriptor: [Social Support] this term only
#58	MeSH descriptor: [Self-Help Groups] this term only
#59	(((support or therapeutic* or telephone*) NEXT group*)):ti,ab,kw
#60	((group* NEXT (therap* or educat*))):ti,ab,kw
#61	MeSH descriptor: [Counseling] this term only
#62	MeSH descriptor: [Directive Counseling] this term only
#63	((counseling or counselling)):ti
#64	MeSH descriptor: [Dialectical Behavior Therapy] this term only
#65	(dialectical*):ti,ab,kw
#66	MeSH descriptor: [Psychotherapy] this term only
#67	(((interpersonal* or inter-personal* or dynamic*) NEXT (psychotherapy* or psycho-therap*))):ti,ab,kw
#68	MeSH descriptor: [Psychotherapy, Psychodynamic] this term only
#69	(((psychodynamic* or psycho-dynamic*) NEAR/3 (psychotherapy* or psycho-therap* or approach* or intervention* or support* or group* or therap*))):ti,ab,kw
#70	(((behavior* or behaviour*) NEXT (psychotherapy* or psycho-therap*))):ti,ab,kw
#71	MeSH descriptor: [Self Care] explode all trees and with qualifier(s): [methods - MT]
#72	((guide* NEXT (selfhelp* or self-help*))):ti,ab,kw
#73	(((selfhelp* or self-help*) NEXT (approach* or intervention* or support* or group* or therap* or strateg*))):ti,ab,kw

#	Searches
#74	MeSH descriptor: [Humanism] explode all trees
#75	(humanist*):ti,ab,kw
#76	MeSH descriptor: [Hypnosis] this term only
#77	((hypnosis or hypnotherap*)):ti,ab,kw
#78	MeSH descriptor: [Mindfulness] this term only
#79	MeSH descriptor: [Meditation] this term only
#80	((mindfulness-based or mindfulnessbased)):ti,ab,kw
#81	((mindfulness* NEAR/3 therap*)):ti,ab,kw
#82	MeSH descriptor: [Motivational Interviewing] this term only
#83	((motivational* NEAR/3 interview*)):ti,ab,kw
#84	((value* NEXT (intervention* or therap*))):ti,ab,kw
#85	MeSH descriptor: [Psychoanalytic Therapy] this term only
#86	(((psychosexual* or psycho-sexual* or sexodynamic* or sexological*) NEXT (approach* or intervention* or support* or group* or therap* or treatment* or service* or gynecolog* or gynaecolog*))):ti,ab,kw
#87	MeSH descriptor: [Psychosocial Support Systems] this term only
#88	(((psychoeducat* or psycho-educat* or psychosocial* or psycho-social*) NEXT (approach* or intervention* or support* or group* or therap* or treatment* or service* or gynecolog* or gynaecolog*))):ti,ab,kw
#89	((psycholog* NEXT intervention*)):ti,ab,kw
#90	MeSH descriptor: [Telemedicine] this term only
#91	MeSH descriptor: [Telerehabilitation] this term only
#92	MeSH descriptor: [Distance Counseling] this term only
#93	MeSH descriptor: [Remote Consultation] this term only
#94	((online NEXT therap*)):ti,ab,kw
#95	((e-therap* or etherap*)):ti,ab,kw
#96	((helpline* or help line* or help-line* or hotline* or hot line* or hot-line*)):ti,ab,kw
#97	(((telephone* or phone* or smartphone*) NEXT (support* or counsel*))):ti,ab,kw
#98	(((mobile* or mHealth* or eHealth*) NEXT (communicat* or technolog*))):ti,ab,kw
#99	#47 or #48 or #49 or #50 or #51 or #52 or #53 or #54 or #55 or #56 or #57 or #58 or #59 or #60 or #61 or #62 or #63 or #64 or #65 or #66 or #67 or #68 or #69 or #70 or #71 or #72 or #73 or #74 or #75 or #76 or #77 or #78 or #79 or #80 or #81 or #82 or #83 or #84 or #85 or #86 or #87 or #88 or #89 or #90 or #91 or #92 or #93 or #94 or #95 or #96 or #97 or #98
#100	#46 and #99

Database(s): Database of Abstracts of Reviews of Effects (DARE); HTA Database – CRD interface

Date of last search: 9 January 2020

#	Searches
1	MeSH DESCRIPTOR Pelvic Floor IN DARE,HTA
2	MeSH DESCRIPTOR Pelvic Floor Disorders IN DARE,HTA
3	((pelvi* NEXT (floor* or diaphragm*) NEAR3 (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or change* or care* or health* or wellbeing* or well-being* or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or over activ* or over-activ*))) IN DARE, HTA
4	((pelvi* NEXT (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or care* or health* or wellbeing* or well-being* or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or over activ* or over-activ*))) IN DARE, HTA
5	MeSH DESCRIPTOR Urinary Incontinence EXPLODE ALL TREES IN DARE,HTA
6	MeSH DESCRIPTOR Urinary Bladder, Overactive IN DARE,HTA
7	(((stress* or mix* or urg* or urin*) NEAR5 incontinen*)) IN DARE, HTA
8	((bladder* NEAR5 (overactiv* or over activ* or over-activ* or instabilit* or hyper-reflex* or hyperreflex* or hyper reflex* or incontinen*))) IN DARE, HTA
9	((detrusor* NEAR5 (overactiv* or over activ* or over-activ* or instabilit* or hyper-reflex* or hyperreflex* or hyper reflex*))) IN DARE, HTA
10	(((urgency NEAR2 frequency) or (frequency NEAR2 urgency))) IN DARE, HTA
11	(((urin* or bladder*) NEAR2 (urg* or frequen*))) IN DARE, HTA
12	((SUI or OAB)) IN DARE, HTA
13	MeSH DESCRIPTOR Pelvic Organ Prolapse EXPLODE ALL TREES IN DARE,HTA
14	MeSH DESCRIPTOR Rectocele IN DARE,HTA
15	((pelvic* NEAR3 organ* NEAR3 prolaps*)) IN DARE, HTA
16	((urinary NEAR3 bladder NEAR3 prolaps*)) IN DARE, HTA
17	(((vagin* or urogenital* or genit* or uter* or viscer* or anterior* or posterior* or apical or pelvi* or vault* or urethr* or bladder* or cervi* or rectal or rectum) NEAR3 prolaps*)) IN DARE, HTA
18	((splanchnoptos* or visceroptos*)) IN DARE, HTA
19	((hernia* NEAR3 (pelvi* or vagin* or urogenital* or uter* or bladder* or urethr* or viscer*))) IN DARE, HTA
20	((urethroc?ele* or enteroc?ele* or sigmoidoc?ele* or proctoc?ele* or rectoc?ele* or cystoc?ele* or rectoenteroc?ele* or cystourethroc?ele*)) IN DARE, HTA
21	MeSH DESCRIPTOR Fecal Incontinence IN DARE,HTA
22	(((faecal or fecal or faeces or feces or fecally or faecally or anal or anally or stool or stools or bowel or double or defecat* or defaecat*) NEAR5 (incontinence or incontinent or urge* or leak or leaking or leakage or soiling or seeping or seepage or impacted or impaction))) IN DARE, HTA
23	MeSH DESCRIPTOR Urinary Retention IN DARE,HTA

#	Searches
24	((urin* NEAR3 (retention* or retain*))) IN DARE, HTA
25	((voiding NEXT (disorder* or dysfunction* or problem*))) IN DARE, HTA
26	((empty* NEXT disorder* NEAR3 (bowel* or bladder* or vesical* or stool*))) IN DARE, HTA
27	(((urogeni* or anorec* or ano-rec* or ano rec*) NEAR3 dysfunction*)) IN DARE, HTA
28	MeSH DESCRIPTOR Fecal Impaction IN DARE,HTA
29	(((difficult* or delay* or irregular* or infrequen* or pain*) NEAR3 (defecat* or defaecat* or stool* or faecal or fecal or faeces or feces or fecally or faecally or bowel movement*))) IN DARE, HTA
30	((obstruct* NEAR3 (defecat* or defaecat*))) IN DARE, HTA
31	(((defecat* or defaecat* or evacuat*) NEAR3 (disorder* or dysfunction*))) IN DARE, HTA
32	(((outlet* NEXT dysfunction* NEXT constipa*))) IN DARE, HTA
33	((dys?ynerg* NEXT (defecat* or defaecat*))) IN DARE, HTA
34	((pelvi* NEAR3 dyskines*)) IN DARE, HTA
35	((pelvi* NEXT outlet* NEXT obstruct*)) IN DARE, HTA
36	((anismus*)) IN DARE, HTA
37	((puborectal* NEXT contract*)) IN DARE, HTA
38	(((rectal or rectum) NEAR3 urge*)) IN DARE, HTA
39	((female NEXT sex* NEXT (dysfunct* or satisf* or problem* or symptom* or arous* or activit* or disorder*))) IN DARE, HTA
40	((obstruct* NEAR3 intercourse)) IN DARE, HTA
41	((vagin* NEAR3 laxity*)) IN DARE, HTA
42	((vagin* NEXT wind)) IN DARE, HTA
43	MeSH DESCRIPTOR Vaginismus IN DARE,HTA
44	((vaginismus*)) IN DARE, HTA
45	((vagin* NEXT penetrat* NEXT disorder*)) IN DARE, HTA
46	#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40 OR #41 OR #42 OR #43 OR #44 OR #45
47	MeSH DESCRIPTOR Acceptance and Commitment Therapy IN DARE,HTA
48	(((acceptance* or commitment*) NEXT (therap* or treatment*))) IN DARE, HTA
49	((applied* NEXT (behavior* or behaviour*) NEXT analy*)) IN DARE, HTA
50	MeSH DESCRIPTOR Behavior Therapy IN DARE,HTA
51	(((behavior* or behaviour*) NEXT therap*)) IN DARE, HTA
52	MeSH DESCRIPTOR Cognitive Therapy IN DARE,HTA
53	((CBT* NEAR3 (technique* or strateg* or process* or treatment* or therap* or exercise* or rehabilitation* or session*))) IN DARE, HTA
54	((cogniti* NEAR3 (therap* or psychotherapy* or psycho-therap*))) IN DARE, HTA
55	MeSH DESCRIPTOR Cognitive Remediation IN DARE,HTA
56	((cognitiv* NEAR3 remediat*)) IN DARE, HTA
57	MeSH DESCRIPTOR Social Support IN DARE,HTA
58	MeSH DESCRIPTOR Self-Help Groups IN DARE,HTA
59	(((support or therapeutic* or telephone*) NEXT group*)) IN DARE, HTA
60	((group* NEXT (therap* or educat*))) IN DARE, HTA
61	MeSH DESCRIPTOR Counseling IN DARE,HTA
62	MeSH DESCRIPTOR Directive Counseling IN DARE,HTA
63	((counseling or counselling)) IN DARE, HTA
64	((dialectical*)) IN DARE, HTA
65	MeSH DESCRIPTOR Psychotherapy IN DARE,HTA
66	(((interpersonal* or inter-personal* or dynamic*) NEXT (psychotherapy* or psycho-therap*))) IN DARE, HTA
67	MeSH DESCRIPTOR Psychotherapy, Psychodynamic IN DARE,HTA
68	(((psychodynamic* or psycho-dynamic*) NEAR3 (psychotherapy* or psycho-therap* or approach* or intervention* or support* or group* or therap*))) IN DARE, HTA
69	(((behavior* or behaviour*) NEXT (psychotherapy* or psycho-therap*))) IN DARE, HTA
70	MeSH DESCRIPTOR Self Care WITH QUALIFIER MT IN DARE,HTA
71	((guide* NEXT (selfhelp* or self-help*))) IN DARE, HTA
72	(((selfhelp* or self-help*) NEXT (approach* or intervention* or support* or group* or therap* or strateg*))) IN DARE, HTA
73	MeSH DESCRIPTOR Humanism IN DARE,HTA
74	((humanist*)) IN DARE, HTA
75	MeSH DESCRIPTOR Hypnosis IN DARE,HTA
76	(((hypnosis or hypnotherap*))) IN DARE, HTA
77	MeSH DESCRIPTOR Mindfulness IN DARE,HTA
78	MeSH DESCRIPTOR Meditation IN DARE,HTA
79	(((mindfulness-based or mindfulnessbased))) IN DARE, HTA
80	(((mindfulness* NEAR3 therap*))) IN DARE, HTA
81	MeSH DESCRIPTOR Motivational Interviewing IN DARE,HTA
82	((motivational* NEAR3 interview*)) IN DARE, HTA
83	((value* NEXT (intervention* or therap*))) IN DARE, HTA
84	MeSH DESCRIPTOR Psychoanalytic Therapy IN DARE,HTA
85	(((psychosexual* or psycho-sexual* or sexodynamic* or sexological*) NEXT (approach* or intervention* or support* or group* or therap* or treatment* or service* or gynecolog* or gynaecolog*))) IN DARE, HTA

#	Searches
86	MeSH DESCRIPTOR Psychosocial Support Systems IN DARE,HTA
87	(((psychoeducat* or psycho-educat* or psychosocial* or psycho-social*) NEXT (approach* or intervention* or support* or group* or therap* or treatment* or service* or gynecolog* or gynaecolog*))) IN DARE, HTA
88	((psycholog* NEXT intervention*)) IN DARE, HTA
89	MeSH DESCRIPTOR Telemedicine IN DARE,HTA
90	MeSH DESCRIPTOR Telerehabilitation IN DARE,HTA
91	MeSH DESCRIPTOR Distance Counseling IN DARE,HTA
92	MeSH DESCRIPTOR Remote Consultation IN DARE,HTA
93	((online NEXT therap*)) IN DARE, HTA
94	((e-therap* or etherap*)) IN DARE, HTA
95	((helpline* or help line* or help-line* or hotline* or hot line* or hot-line*)) IN DARE, HTA
96	(((telephone* or phone* or smartphone*) NEXT (support* or counsel*))) IN DARE, HTA
97	(((mobile* or mHealth* or eHealth*) NEXT (communicat* or technolog*))) IN DARE, HTA
98	#47 OR #48 OR #49 OR #50 OR #51 OR #52 OR #53 OR #54 OR #55 OR #56 OR #57 OR #58 OR #59 OR #60 OR #61 OR #62 OR #63 OR #64 OR #65 OR #66 OR #67 OR #68 OR #69 OR #70 OR #71 OR #72 OR #73 OR #74 OR #75 OR #76 OR #77 OR #78 OR #79 OR #80 OR #81 OR #82 OR #83 OR #84 OR #85 OR #86 OR #87 OR #88 OR #89 OR #90 OR #91 OR #92 OR #93 OR #94 OR #95 OR #96 OR #97
99	#46 AND #98

Database(s): Cinahl Plus – EBSCOhost interface

Date of last search: 9 January 2020

#	Searches
S96	S94 NOT S95 Limiters - Publication Year: 1980-2020; English Language;
S95	PT anecdote or PT audiovisual or PT bibliography or PT biography or PT book or PT book review or PT brief item or PT cartoon or PT commentary or PT computer program or PT editorial or PT games or PT glossary or PT historical material or PT interview or PT letter or PT listservs or PT masters thesis or PT obituary or PT pamphlet or PT pamphlet chapter or PT pictorial or PT poetry or PT proceedings or PT “questions and answers” or PT response or PT software or PT teaching materials or PT website
S94	S45 AND S93
S93	S46 OR S47 OR S48 OR S49 OR S50 OR S51 OR S52 OR S53 OR S54 OR S55 OR S56 OR S57 OR S58 OR S59 OR S60 OR S61 OR S62 OR S63 OR S64 OR S65 OR S66 OR S67 OR S68 OR S69 OR S70 OR S71 OR S72 OR S73 OR S74 OR S75 OR S76 OR S77 OR S78 OR S79 OR S80 OR S81 OR S82 OR S83 OR S84 OR S85 OR S86 OR S87 OR S88 OR S89 OR S90 OR S91 OR S92
S92	TI ((mobile* or mHealth* or eHealth*) N1 (communicat* or technolog*)) OR AB ((mobile* or mHealth* or eHealth*) N1 (communicat* or technolog*))
S91	TI ((telephone* or phone* or smartphone*) N1 (support* or counsel*)) OR AB ((telephone* or phone* or smartphone*) N1 (support* or counsel*))
S90	TI (helpline* or help line* or help-line* or hotline* or hot line* or hot-line*) OR AB (helpline* or help line* or help-line* or hotline* or hot line* or hot-line*)
S89	TI (e-therap* or etherap*) OR AB (e-therap* or etherap*)
S88	TI (online N1 therap*) OR AB (online N1 therap*)
S87	(MH "Remote Consultation")
S86	(MH "Telehealth") OR (MH "Telemedicine") OR (MH "Telenursing")
S85	TI (psycholog* N1 intervention*) OR AB (psycholog* N1 intervention*)
S84	TI ((psychoeducat* or psycho-educat* or psychosocial* or psycho-social*) N1 (approach* or intervention* or support* or group* or therap* or treatment* or service* or gyn?ecolog*)) OR AB ((psychoeducat* or psycho-educat* or psychosocial* or psycho-social*) N1 (approach* or intervention* or support* or group* or therap* or treatment* or service* or gyn?ecolog*))
S83	TI ((psychosexual* or psycho-sexual* or sexodynamic* or sexological*) N1 (approach* or intervention* or support* or group* or therap* or treatment* or service* or gyn?ecolog*)) OR AB ((psychosexual* or psycho-sexual* or sexodynamic* or sexological*) N1 (approach* or intervention* or support* or group* or therap* or treatment* or service* or gyn?ecolog*))
S82	TI (value* N1 (intervention* or therap*)) OR AB (value* N1 (intervention* or therap*))
S81	TI (motivational* N3 interview*) OR AB (motivational* N3 interview*)
S80	(MH "Motivational Interviewing")
S79	TI (mindfulness* N3 therap*) OR AB (mindfulness* N3 therap*)
S78	TI (mindfulness-based or mindfulnessbased) OR AB (mindfulness-based or mindfulnessbased)
S77	(MH "Meditation")
S76	(MH "Mindfulness")
S75	TI (hypnosis or hypnotherap*) OR AB (hypnosis or hypnotherap*)
S74	(MH "Hypnosis")
S73	TI humanist* OR AB humanist*
S72	(MH "Humanism")
S71	TI ((selfhelp* or self-help*) N1 (approach* or intervention* or support* or group* or therap* or strateg*)) OR AB ((selfhelp* or self-help*) N1 (approach* or intervention* or support* or group* or therap* or strateg*))
S70	TI (guide* N1 (selfhelp* or self-help*)) OR AB (guide* N1 (selfhelp* or self-help*))
S69	(MM "Self Care")
S68	TI ((behavior* or behaviour*) N1 (psychotherapy* or psycho-therap*)) OR AB ((behavior* or behaviour*) N1 (psychotherapy* or psycho-therap*))

#	Searches
S67	TI ((psychodynamic* or psycho-dynamic*) N3 (psychotherapy* or psycho-therap* or approach* or intervention* or support* or group* or therap*)) OR AB ((psychodynamic* or psycho-dynamic*) N3 (psychotherapy* or psycho-therap* or approach* or intervention* or support* or group* or therap*))
S66	(MH "Psychotherapy, Psychodynamic")
S65	TI ((interpersonal* or inter-personal* or dynamic*) N1 (psychotherapy* or psycho-therap*)) OR AB ((interpersonal* or inter-personal* or dynamic*) N1 (psychotherapy* or psycho-therap*))
S64	(MH "Psychotherapy")
S63	TI dialectical* OR AB dialectical*
S62	TI (counseling or counselling)
S61	(MH "Counseling")
S60	TI (group* N1 (therap* or educat*)) OR AB (group* N1 (therap* or educat*))
S59	TI ((support or therapeutic* or telephone*) N1 group*) OR AB ((support or therapeutic* or telephone*) N1 group*)
S58	(MH "Support Groups")
S57	(MM "Support, Psychosocial")
S56	TI (cognitiv* N3 remediat*) OR AB (cognitiv* N3 remediat*)
S55	(MH "Cognitive Remediation")
S54	TI (cogniti* N3 (therap* or psychotherapy* or psycho-therap*)) OR AB (cogniti* N3 (therap* or psychotherapy* or psycho-therap*))
S53	TI (CBT* N3 (technique* or strateg* or process* or treatment* or therap* or exercise* or rehabilitation* or session*)) OR AB (CBT* N3 (technique* or strateg* or process* or treatment* or therap* or exercise* or rehabilitation* or session*))
S52	(MH "Cognitive Therapy")
S51	TI ((behavior* or behaviour*) N1 therap*) OR AB ((behavior* or behaviour*) N1 therap*)
S50	(MH "Dialectical Behavior Therapy")
S49	(MM "Behavior Therapy")
S48	TI (applied* N1 (behavior* or behaviour*) N1 analy*) OR AB (applied* N1 (behavior* or behaviour*) N1 analy*)
S47	TI ((acceptance* or commitment*) N1 (therap* or treatment*)) OR AB ((acceptance* or commitment*) N1 (therap* or treatment*))
S46	(MH "Acceptance and Commitment Therapy")
S45	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32 OR S33 OR S34 OR S35 OR S36 OR S37 OR S38 OR S39 OR S40 OR S41 OR S42 OR S43 OR S44
S44	TI (vagin* penetrat* disorder*) OR AB (vagin* penetrat* disorder*)
S43	TI vaginism* OR AB vaginism*
S42	TI (vagin* N1 wind) OR AB (vagin* N1 wind)
S41	TI (vagin* N3 laxity*) OR AB (vagin* N3 laxity*)
S40	TI (obstruct* N3 intercourse) OR AB (obstruct* N3 intercourse)
S39	TI (obstruct* N3 intercourse) OR AB (obstruct* N3 intercourse)
S38	TI (female N1 sex* N (dysfunct* or satisf* or problem* or symptom* or arous* or activit* or disorder*)) OR AB (female N1 sex* N (dysfunct* or satisf* or problem* or symptom* or arous* or activit* or disorder*))
S37	(MH "Sexual Dysfunction, Female")
S36	TI ((rectal or rectum) N3 urge*) OR AB ((rectal or rectum) N3 urge*)
S35	TI puborectal* contract* OR AB puborectal* contract*
S34	TI anismus* OR AB anismus*
S33	TI pelvi* outlet* obstruct* OR AB pelvi* outlet* obstruct*
S32	TI (pelvi* N3 dyskines*) OR AB (pelvi* N3 dyskines*)
S31	TI (pelvi* N3 dyskines*) OR AB (pelvi* N3 dyskines*)
S30	TI (dys?ynerg* N1 (defecat* or defaecat*)) OR AB (dys?ynerg* N1 (defecat* or defaecat*))
S29	TI outlet* dysfunction* constipa* OR AB outlet* dysfunction* constipa*
S28	TI ((defecat* or defaecat* or evacuat*) N3 (disorder* or dysfunction*)) OR AB ((defecat* or defaecat* or evacuat*) N3 (disorder* or dysfunction*))
S27	TI (obstruct* N3 (defecat* or defaecat*)) OR AB (obstruct* N3 (defecat* or defaecat*))
S26	TI ((difficult* or delay* or irregular* or infrequen* or pain*) N3 (defecat* or defaecat* or stool* or faeces or feces or bowel movement*)) OR AB ((difficult* or delay* or irregular* or infrequen* or pain*) N3 (defecat* or defaecat* or stool* or faeces or feces or bowel movement*))
S25	(MH "Feces, Impacted")
S24	TI ((urogeni* or anorec* or ano-rec* or ano rec*) N3 dysfunction*) OR AB ((urogeni* or anorec* or ano-rec* or ano rec*) N3 dysfunction*)
S23	TI (empty* N1 disorder* N3 (bowel* or bladder* or vesical* or stool*)) OR AB (empty* N1 disorder* N3 (bowel* or bladder* or vesical* or stool*))
S22	TI (voiding N1 (disorder* or dysfunction* or problem*)) OR AB (voiding N1 (disorder* or dysfunction* or problem*))
S21	TI (urin* N3 (retention* or retain*)) OR AB (urin* N3 (retention* or retain*))
S20	(MH "Urinary Retention")
S19	TI ((faecal or fecal or faeces or feces or fecally or faecally or anal or anally or stool or stools or bowel or double or defecat* or defaecat*) N5 (incontinence or incontinent or urge* or leak or leaking or leakage or soiling or seeping or seepage or impacted or impaction))
S18	(MM "Fecal Incontinence")
S17	TI (urethroc?ele* or enteroc?ele* or sigmoidoc?ele* or proctoc?ele* or rectoc?ele* or cystoc?ele* or rectoenteroc?ele* or cystourethroc?ele*)
S16	TI (hernia* N3 (pelvi* or vagin* or urogenital* or uter* or bladder* or urethr* or viscer*))
S15	TI (splanchnoptos* or visceroptos*)

#	Searches
S14	TI ((vagin* or urogenital* or genit* or uter* or viscer* or anterior* or posterior* or apical or pelvi* or vault* or urethr* or bladder* or cervi* or rectal or rectum) N3 prolaps*)
S13	TI (urinary N3 bladder N3 prolaps*)
S12	TI (pelvic* N3 organ* N3 prolaps*)
S11	(MM "Pelvic Organ Prolapse+") OR (MM "Rectocele")
S10	TI (SUI or OAB)
S9	TI ((urin* or bladder*) N2 (urg* or frequen*))
S8	TI ((urgency N2 frequency) or (frequency N2 urgency))
S7	TI (detrusor* N5 (overactiv* or over activ* or over-activ* or instabilit* or hyper-reflex* or hyperreflex* or hyper reflex*))
S6	TI (bladder* N5 (overactiv* or over activ* or over-activ* or instabilit* or hyper-reflex* or hyperreflex* or hyper reflex* or incontinen*))
S5	TI ((stress* or mix* or urg* or urin*) N5 incontinen*)
S4	(MM "Urinary Incontinence+") OR (MM "Overactive Bladder")
S3	TI (pelvi* N1 (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or care* or health* or wellbeing* or well-being* or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or over activ* or over-activ*)) OR AB (pelvi* N1 (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or care* or health* or wellbeing* or well-being* or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or over activ* or over-activ*))
S2	TI (pelvi* N1 (floor* or diaphragm*) N33 (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or change* or care* or health* or wellbeing* or well-being* or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or over activ* or over-activ*)) OR AB (pelvi* N1 (floor* or diaphragm*) N33 (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or change* or care* or health* or wellbeing* or well-being* or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or over activ* or over-activ*))
S1	(MH "Pelvic Floor Disorders") OR (MH "Pelvic Floor Muscles")

Database(s): PsycINFO 1806 to January Week 1 2020 **– OVID interface**
Date of last search: 9 January 2020

#	Searches
1	pelvis floor/
2	pelvic floor disorder/
3	(pelvi$ adj (floor$ or diaphragm$) adj3 (dysfunction$ or disorder$ or fail$ or impair$ or incompeten$ or insufficien$ or dyssynerg$ or symptom$ or laxity or change$ or care$ or health$ or wellbeing$ or well-being$ or prevent$ or rehabilitat$ or weak$ or hypertonic$ or overactiv$ or over activ$ or over-activ$)).tw.
4	(pelvi$ adj (dysfunction$ or disorder$ or fail$ or impair$ or incompeten$ or insufficien$ or dyssynerg$ or symptom$ or laxity or care$ or health$ or wellbeing$ or well-being$ or prevent$ or rehabilitat$ or weak$ or hypertonic$ or overactiv$ or over activ$ or over-activ$)).tw.
5	or/1-4
6	exp *Urinary Incontinence/
7	*overactive bladder/
8	*bladder instability/
9	((stress$ or mix$ or urg$ or urin$) adj5 incontinen$).ti.
10	(bladder$ adj5 (overactiv$ or over activ$ or over-activ$ or instabilit$ or hyper-reflex$ or hyperreflex$ or hyper reflex$ or incontinen$)).ti.
11	(detrusor$ adj5 (overactiv$ or over activ$ or over-activ$ or instabilit$ or hyper-reflex$ or hyperreflex$ or hyper reflex$)).ti.
12	((urgency adj2 frequency) or (frequency adj2 urgency)).ti.
13	((urin$ or bladder$) adj2 (urg$ or frequen$)).ti.
14	(SUI or OAB).ti.
15	or/6-14
16	exp *pelvic organ prolapse/
17	*rectocele/
18	(pelvic$ adj3 organ$ adj3 prolaps$).ti.
19	(urinary adj3 bladder adj3 prolaps$).ti.
20	((vagin$ or urogenital$ or genit$ or uter$ or viscer$ or anterior$ or posterior$ or apical or pelvi$ or vault$ or urethr$ or bladder$ or cervi$ or rectal or rectum) adj3 prolaps$).ti.
21	(splanchnoptos$ or visceroptos$).ti.
22	(hernia$ adj3 (pelvi$ or vagin$ or urogenital$ or uter$ or bladder$ or urethr$ or viscer$)).ti.
23	(urethroc?ele$ or enteroc?ele$ or sigmoidoc?ele$ or proctoc?ele$ or rectoc?ele$ or cystoc?ele$ or rectoenteroc?ele$ or cystourethroc?ele$).ti.
24	or/16-23
25	exp *Fecal Incontinence/
26	((faecal or fecal or faeces or feces or fecally or faecally or anal or anally or stool or stools or bowel or double or defecat$ or defaecat$) adj5 (incontinence or incontinent or urge$ or leak or leaking or leakage or soiling or seeping or seepage or impacted or impaction)).ti.
27	25 or 26
28	urine retention/
29	(urin$ adj3 (retention$ or retain$)).tw.
30	(voiding adj (disorder$ or dysfunction$ or problem$)).tw.
31	(empty$ adj disorder$ adj3 (bowel$ or bladder$ or vesical$ or stool$)).tw.
32	((urogeni$ or anorec$ or ano-rec$ or ano rec$) adj3 dysfunction$).tw.

#	Searches
33	defecation disorder/
34	feces impaction/
35	((difficult$ or delay$ or irregular$ or infrequen$ or pain$) adj3 (defecat$ or defaecat$ or stool$ or faeces or feces or bowel movement$)).tw.
36	(obstruct$ adj3 (defecat$ or defaecat$)).tw.
37	((defecat$ or defaecat$ or evacuat$) adj3 (disorder$ or dysfunction$)).tw.
38	outlet$ dysfunction$ constipa$.tw.
39	(dys?ynerg$ adj (defecat$ or defaecat$)).tw.
40	(pelvi$ adj3 dyskines$).tw.
41	pelvi$ outlet$ obstruct$.tw.
42	anismus$.tw.
43	puborectal$ contract$.tw.
44	((rectal or rectum) adj3 urge$).tw.
45	or/28-44
46	female sexual dysfunction/
47	(female adj sex$ adj (dysfunct$ or satisf$ or problem$ or symptom$ or arous$ or activit$ or disorder$)).tw.
48	(obstruct$ adj3 intercourse).tw.
49	(vagin$ adj3 laxity$).tw.
50	(vagin$ adj wind).tw.
51	Vaginismus/
52	vaginismus$.tw.
53	(vagin$ adj penetrat$ adj disorder$).tw.
54	or/46-53
55	5 or 15 or 24 or 27 or 45 or 54
56	"Acceptance and Commitment Therapy"/
57	((acceptance$ or commitment$) adj (therap$ or treatment$)).tw.
58	(applied$ adj (behavior$ or behaviour$) adj analy$).tw.
59	*Behavior Therapy/
60	Dialectical Behavior Therapy/
61	((behavior$ or behaviour$) adj therap$).tw.
62	Cognitive Behavior Therapy/
63	Cognitive Therapy/
64	(CBT$ adj3 (technique$ or strateg$ or process$ or treatment$ or therap$ or exercise$ or rehabilitation$ or session$)).tw.
65	(cogniti$ adj3 (therap$ or psychotherapy$ or psycho-therap$)).tw.
66	(cognitiv$ adj3 remediat$).tw.
67	Social Support/
68	Support Groups/
69	((support or therapeutic$ or telephone$) adj group$).tw.
70	(group$ adj (therap$ or educat$)).tw.
71	Counseling/
72	(counseling or counselling).ti.
73	Dialectical Behavior Therapy/
74	dialectical$.tw.
75	Psychotherapy/
76	((interpersonal$ or inter-personal$ or dynamic$) adj (psychotherapy$ or psycho-therap$)).tw.
77	Psychodynamic Psychotherapy/
78	((psychodynamic$ or psycho-dynamic$) adj3 (psychotherapy$ or psycho-therap$ or approach$ or intervention$ or support$ or group$ or therap$)).tw.
79	((behavior$ or behaviour$) adj (psychotherapy$ or psycho-therap$)).tw.
80	Self-Help Techniques/
81	Self-Care Skills/
82	(guide$ adj (selfhelp$ or self-help$)).tw.
83	((selfhelp$ or self-help$) adj (approach$ or intervention$ or support$ or group$ or therap$ or strateg$)).tw.
84	Humanism/
85	humanist$.tw.
86	(humanist$ adj3 therap$).tw.
87	Hypnosis/
88	Hypnotherapy/
89	(hypnosis or hypnotherap$).tw.
90	Mindfulness/
91	Mindfulness-Based Interventions/
92	Meditation/
93	Psychoeducation/
94	(mindfulness-based or mindfulnessbased).tw.
95	(mindfulness$ adj3 therap$).tw.
96	Motivational Interviewing/
97	(motivational$ adj3 interview$).tw.
98	Personal Values/
99	(value$ adj (intervention$ or therap$)).tw.

#	Searches
100	Psychoanalysis/
101	((psychosexual$ or psycho-sexual$ or sexodynamic$ or sexological$) adj (approach$ or intervention$ or support$ or group$ or therap$ or treatment$ or service$ or gyn?ecolog$)).tw.
102	Psychosocial Rehabilitation/
103	((psychoeducat$ or psycho-educat$ or psychosocial$ or psycho-social$) adj (approach$ or intervention$ or support$ or group$ or therap$ or treatment$ or service$ or gyn?ecolog$)).tw.
104	(psycholog$ adj intervention$).tw.
105	Telemedicine/
106	Telerehabilitation/
107	Online Therapy/
108	(online adj therap$).tw.
109	(e-therap$ or etherap$).tw.
110	(helpline$ or help line$ or help-line$ or hotline$ or hot line$ or hot-line$).tw.
111	((telephone$ or phone$ or smartphone$) adj (support$ or counsel$)).tw.
112	((mobile$ or mHealth$ or eHealth$) adj (communicat$ or technolog$)).tw.
113	or/56-112
114	55 and 113
115	limit 114 to (english language and yr="1980 -Current") [General Exclusions filter applied]

Economic Search

One global search was conducted for economic evidence across the guideline.

Database(s): NHS Economic Evaluation Database (NHS EED); HTA Database – CRD interface

Date of last search: 3 February 2021

#	Searches
1	MeSH DESCRIPTOR Pelvic Floor IN NHSEED,HTA
2	MeSH DESCRIPTOR Pelvic Floor Disorders IN NHSEED,HTA
3	MeSH DESCRIPTOR Urinary Bladder, Overactive IN NHSEED,HTA
4	(((pelvi* NEXT (floor* or diaphragm*) NEAR3 (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or change* or care* or health* or wellbeing* or well-being* or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or over activ* or over-activ*)))) IN NHSEED, HTA
5	MeSH DESCRIPTOR Urinary Incontinence EXPLODE ALL TREES IN NHSEED,HTA
6	MeSH DESCRIPTOR Urinary Bladder, Overactive IN NHSEED,HTA
7	((((stress* or mix* or urg* or urin*) NEAR5 incontinen*))) IN NHSEED, HTA
8	(((bladder* NEAR5 (overactiv* or over activ* or over-activ* or instabilit* or hyper-reflex* or hyperreflex* or hyper reflex* or incontinen*)))) IN NHSEED, HTA
9	(((detrusor* NEAR5 (overactiv* or over activ* or over-activ* or instabilit* or hyper-reflex* or hyperreflex* or hyper reflex*)))) IN NHSEED, HTA
10	((((urgency NEAR2 frequency) or (frequency NEAR2 urgency)))) IN NHSEED, HTA
11	((((urin* or bladder*) NEAR2 (urg* or frequen*)))) IN NHSEED, HTA
12	(((SUI or OAB))) IN NHSEED, HTA
13	MeSH DESCRIPTOR Pelvic Organ Prolapse EXPLODE ALL TREES IN NHSEED,HTA
14	MeSH DESCRIPTOR Rectocele IN NHSEED,HTA
15	(((pelvic* NEAR3 organ* NEAR3 prolaps*))) IN NHSEED, HTA
16	(((urinary NEAR3 bladder NEAR3 prolaps*))) IN NHSEED, HTA
17	((((vagin* or urogenital* or genit* or uter* or viscer* or anterior* or posterior* or apical or pelvi* or vault* or urethr* or bladder* or cervi* or rectal or rectum) NEAR3 prolaps*))) IN NHSEED, HTA
18	(((splanchnoptos* or visceroptos*))) IN NHSEED, HTA
19	(((hernia* NEAR3 (pelvi* or vagin* or urogenital* or uter* or bladder* or urethr* or viscer*)))) IN NHSEED, HTA
20	(((urethroc?ele* or enteroc?ele* or sigmoidoc?ele* or proctoc?ele* or rectoc?ele* or cystoc?ele* or rectoenteroc?ele* or cystourethroc?ele*))) IN NHSEED, HTA
21	MeSH DESCRIPTOR Fecal Incontinence IN NHSEED,HTA
22	((((faecal or fecal or faeces or feces or fecally or faecally or anal or anally or stool or stools or bowel or double or defecat* or defaecat*) NEAR5 (incontinence or incontinent or urge* or leak or leaking or leakage or soiling or seeping or seepage or impacted or impaction)))) IN NHSEED, HTA
23	MeSH DESCRIPTOR Urinary Retention IN NHSEED,HTA
24	(((urin* NEAR3 (retention* or retain*)))) IN NHSEED, HTA
25	(((voiding NEXT (disorder* or dysfunction* or problem*)))) IN NHSEED, HTA
26	(((empty* NEXT disorder* NEAR3 (bowel* or bladder* or vesical* or stool*)))) IN NHSEED, HTA
27	((((urogeni* or anorec* or ano-rec* or ano rec*) NEAR3 dysfunction*))) IN NHSEED, HTA
28	MeSH DESCRIPTOR Fecal Impaction IN NHSEED,HTA
29	((((difficult* or delay* or irregular* or infrequen* or pain*) NEAR3 (defecat* or defaecat* or stool* or faecal or fecal or faeces or feces or fecally or faecally or bowel movement*)))) IN NHSEED, HTA
30	(((obstruct* NEAR3 (defecat* or defaecat*)))) IN NHSEED, HTA
31	((((defecat* or defaecat* or evacuat*) NEAR3 (disorder* or dysfunction*)))) IN NHSEED, HTA
32	((((outlet* NEXT dysfunction* NEXT constipa*)))) IN NHSEED, HTA
33	(((dys?ynerg* NEXT (defecat* or defaecat*)))) IN NHSEED, HTA

#	Searches
34	(((pelvi* NEAR3 dyskines*))) IN NHSEED, HTA
35	(((pelvi* NEXT outlet* NEXT obstruct*))) IN NHSEED, HTA
36	(((anismus*))) IN NHSEED, HTA
37	(((puborectal* NEXT contract*))) IN NHSEED, HTA
38	((((rectal or rectum) NEAR3 urge*))) IN NHSEED, HTA
39	(((female NEXT sex* NEXT (dysfunct* or satisf* or problem* or symptom* or arous* or activit* or disorder*)))) IN NHSEED, HTA
40	(((obstruct* NEAR3 intercourse))) IN NHSEED, HTA
41	(((vagin* NEAR3 laxity*))) IN NHSEED, HTA
42	(((vagin* NEXT wind))) IN NHSEED, HTA
43	MeSH DESCRIPTOR Vaginismus IN NHSEED,HTA
44	(((vaginismus*))) IN NHSEED, HTA
45	(((vagin* NEXT penetrat* NEXT disorder*))) IN NHSEED, HTA
46	(#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40 OR #41 OR #42 OR #43 OR #44 OR #45) IN NHSEED, HTA

Database(s): Medline & Embase (Multifile) – OVID interface
Embase Classic+Embase 1947 to 2021 February 01; **Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily** 1946 to February 01, 2021
Date of last search: 3 February 2021

Multifile database codes: emczd = Embase Classic+Embase; ppez= MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily

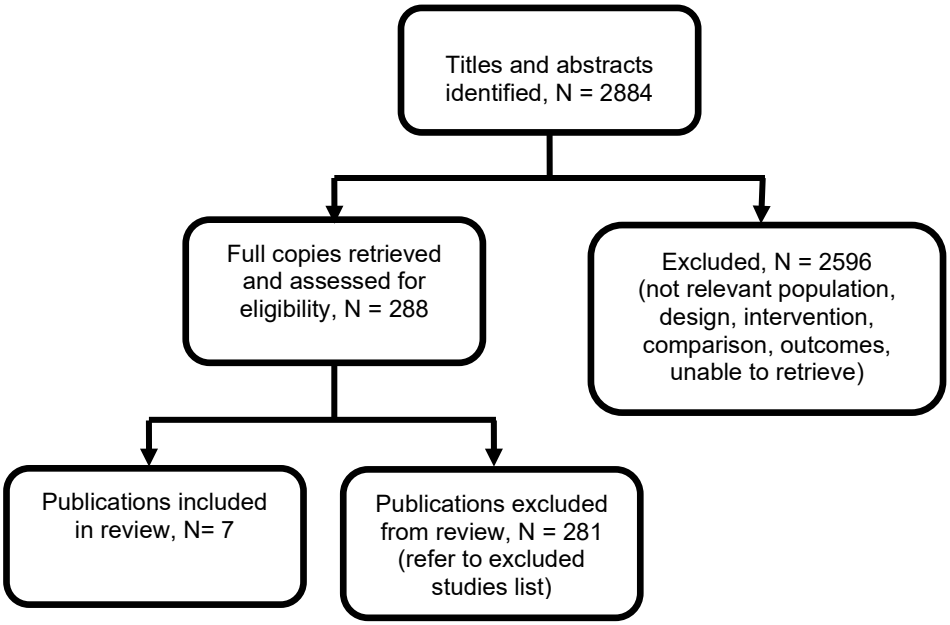
#	Searches
1	Pelvic Floor/ use ppez
2	Pelvic Floor Disorders/ use ppez
3	pelvis floor/ use emczd
4	pelvic floor disorder/ use emczd
5	(pelvi$ adj (floor$ or diaphragm$) adj3 (dysfunction$ or disorder$ or fail$ or impair$ or incompeten$ or insufficien$ or dyssynerg$ or symptom$ or laxity or change$ or care$ or health$ or wellbeing$ or well-being$ or prevent$ or rehabilitat$ or weak$ or hypertonic$ or overactiv$ or over activ$ or over-activ$)).tw.
6	(pelvi$ adj (dysfunction$ or disorder$ or fail$ or impair$ or incompeten$ or insufficien$ or dyssynerg$ or symptom$ or laxity or care$ or health$ or wellbeing$ or well-being$ or prevent$ or rehabilitat$ or weak$ or hypertonic$ or overactiv$ or over activ$ or over-activ$)).tw.
7	or/1-6
8	exp *Urinary Incontinence/ use ppez
9	*Urinary Bladder, Overactive/ use ppez
10	exp *urine incontinence/ use emczd
11	*overactive bladder/ use emczd
12	*bladder instability/ use emczd
13	((stress$ or mix$ or urg$ or urin$) adj5 incontinen$).ti.
14	(bladder$ adj5 (overactiv$ or over activ$ or over-activ$ or instabilit$ or hyper-reflex$ or hyperreflex$ or hyper reflex$ or incontinen$)).ti.
15	(detrusor$ adj5 (overactiv$ or over activ$ or over-activ$ or instabilit$ or hyper-reflex$ or hyperreflex$ or hyper reflex$)).ti.
16	((urgency adj2 frequency) or (frequency adj2 urgency)).ti.
17	((urin$ or bladder$) adj2 (urg$ or frequen$)).ti.
18	(SUI or OAB).ti.
19	or/8-18
20	exp *Pelvic Organ Prolapse/ use ppez
21	exp *pelvic organ prolapse/ use emczd
22	*Rectocele/ use ppez
23	*rectocele/ use emczd
24	(pelvic$ adj3 organ$ adj3 prolaps$).ti.
25	(urinary adj3 bladder adj3 prolaps$).ti.
26	((vagin$ or urogenital$ or genit$ or uter$ or viscer$ or anterior$ or posterior$ or apical or pelvi$ or vault$ or urethr$ or bladder$ or cervi$ or rectal or rectum) adj3 prolaps$).ti.
27	(splanchnoptos$ or visceroptos$).ti.
28	(hernia$ adj3 (pelvi$ or vagin$ or urogenital$ or uter$ or bladder$ or urethr$ or viscer$)).ti.
29	(urethroc?ele$ or enteroc?ele$ or sigmoidoc?ele$ or proctoc?ele$ or rectoc?ele$ or cystoc?ele$ or rectoenteroc?ele$ or cystourethroc?ele$).ti.
30	or/20-29
31	*Fecal Incontinence/ use ppez
32	*feces incontinence/ use emczd
33	((faecal or fecal or faeces or feces or fecally or faecally or anal or anally or stool or stools or bowel or double or defecat$ or defaecat$) adj5 (incontinence or incontinent or urge$ or leak or leaking or leakage or soiling or seeping or seepage or impacted or impaction)).ti.

#	Searches
34	or/31-33
35	Urinary Retention/ use ppez
36	urine retention/ use emczd
37	(urin$ adj3 (retention$ or retain$)).tw.
38	(voiding adj (disorder$ or dysfunction$ or problem$)).tw.
39	(empty$ adj disorder$ adj3 (bowel$ or bladder$ or vesical$ or stool$)).tw.
40	((urogeni$ or anorec$ or ano-rec$ or ano rec$) adj3 dysfunction$).tw.
41	defecation disorder/ use emczd
42	Fecal Impaction/ use ppez
43	Feces Impaction/ use emczd
44	((difficult$ or delay$ or irregular$ or infrequen$ or pain$) adj3 (defecat$ or defaecat$ or stool$ or faeces or feces or bowel movement$)).tw.
45	(obstruct$ adj3 (defecat$ or defaecat$)).tw.
46	((defecat$ or defaecat$ or evacuat$) adj3 (disorder$ or dysfunction$)).tw.
47	outlet$ dysfunction$ constipa$.tw.
48	(dys?ynerg$ adj (defecat$ or defaecat$)).tw.
49	(pelvi$ adj3 dyskines$).tw.
50	pelvi$ outlet$ obstruct$.tw.
51	anismus$.tw.
52	puborectal$ contract$.tw.
53	((rectal or rectum) adj3 urge$).tw.
54	or/35-53
55	female sexual dysfunction/ use emczd
56	(female adj sex$ adj (dysfunct$ or satisf$ or problem$ or symptom$ or arous$ or activit$ or disorder$)).tw.
57	(obstruct$ adj3 intercourse).tw.
58	(vagin$ adj3 laxity$).tw.
59	(vagin$ adj wind).tw.
60	Vaginismus/ use ppez
61	vaginism/ use emczd
62	vaginismus$.tw.
63	(vagin$ adj penetrat$ adj disorder$).tw.
64	or/55-63
65	7 or 19 or 30 or 34 or 54 or 64
66	Economics/ use ppez
67	Value of life/ use ppez
68	exp "Costs and Cost Analysis"/ use ppez
69	exp Economics, Hospital/ use ppez
70	exp Economics, Medical/ use ppez
71	Economics, Nursing/ use ppez
72	Economics, Pharmaceutical/ use ppez
73	exp "Fees and Charges"/ use ppez
74	exp Budgets/ use ppez
75	health economics/ use emczd
76	exp economic evaluation/ use emczd
77	exp health care cost/ use emczd
78	exp fee/ use emczd
79	budget/ use emczd
80	funding/ use emczd
81	budget*.ti,ab.
82	cost*.ti.
83	(economic* or pharmaco?economic*).ti.
84	(price* or pricing*).ti,ab.
85	(cost* adj2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)).ab.
86	(financ* or fee or fees).ti,ab.
87	(value adj2 (money or monetary)).ti,ab.
88	or/66-87
89	65 and 88
90	limit 89 to english language

Appendix C – Clinical evidence study selection

Study selection for: What is the effectiveness of psychological interventions for women with symptoms associated with pelvic floor dysfunction?

Figure 1: Study selection flow chart



Appendix D – Clinical evidence tables

Evidence tables for review question: What is the effectiveness of psychological interventions for women with symptoms associated with pelvic floor dysfunction?

Table 5: Evidence tables

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
Full citation Carty, J. N., Ziadni, M. S., Holmes, H. J., Tomakowsky, J., Peters, K., Schubiner, H., Lumley, M. A., The Effects of a Life Stress Emotional Awareness and Expression Interview for Women with Chronic Urogenital Pain: A Randomized Controlled Trial, Pain medicine, 24, 2018 **Ref Id** 1176409 **Country/ies where the study was carried out** USA **Study type** Parallel group RCT	**Sample size** N=70 Intervention n=45 Control n=25 **Characteristics** <u>Mean age (SD)</u> Intervention 44.89 years (15.34) control 47.72 years (14.88) <u>Mean duration of pelvic symptoms (SD)</u> Intervention 8.33 years (10.29) control 7.36 years (8.83) Pain Severity, Brief Pain Inventory: Intervention 3.87 (2.03), control 4.24 (1.64) Pain interference, Brief Pain Inventory: Intervention 3.85 (2.47), control 5.92 (3.19) Pelvic Floor Symptoms, Pelvic Floor Distress Inventory-Short Form-20: Intervention 20.37 (12.48), control 27.63 (14.24) Depression, Brief Symptom Inventory-18: Intervention 0.61 (0.76), control 1.27 (1.05)	**Interventions** A 90-minute interview or treatment as usual. Intervention group: A 90-minute interview with one of two trained female doctoral (clinical psychology) students and audio recorded for supervision by a licenced clinical psychologist. The interview was designed to increase the patient's awareness of their physical and psychological health through their lives and the role stress played. The interview had 4 phases: Phase 1: Around 10-15 minutes. Life history of health and physical symptoms, created a visual timeline. Phase 2: Around 30 minutes. Added to the timeline stressful or traumatic (including neglect, physical and sexual abuse) life experiences, relationships with important people with their lives. Links between stressors and physical health issues were pointed out	**Details** Patients were randomly assigned in a 2:1 ratio to a 90-minute interview (intervention) or treatment as usual (control). Patients were scheduled for a follow up appointment 6 weeks after randomisation. Patients continued with their usual medical, behavioural or psychiatric care.	**Results** Study completed by n=37 in the intervention group (n=8 not available) and n=25 in the control group. <u>Pain severity</u> Intervention (n=37): Follow up 3.30 (2.24) Adjusted follow up 3.42 (0.26), Control (n=25): Follow up 4.51 (1.61) Adjusted follow up 4.33 (0.32), Condition effect 4.52 <u>Pain Interference</u> Intervention (n=37): Follow up 3.31 (2.50) Adjusted follow up 3.81 (0.34), Control (n=25): Follow up 4.84 (2.72) Adjusted follow up 4.1 (0.42), Condition effect 0.26	**Limitations** Limitations were assessed using the revised Cochrane risk-of-bias tool for randomised trials (RoB2). Domain 1-randomisation: Low risk 1.1: Yes, randomisation schedule created by an independent investigator using a web based tool 1.2: Yes, sealed documentation 1.3: No Domain 2a- Deviations from intended interventions (effect of assignment to interventions): Low risk 2.1: Yes, due to the nature of the intervention, participants were aware of the intervention assignment

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
Aim of the study To assess whether an intensive, patients' life stress targeted interview with women diagnosed with chronic urogenital pain effects pain severity and pelvic symptoms, and psychological symptoms **Study dates** September 2014 - January 2016 (dates taken from the Clinical Trials Registry: NCT02286115) **Source of funding** Student Award from the Blue Cross Blue Shield of Michigan Foundation and grants from the National Institute of Arthritis and Musculoskeletal and Skin Diseases	Anxiety, Brief Symptom Inventory-18: Intervention 0.79 (0.77), control 1.18 (0.87) **Inclusion criteria** • Women aged 18 to 80 • Diagnosed with chronic urogenital pain conditions **Exclusion criteria** • Current psychotic disorder • Cognitively impaired or had dementia • Unable to communicate or read in English • Were deemed too psychiatrically unstable by their clinician	Phase 3: Around 30 minutes. Patients were encouraged to express 2 important relational emotions as if the person was there. Phase 4: Around 10-15 minutes. Reflected on what they had learnt and a summary of their strengths and weaknesses Participants received a handout describing the relationship between emotions, emotional suppression and health Control: Treatment as usual		<u>Pelvic Floor Symptoms</u> Intervention (n=37): Follow up 15.86 (11.69) Adjusted follow up 17.74 (1.49), Control (n=25): Follow up 27.46 (15.20) Adjusted follow up 24.67 (1.84), Condition effect 8.01 <u>Depression</u> Intervention (n=37): Follow up 0.64 (0.73) Adjusted follow up 0.83 (0.10), Control (n=25): Follow up 1.04 (1.03) Adjusted follow up 0.75 (0.12), Condition effect 0.20 <u>Anxiety</u> Intervention (n=37): Follow up 0.72 (0.67) Adjusted follow up 0.82 (0.09), Control (n=25): Follow up 1.05 (0.87) Adjusted follow up 0.90 (0.11), Condition effect 0.30	2.2. Yes 2.3. No, no differences in drop outs 2.6. Yes, ITT analysis conducted Domain 2b- Deviations from intended interventions (effect of adhering to the interventions): Some concerns 2.1: Yes 2.2. Yes 2.3. No Information 2.4. Probably no 2.5. No, higher loss to follow up in control arm 2.6 Probably yes Domain 3 - Risk of bias due to missing outcome data: High risk 3.1. No, 20% loss to follow up in control arm 3.2. No, imputed data may not account for differences 3.3. Yes 3.4. Probably yes, different amounts of missing data between groups Domain 4 - Measurement of the outcome: High risk 4.1. No 4.2. No 4.3. Yes, all self-report measures

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
					4.4. Yes 4.5 No Domain 5- Selection of the reported result: Low risk 5.1. Yes 5.2. Probably no 5.3. No **Domain 6- Overall judgment of bias: High risk** **Other information**
Full citation Felsted, Katarina Friberg, Supiano, Katherine P., Mindfulness-Based Stress Reduction Versus a Health Enhancement Program in the Treatment of Urge Urinary Incontinence in Older Adult Women: A Randomized Controlled Feasibility Study, Research in Gerontological Nursing, 12, 285-297, 2019 **Ref Id**	**Sample size** N=25 Intervention n=13 Control n=12 **Characteristics** <u>Mean age (SD)</u> 73.52 years (8.45) <u>Mean BMI (SD)</u> 28.33 kg/m^2 (8.88) <u>History of pregnancy (%):</u> Yes: Intervention: 12 (92.3) Control 11 (91.7) No: Intervention: 1 (7.7) Control 1 (8.3) Mean number of term pregnancies: 3.44 (SD 2.55) <u>Life Stressors (%):</u>	**Interventions** Mindfulness-Based stress reduction vs. a health enhancement program <u>Intervention group</u> 8 weekly sessions, approximately 2 hours each MBSR protocol standardisation intervention focused on mindfulness Daily homework practice <u>Control group</u> 8 weekly sessions, approximately 2 hours each HEP protocol standardisation intervention focused on functional movement, nutrition, physical activity and music therapy Daily homework practice	**Details** Both MBSR and HEP interventionists confirmed 100% of the content was delivered	**Results** <u>Retention</u> Intervention 11/13 (84.6%) control 8/12 (66.7%)	**Limitations** Limitations were assessed using the revised Cochrane risk-of-bias tool for randomised trials (RoB2). Domain 1- randomisation: Low risk 1.1: Yes, block randomisation 1.2: Yes, sealed envelopes 1.3: Probably no Domain 2a- Deviations from intended interventions (effect of assignment to interventions): Low risk 2.1: No 2.2. No information

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
1197803 **Country/ies where the study was carried out** USA **Study type** Parallel group RCT **Aim of the study** Determine the research and intervention feasibility of a RCT comparing Mindfulness-Based stress reduction (MBSR) and health enhancement program (HEP) in older adult women presenting with urge urinary incontinence **Study dates** Not reported **Source of funding** Not reported	Yes: Intervention: 2 (15.4) Control 4 (33.3) No: Intervention: 11 (84.6) Control 8 (66.7) **Inclusion criteria** • menopausal, emphasis on over 65 • experience moderate to severe levels of urge urinary incontinence for at least 3 months (>3 Incontinence Severity Index) • having predominant urges not stress UI • committed to attending 8 weekly sessions and half a day retreat • no pharmacological therapy for UUI within 3 weeks of the start of the intervention and no plans to start during the intervention • no previous botox or neurostimulation for UUI and no plans to receive it during the intervention • no or mild cognitive impairment • ability to speak, read and write English				2.3. No information, no reported deviations 2.6. Probably yes Domain 2b- Deviations from intended interventions (effect of adhering to the interventions): Low risk 2.1: No 2.2. No information 2.3. No information 2.6. Yes, only adherence data Domain 3 - Risk of bias due to missing outcome data: Low risk 3.1. Yes 3.2. Probably yes 3.3. No, only adherence data Domain 4 - Measurement of the outcome: Low risk 4.1. No 4.2. No 4.3. Probably yes 4.4. No, attendance to appointments was the only data Domain 5- Selection of the reported result: Low Risk 5.1. Yes, feasibility and intervention objectives predetermined 5.2. No

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
	Exclusion criteria Not reported				5.3. No, retention measured only Domain 6- Overall judgment of bias: Low risk **Other information**
Full citation Komesu, Y. M., Sapien, R. E., Rogers, R. G., Ketai, L. H., Hypnotherapy for treatment of overactive bladder: a randomized controlled trial pilot study, Female Pelvic Medicine & Reconstructive Surgery Female pelvic med, 17, 308-13, 2011 **Ref Id** 1176473 **Country/ies where the study was carried out** US **Study type**	**Sample size** N = 22 Hypnotherapy = 11 Behavioural therapy = 11 Analysed, N = 20 (1 participant excluded from analysis in each arm, both discontinued intervention). **Characteristics** <u>Mean age (SD)</u> Hypnotherapy group: 51.1 years (14.0) Behavioural group: 56.0 years (7.4) <u>Parity</u> Hypnotherapy group: 0 = 30%, 1 = 30%, 2 = 20%, 3 = 20%, ≥4 = 10% Behavioural group: 0 =20%, 1 = 30%, 2 = 10%, 3 = 30%, ≥4 = 10% <u>Prior incontinence surgery</u>	**Interventions** <u>Hypnotherapy group</u> Three 60 minute sessions over 6 to 8 weeks with a certified clinical hypnotherapist During these sessions the hypnotherapist also replicated the patient counselling provided in the behavioural therapy group <u>Behavioural therapy</u> Visited a research nurse for three 60minute counselling sessions over 6 to 8 weeks.	**Details** Hypnotherapy The hypnotherapist explained hypnotherapeutic principals, used images to help with visualization of bladder relaxing and stretching. Subjects underwent hypnotic induction using guided imagery and therapeutic suggestion. Subjects were also advised to practice relaxation responses at home. During hypnosis potential emotions blocking OAB improvements were identified. At each session timed voiding and pelvic floor muscle exercises were discussed, and the behavioural therapy of the behaviour group was replicated. <u>Behavioural therapy</u> Voiding diaries were reviewed, and fluid management discussed and suggestions for changes in schedules made.	**Results** <u>Mean change in OAB-q SF Distress Score (SD)</u> Hypnotherapy group: 27.7 (14.4) Behavioural group: 21.3 (25.3) <u>Mean change in OAB-q SF QOL Score (SD)</u> Hypnotherapy group: 33.4 (15.2) Behavioural group: 19.0 (24.9) <u>Mean change in number of voids (SD)</u> Hypnotherapy group: 2.4 (2.0) Behavioural group: 1.4 (1.4) <u>Global impression of improvement (SD) (1=very much better, 7 = very much worse)</u>	**Limitations** Limitations were assessed using the revised Cochrane risk-of-bias tool for randomised trials (RoB2). Domain 1- randomisation: Low risk 1.1: Yes, computer generated sequence 1.2: Yes, sealed opaque envelopes used to conceal allocation 1.3: No Domain 2a- Deviations from intended interventions (effect of assignment to interventions): Low risk 2.1: Yes, due to nature of the interventions participants were aware of intervention assignment 2.2. Yes

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
Pilot, parallel-group randomised controlled trial **Aim of the study** To compare hypnotherapy to standard treatment (behavioural therapy) for OAB **Study dates** Not reported **Source of funding** Supported by DHHS/NIH/NCRR grant, The University of New Mexico Clinical and Translational Science Centre and grants from Pfizer.	Hypnotherapy group: 0% Behavioural group: 30% <u>History of hysterectomy</u> Hypnotherapy group: 60% Behavioural group: 50% <u>Past OAB therapy</u> Physical therapy: Hypnotherapy group = 50%, Behavioural group = 50% Anticholinergics: Hypnotherapy group = 70%, Behavioural group = 50% Voiding diary: Hypnotherapy group = 20%, Behavioural group = 60% Pelvic floor exercises: Hypnotherapy group = 30%, Behavioural group = 90% Timed voiding: Hypnotherapy group = 0%, Behavioural group = 40% **Inclusion criteria** • women with scores 8 or greater on the OAB awareness tool • women with or without urinary incontinence **Exclusion criteria** • women with untreated urinary tract infection		Timed voiding was initiated. Urge distraction techniques were also introduced. Pelvic floor exercises were discussed and practice encouraged.	Hypnotherapy group: 2.15 (0.30) Behavioural group: 3.40 (0.97) <u>Helpfulness of treatment (SD) (0=not helpful, 10 = extremely helpful)</u> Hypnotherapy group: 7.5 (2.1) Behavioural group: 4.7 (3.5)	2.3. Probably no, no differences in drop outs 2.6. Probably yes, limited information on data analysis Domain 2b- Deviations from intended interventions (effect of adhering to the interventions): Low risk 2.1: Yes 2.2. Yes 2.5. Probably no 2.6 Probably yes Domain 3 - Risk of bias due to missing outcome data: Low risk 3.1. yes, only 1 dropout 3.2. NA 3.3. Probably no Domain 4 - Measurement of the outcome: High risk 4.1. No 4.2. Probably no 4.3. Yes - self-report measures Domain 5- Selection of the reported result: Some concerns 5.1. No information 5.2. Probably no 5.3. No Domain 6- Overall judgment of bias: High risk

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
	• women with vaginal descent below the hymen with Valsalva or elevated post void residuals • non-English speaking • pregnant women • incarcerated women • women younger than 18 years • women with a history of psychosis				**Other information**
Full citation Osborne, L. A., Whittall, C. M., Edwards, D. J., Emanuel, R., Emery, S., Reed, P., Randomized control trial of a values-based motivational interview support to promote attendance at pelvic floor muscle training physiotherapy treatment, Journal of Pelvic, Obstetric & Gynaecological Physiotherapy, 38-46, 2016 **Ref Id** 1197568	**Sample size** N=31 Intervention n=16 Control n=15 **Characteristics** <u>Mean age (SD)</u> Intervention 50.33 years (11.56) Control 49.12 years (10.76) <u>Mean Body Mass Index (SD)</u> Intervention 30.00kg/m^2 (6.13) Control 30.94kg/m^2 (5.08) <u>PFD symptoms</u> SUI: 19.4% UUI: 6.5% MUI: 38.7% FI: 3.2% POP: 16.1% Both UI and POP: 16.1%	**Interventions** Motivational interviewing and values support (MIVS) vs. pelvic floor muscle training (PFMT) <u>Intervention MIVS</u> 3 20 minute sessions delivered on a group basis (7 or 8 participants) by a psychologist directly following sessions 2, 3 and 4 of PFMT Each session includes establishing a rapport, opening statement and setting an agenda, exploring chosen health behaviours and health related values exploration and clarification, exploration of ambivalence and readiness to change, negotiation of a plan to change and eliciting commitment, and summary Questions asked to focus participant's aims	**Details** PFMT over 6 months Sessions taken by clinical physiotherapy specialists, senior women's health physiotherapist, surgical nurse specialist or a psychosexual counsellor	**Results** <u>Mean number of classes attended</u> Intervention = 4.75 (1.39) control = 3.33 (1.63)	**Limitations** Limitations were assessed using the revised Cochrane risk-of-bias tool for randomised trials (RoB2). Domain 1-randomisation: Some concerns 1.1: Yes, random number generator 1.2: No information 1.3: No Domain 2a- Deviations from intended interventions (effect of assignment to interventions): Low risk 2.1: Yes, due to nature of the interventions, participants aware of intervention allocation.

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
Country/ies where the study was carried out Wales, UK **Study type** Parallel group RCT **Aim of the study** Assess the degree of the impact of motivational interviewing on pelvic floor muscle training compliance by measuring the attendance at physiotherapy sessions. **Study dates** Not reported **Source of funding** Not reported	**Inclusion criteria** • Mild to moderate depression or anxiety (HADS) **Exclusion criteria** Not reported	Kept a diary for motivation and reinforcement 6 60-minute group PFMT sessions and 2 individual sessions <u>Control PFMT</u> 6 60-minute group PFMT sessions and 2 individual sessions Participants were instructed to practice on a daily basis between sessions increasing number and duration of squeezes			2.2. Yes 2.3. No information 2.4. Probably not 2.6 Probably Yes, only data on adherence reported Domain 2b- Deviations from intended interventions (effect of adhering to the interventions): Low risk 2.1: Yes 2.2. Yes 2.3. No information 2.6. Probably yes - only adherence data Domain 3 - Risk of bias due to missing outcome data: Low risk 3.1. Yes 3.2. NA 3.3. NA 3.4. Probably no, only adherence data Domain 4 - Measurement of the outcome: Low risk 4.1. No 4.2. No 4.3. No information 4.4 Probably no - attendance to appointments is the only data Domain 5- Selection of the reported result: Some concerns

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
					5.1. No information 5.2. No 5.3. No **Domain 6- Overall judgment of bias: Some concerns** **Other information**
Full citation Ter Kuile, M. M., Melles, R., de Groot, H. E., Tuijnman-Raasveld, C. C., van Lankveld, Jjdm, Therapist-aided exposure for women with lifelong vaginismus: a randomized waiting-list control trial of efficacy, Journal of Consulting & Clinical PsychologyJ Consult Clin Psychol, 81, 1127-1136, 2013 **Ref Id** 1176733 **Country/ies where the study was carried out**	**Sample size** N=70 Intervention: n=35 Control n=35 **Characteristics** <u>Mean age (SD)</u> Intervention 28.54 years (7.83) control 29.29 years (6.92) Duration complaint, years: Intervention 9.61 (6.36), control 11.21 (6.71) <u>Sexual and physical abuse n (%)</u> Any sexual abuse: Intervention 11 (31), control 9 (26) Genitals touched: Intervention 8 (23), control 3 (9) Coerced into sexual acts: Intervention 8 (23), control 3 (9) Coerced into intercourse: Intervention 4 (12), control 1 (3)	**Interventions** Therapist aided exposure or waiting list control Intervention: Three 2 hour sessions at hospital where the participants were exposed to feared penetration objects. The female therapist and partner were in the room with the participant while the participant self-performed vaginal penetration exercises. Introductory session in week 1 then the first session in week 2 and in the following 5 weeks were the next 2 sessions. Control: No active treatment, on waiting list. After the trial (12 weeks) the participants received the intervention.	**Details** Sexual intercourse was assessed using a diary. Symptoms of vaginismus were measured using a subscale of the Golombok Rust Inventory of Sexual Satisfaction (GRISS), sexual pain was measured using Female Sexual Function Index (FSFI), negative and positive beliefs regarding vaginal penetration were measured using a subscale of the Vaginal Penetration Cognition Questionnaire (VPCQ), feelings of sexual disgust were measured using a subscale of the Sexual Disgust Questionnaire (SDQ-D-Familiar)	**Results** <u>Coitus n (%)</u> Baseline, intervention (n=35) 0 (0), control (n=35) 0 (0) 6 weeks, intervention (n=35) 31 (88.6), control (n=35) 0 (0) 12 weeks, intervention (n=35) 29 (82.9), control (n=31) 4 (11.4) <u>GRISS vaginismus mean (SD)</u> Baseline, intervention (n=35) 17.63 (2.56), control (n=35) 17.83 (2.50) 6 weeks, intervention (n=35) 9.10 (4.08), control (n=35) 17.06 (2.95) 12 weeks, intervention (n=35) 8.96 (3.68), control (n=31) 16.21 (4.03)	**Limitations** Limitations were assessed using the revised Cochrane risk-of-bias tool for randomised trials (RoB2). Domain 1-randomisation: Some concerns 1.1: Yes, block stratified 1.2: No information 1.3: No Domain 2a- Deviations from intended interventions (effect of assignment to interventions): Low risk 2.1: Yes, due to the nature of the intervention, participants aware of intervention assignment 2.2. Yes 2.3. Probably no

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
The Netherlands **Study type** See ter Kuile 2015 **Aim of the study** See ter Kuile 2015 **Study dates** See ter Kuile 2015 **Source of funding** See ter Kuile 2015	Physical assault: Intervention 4 (12), control - **Inclusion criteria** • Heterosexual women • Aged at least 18 years old • Diagnosis of lifelong vaginismus • In a relationship of at least 3 months • In good general health **Exclusion criteria** • Full sexual intercourse at any time • Received a somatic explanation for the complaint of vaginismus • Received a diagnosis of affected disorder, psychotic disorder, substance-related disorder or post-traumatic stress disorder related to the genitals • Did not speak Dutch well enough to participate			<u>FSFI pain mean (SD)</u> Baseline, intervention (n=35) 0.25 (0.64), control (n=35) 0.46 (0.86) 6 weeks, intervention (n=35) 3.34 (1.80), control (n=35) 0.67 (1.18) 12 weeks, intervention (n=35) 3.09 (2.08), control (n=31) 1.04 (1.45) <u>Fear of coitus mean (SD)</u> Baseline, intervention (n=35) 3.10 (1.11), control (n=35) 3.23 (1.01) 6 weeks, intervention (n=35) 2.20 (0.92), control (n=35) 3.01 (1.12) 12 weeks, intervention (n=35) 1.98 (0.92), control (n=31) 2.76 (1.00) <u>FSFI total mean (SD)</u> Baseline, intervention (n=35) 20.12 (7.51), control (n=35) 19.26 (6.70) 6 weeks, intervention (n=35) 19.85 (7.38), control (n=35) 18.32 (7.71) 12 weeks, intervention (n=35) 20.55 (7.36),	2.6. Probably yes Domain 2b- Deviations from intended interventions (effect of adhering to the interventions): Low risk 2.1: Yes 2.2. Yes 2.5. Probably no, drop outs similar across groups 2.6. Yes Domain 3 - Risk of bias due to missing outcome data: Low risk 3.1. Yes, less than 15% drop out 3.2. No 3.3. Probably yes 3.4. Probably no, similar drop outs across groups Domain 4 - Measurement of the outcome: High risk 4.1. Probably no 4.2. Probably no 4.3. Probably yes, all self-report measures 4.4 Probably yes 4.5 Probably no Domain 5- Selection of the reported result: Low risk 5.1. Yes 5.2. No 5.3. No

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
				control (n=31) 18.64 (8.48) FSDS sexual distress mean (SD) Baseline, intervention (n=35) 21.11 (8.46), control (n=35) 26.26 (9.58) 6 weeks, intervention (n=35) 14.87 (11.10), control (n=35) 24.53 (11.12) 12 weeks, intervention (n=35) 14.76 (11.25), control (n=31) 23.13 (12.09)	**Domain 6- Overall judgment of bias: High risk** **Other information**
Full citation van Lankveld, J. J., ter Kuile, M. M., de Groot, H. E., Melles, R., Nefs, J., Zandbergen, M., Cognitive-behavioral therapy for women with lifelong vaginismus: a randomized waiting-list controlled trial of efficacy, Journal of Consulting & Clinical PsychologyJ Consult Clin Psychol, 74, 168-78, 2006 **Ref Id** 1176330	**Sample size** N=117 couples enrolled Intervention: group therapy n=43, (34 completed 12 months FU) bibliotherapy format n=38 (26 completed 12 months FU) Control: n=36 **Characteristics** Mean age (SD) Intervention group therapy 28.1 years (6.0) intervention bibliotherapy 29.6 years (8.8) control 28.2 years (5.8) Duration complaint (SD) Intervention group therapy 10.0 years (6.2)	**Interventions** Cognitive behavioural therapy, as group therapy or in a bibliotherapy, or waiting list control Intervention groups: Participants received a 50-page manual on the treatment of vaginismus and a CD-ROM with spoken instructions for relaxation and sexual fantasy exercises. Treatment included sexual education, relaxation exercises, gradual exposure, cognitive therapy and sensate focus exercises. Participants were encouraged to practice twice daily and monitor progress using a diary. Group therapy: Ten 2-hour group sessions. Groups	**Details** Ten therapists, 1 male and 9 female, were involved in delivering the treatment. Behavioural functioning, Primary Endpoint Questionnaire (PEQ), Mini International Neuropsychiatric Interview (MINI), Female Sexual Function Index (FSFI), Maudsley Marital Questionnaire (MMQ), Golombok Rust Inventory of Sexual Satisfaction (GRISS) were completed at baseline, post treatment, 3 months post treatment and 12 months post treatment but not reported in this paper	**Results** Vaginal Intercourse (%) Baseline: group therapy (n=43) 0, bibliotherapy (n=38) 0, control (n=36) 0 Post treatment: group therapy 9, bibliotherapy 10, control 0 Adherence n (%) Dropped out before post treatment assessment: group therapy 10 (23.3), bibliotherapy 11 (28.9), control 3 (8.3)	**Limitations** Limitations were assessed using the revised Cochrane risk-of-bias tool for randomised trials (RoB2). Domain 1-randomisation: Low risk 1.1: Yes, allocation randomised by "urn randomisation" 1.2: Yes, a researcher not involved with the treatment delivery conducted randomisation 1.3: No Domain 2a- Deviations from intended

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
Country/ies where the study was carried out The Netherlands **Study type** Parallel group RCT **Aim of the study** To assess the effect of cognitive behavioural therapy (CBT), administered as a group and in a bibliotherapy format, compared with a waiting list control group on women with lifelong vaginismus. **Study dates** Not reported **Source of funding** Not reported	intervention bibliotherapy 12.6 years (8.8) control 10.6 years (5.4) <u>Sexual and physical abuse (%)</u> Any sexual abuse: Intervention group therapy 23, intervention bibliotherapy 23, control 28 Genitals touched: Intervention group therapy 19, intervention bibliotherapy 24, control 25 Coerced into sexual acts: Intervention group therapy 7, intervention bibliotherapy 10, control 14 Coerced into intercourse: Intervention group therapy 0, intervention bibliotherapy 10, control 6 Physical assault: Intervention group therapy 7, intervention bibliotherapy 5, control 11 **Inclusion criteria** • Women at least 18 years of age • Heterosexual • Diagnosis of lifelong vaginismus • Heterosexual relationship for at least 3 month • In good general health	consisted of 6-9 participants. Partners did not attend the group sessions. Bibliotherapy: Six biweekly telephone calls of 15 minutes <u>Control group:</u> Waiting list control			interventions (effect of assignment to interventions): Low risk 2.1: Yes, due to the nature of the interventions participants were aware of the treatment allocation. 2.2. Yes 2.3. Probably no, no reported deviations, adherence reported, no information if related to treatment assignment 2.6. Yes, ITT analysis conducted Domain 2b- Deviations from intended interventions (effect of adhering to the interventions): Some concerns 2.1: Yes 2.2. Yes 2.3. No information 2.5 Probably yes, drop out over 20% in both arms 2.6. Probably yes Domain 3 - Risk of bias due to missing outcome data: Some concerns 3.1. No, over 20% drop out 3.2. No, imputed data may not account for drop outs

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
	Exclusion criteria • Patients had full intercourse at any time • Patients who received a DSM-IV-TR diagnosis of effective disorder, psychotic disorder, substance related disorder or posttraumatic stress disorder related to the genitals • Did not speak Dutch well enough to participate in assessment and treatment • Were on a waiting list for treatment of vaginismus for longer than 1 week				3.3. Probably yes, health state of participants may have influenced adherence 3.4. Probably no, drop outs similar across groups Domain 4 - Measurement of the outcome: High risk 4.1. No 4.2. No 4.3. Yes - all measure self-report 4.4 Probably yes 4.5 Probably yes Domain 5- Selection of the reported result: Low risk 5.1. Yes 5.2. Probably no 5.3. No, data reported as expected. **Domain 6- Overall judgment of bias: High risk** **Other information**
Full citation Zarski, A. C., Berking, M., Fackiner, C., Rosenau, C., Ebert, D. D., Internet-Based Guided Self-Help for	**Sample size** N=77 Intervention n=40 Control n=37	**Interventions** 10 week internet based treatment or waiting list control Intervention: 10 sessions including modules on psychoeducation, relaxation exercises, cognitive	**Details** The study measured intercourse penetration and non-intercourse penetration using Primary Endpoint Questionnaire (PEQ), Fear of Sexuality using the Fear of Sexuality Questionnaire,	**Results** <u>Intercourse Penetration:</u> Before treatment, intervention (n=40) 0.48 (0.51),	**Limitations** Limitations were assessed using the revised Cochrane risk-of-bias tool for randomised trials (RoB2).

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
Vaginal Penetration Difficulties: Results of a Randomized Controlled Pilot Trial, Journal of sexual medicine, 14, 238-254, 2017 **Ref Id** 1174804 **Country/ies where the study was carried out** Germany **Study type** Two arm RCT **Aim of the study** To assess the acceptability and effectiveness of an internet-based guided self-help intervention for vaginismus compared with wait list control **Study dates** 2012 to 2014 **Source of funding** None	**Characteristics** <u>Mean age (SD)</u> Intervention 25.83 years (6.46) control 28.95 years (8.92) <u>Duration of acquired vaginismus (SD)</u> Intervention 5.36 years (5.46) control 5.53 years (7.12) <u>Vaginismus n (%)</u> Lifelong: Intervention 19 (47.50), control 15 (40.54) Acquired: Intervention 21 (52.50), control 22 (59.46) **Inclusion criteria** • Women at least 18 years of age • Not able to have sexual intercourse in the last 6 months • Were in a heterosexual relationship for at least 3 months • Had internet access • Had sufficient reading and writing in German **Exclusion criteria**	restructuring, body exposure, sensate focus exercises, gradual exposure using insertion exercises with fingers and dilators and preparation exercises for intercourse with partner. Each session was 30 - 45 minutes. The participants were asked to complete one or two sessions a week, therefore the training would last 5 to 10 weeks. Between sessions 2 and 7 the participants received diary modules to reflect on their thoughts and feelings regarding the treatment and their progress. Participants were also supported by an eCoach, a masters student who was trained in the study, they monitored adherence, supplied feedback and answered questions.	female sexual functioning using the Female Sexual Function Index.	control (n=37) 0.51 (0.51) After treatment, intervention (n=36) 0.47 (0.84), control (n=31) 0.42 (0.62) 6 Month follow up, intervention (n=22) 1.08 (1.21), control (n=29) 0.66 (0.90) <u>Fear of Sexuality (FSQ):</u> <u>Fear of coitus:</u> Before treatment, intervention (n=40) 16.08 (4.42), control (n=37) 15.68 (3.52) After treatment, intervention (n=36) 13.78 (3.80), control (n=31) 14.90 (4.41) 6 Month follow up, intervention (n=22) 13.55 (4.56), control (n=29) 14.31 (4.74) <u>Fear of non-coital sexual activity</u> Before treatment, intervention (n=40) 6.35 (2.91), control (n=37) 5.78 (3.52)	Domain 1- randomisation: Low risk 1.1: Yes, computer based random generator 1.2: Yes, performed by a researcher not involved with the study 1.3: No Domain 2a- Deviations from intended interventions (effect of assignment to interventions): Some concerns 2.1: Yes, due to the nature of the intervention participants were aware of intervention assignment 2.2. Yes 2.3. No information 2.6. Yes, both completer and ITT analysis conducted Domain 2b- Deviations from intended interventions (effect of adhering to the interventions): Some concerns 2.1: Yes 2.2. Yes 2.3. No information 2.5. Probably yes, fewer follow ups in the intervention arm as compared to control

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
	• Current or previous post-traumatic stress disorder • Current or previous psychosis or dissociative symptoms • Current substance abuse or dependency • Current moderate or severe depression • Bipolar disorder • Current treatment for vaginismus			After treatment, intervention (n=36) 5.39 (2.21), control (n=31) 5.77 (2.79) 6 Month follow up, intervention (n=22) 5.41 (1.97), control (n=29) 5.62 (3.06) <u>Female sexual function (FSFI):</u> <u>Overall sexual functioning:</u> Before treatment, intervention (n=40) 21.82 (5.89), control (n=37) 18.70 (7.10) After treatment, intervention (n=36) 21.86 (6.59), control (n=31) 18.62 (6.64) 6 Month follow up, intervention (n=22) 23.10 (5.93), control (n=29) 19.74 (6.06)	2.6 Probably yes, analysis conducted to examine effects of completing the intervention Domain 3 - Risk of bias due to missing outcome data: High risk 3.1. No, 40% loss to follow up in intervention arm and 22% loss in control 3.2. No 3.3. Probably yes 3.4. Probably yes, differences in drop out across groups Domain 4 - Measurement of the outcome: High risk 4.1. No 4.2. No 4.3. Yes, all measures self-report Domain 5- Selection of the reported result: Low risk 5.1. Yes 5.2. Probably no 5.3. No Domain 6- Overall judgment of bias: High risk **Other information**

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments

FI: Faecal incontinence; FSDS: Female sexual distress scale; FSFI: Female sexual function index; GRISS: Golombok rust inventory for sexual satisfaction; HADS: Hospital anxiety and depression scale; HEP: Health enhancement programme; MBSR: Mindfulness based stress reduction; MIVS: Motivational interviews and value support; MUI: Mixed urinary incontinence; OAB: Overactive bladder; OAB-LUTS: Overactive bladder, lower urinary tract symptoms; OAB-q-QOL: Overactive bladder questionnaire, short from, quality of life; OAB-q-SF: Overactive bladder questionnaire short form; PFD: Pelvic floor dysfunction; PFMT: Pelvic floor muscle training; POP: Pelvic organ prolapse; RCT: Randomised controlled trial; SD: Standard deviation; SDQ: Sexual disgust questionnaire; SE: Standard error; SUI: Stress urinary incontinence; UUI: Urge urinary incontinence.

Appendix E – Forest plots

Forest plots for review question: What is the effectiveness of psychological interventions for women with symptoms associated with pelvic floor dysfunction?

No meta-analysis was conducted for this review question and so there are no forest plots.

Appendix F – GRADE tables

GRADE tables for review question: What is the effectiveness of psychological interventions for women with symptoms associated with pelvic floor dysfunction?

Table 6: Clinical evidence profile for comparison exposure therapy as compared to waitlist control for vaginismus

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Exposure therapy	waiting list control	Relative (95% CI)	Absolute		
GRISS vaginismus (follow-up mean 6 weeks; Better indicated by lower values)												
Ter Kuile 2013	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	35	35	-	MD 8.05 lower (9.72 to 6.38 lower)	VERY LOW	CRITICAL
GRISS vaginismus (follow-up mean 12 weeks; Better indicated by lower values)												
Ter Kuile 2013	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	35	35	-	MD 7.25 lower (9.06 to 5.44 lower)	VERY LOW	CRITICAL
Mean FSFI pain (follow-up mean 6 weeks; Better indicated by higher values)												
Ter Kuile 2013	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	35	35	-	MD 2.67 higher (1.96 to 3.38 higher)	VERY LOW	CRITICAL
Mean FSFI pain (follow-up mean 12 weeks; Better indicated by higher values)												
Ter Kuile 2013	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	35	35	-	MD 2.05 higher (1.21 to 2.89 higher)	VERY LOW	CRITICAL
Fear of coitus (follow-up mean 6 weeks; Better indicated by lower values)												
Ter Kuile 2013	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	35	35	-	MD 0.81 lower (1.29 to 0.33 lower)	VERY LOW	CRITICAL
Fear of coitus (follow-up mean 12 weeks; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Exposure therapy	waiting list control	Relative (95% CI)	Absolute		
Ter Kuile 2013	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	35	35	-	MD 0.78 lower (1.23 to 0.33 lower)	VERY LOW	CRITICAL
FSFI total (follow-up mean 6 weeks; Better indicated by higher values)												
Ter Kuile 2013	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	35	35	-	MD 1.53 higher (2.01 lower to 5.07 higher)	VERY LOW	CRITICAL
FSFI total (follow-up mean 12 weeks; Better indicated by higher values)												
Ter Kuile 2013	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	35	35	-	MD 1.91 higher (1.81 lower to 5.63 higher)	VERY LOW	CRITICAL
FSDS sexual distress (follow-up mean 6 weeks; Better indicated by lower values)												
Ter Kuile 2013	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[6]	none	35	35	-	MD 9.66 lower (14.84 to 4.48 lower)	VERY LOW	CRITICAL
FSDS sexual distress (follow-up mean 12 weeks; Better indicated by lower values)												
Ter Kuile 2013	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[6]	none	35	35	-	MD 8.37 lower (13.84 to 2.9 lower)	VERY LOW	CRITICAL
Coitus (follow-up mean 6 weeks)												
Ter Kuile 2013	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	31/35 (88.6%)	0/35 (0%)	POR 34.41 (13.49 to 87.79)	-	LOW	CRITICAL
Coitus (follow-up mean 12 weeks)												
Ter Kuile 2013	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	29/35 (82.9%)	4/35 (11.4%)	OR 16.87 (6.64 to 42.84)	571 more per 1000 (from 347 more to 733 more)	LOW	CRITICAL

CI: confidence interval; GRISS: Golombok Rust Inventory of Sexual Satisfaction; FSFI: Female Sexual Function Index; MD: mean difference; OR: odds ratio; POR: Peto odds ratio

1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2

2 95% CI crosses 2 MIDs (0.5 x SD control at baseline, 1.25)

3 95% CI crosses 2 MIDs (0.5 x SD control at baseline, 0.43)
4 95% CI crosses 1 MID (0.5 x SD control at baseline, 0.51)
5 95% CI crosses 1 MID (FSFI MID = 2.1)
6 95% CI crosses 1 MID (FSDS MID = 7.0)

Table 7: Clinical evidence profile for comparison cognitive-behavioural therapy as compared to waitlist control for vaginismus

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Group CBT**	**Wait list control**	**Relative (95% CI)**	**Absolute**		
Vaginal intercourse (post treatment)												
Van Lankveld 2006	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	9/43 (20.9%)	0/36 (0%)	POR 7.75 (1.94 to 30.94)	-	LOW	CRITICAL
Drop outs												
Van Lankveld 2006	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	10/43 (23.3%)	3/36 (8.3%)	RR 2.79 (0.83 to 9.38)	149 more per 1000 (from 14 fewer to 698 more)	VERY LOW	IMPORTANT

CI: confidence interval; CBT: Cognitive behavioural therapy; MD: mean difference; POR: Peto odds ratio; RR: relative risk
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (0.8 or 1.25)

Table 8: Clinical evidence profile for comparison cognitive-behavioural therapy as compared to bibliotherapy for vaginismus

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Group CBT**	**Bibliotherapy (information – bi-weekly phone calls)**	**Relative (95% CI)**	**Absolute**		
Vaginal Intercourse												

Van Lankveld 2006	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	9/43 (20.9%)	18/38 (47.4%)	RR 0.44 (0.23 to 0.86)	265 fewer per 1000 (from 66 fewer to 365 fewer)	VERY LOW	CRITICAL
Drop outs												
Van Lankveld 2006	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	10/43 (23.3%)	11/38 (28.9%)	RR 0.8 (0.38 to 1.68)	58 fewer per 1000 (from 179 fewer to 197 more)	VERY LOW	IMPORTANT

CI: confidence interval; CBT: Cognitive behavioural therapy; RR: relative risk

1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2

2 95% CI crosses 1 MID (0.8 or 1.25)

3 95% CI crosses 2 MIDs (0.8 and 1.25)

Table 9: Clinical evidence profile for comparison bibliotherapy versus waitlist control for vaginismus

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Bibliotherapy (information – bi-weekly phone calls)**	**Wait list control**	**Relative (95% CI)**	**Absolute**		
Vaginal Intercourse												
Van Lankveld 2006	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	10/38 (26.3%)	0/36 (0%)	POR 9.22 (2.45 to 34.66)	-	LOW	CRITICAL
Drop outs												
Van Lankveld 2006	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	11/38 (28.9%)	3/36 (8.3%)	RR 3.47 (1.05 to 11.45)	206 more per 1000 (from 4 more to 871 more)	VERY LOW	IMPORTANT

CI: confidence interval; CBT: Cognitive behavioural therapy; POR: Peto odds ratio; RR: relative risk
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 2 MIDs (0.8 and 1.25)

Table 10: Clinical evidence profile for comparison internet based self-help versus waitlist control for vaginismus

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Internet based self help	waiting list control	Relative (95% CI)	Absolute		
Intercourses penetration - post-treatment (Better indicated by lower values)												
Zarski 2017	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	36	31	-	MD 0.05 higher (0.3 lower to 0.4 higher)	VERY LOW	CRITICAL
Intercourses penetration -FU (follow-up mean 6 months; Better indicated by lower values)												
Zarski 2017	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	22	29	-	MD 0.42 higher (0.18 lower to 1.02 higher)	VERY LOW	CRITICAL
Fear of coitus (FSQ) - post-treatment (Better indicated by lower values)												
Zarski 2017	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	36	31	-	MD 1.12 lower (3.11 lower to 0.87 higher)	VERY LOW	CRITICAL
Fear of coitus (FSQ) - FU (follow-up mean 6 months; Better indicated by lower values)												
Zarski 2017	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	22	29	-	MD 0.76 lower (3.33 lower to 1.81 higher)	VERY LOW	CRITICAL
Fear of non-coital sexual activity (FSQ) - post-treatment (Better indicated by lower values)												
Zarski 2017	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	36	31	-	MD 0.38 lower (1.6 lower to 0.84 higher)	VERY LOW	CRITICAL
Fear of non-coital sexual activity (FSQ) - FU (follow-up mean 6 months; Better indicated by lower values)												
Zarski 2017	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	22	29	-	MD 0.21 lower (1.59 lower to 1.17 higher)	VERY LOW	CRITICAL
Female sexual function (FSFI) - post-treatment (Better indicated by higher values)												
Zarski 2017	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[6]	none	36	31	-	MD 3.24 higher (0.06 to 6.42 higher)	VERY LOW	CRITICAL
Female sexual function (FSFI) - FU (follow-up mean 6 months; Better indicated by higher values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Internet based self help	waiting list control	Relative (95% CI)	Absolute		
Zarski 2017	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[6]	none	22	29	-	MD 3.36 higher (0.04 to 6.68 higher)	VERY LOW	CRITICAL

CI: confidence interval; FSFI: female sexual functioning index; FSQ: female sexual quotient; FU: follow-up; MD: mean difference; QOL: quality of life
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (0.5x SD control at baseline, 0.26)
3 95% CI crosses 1 MID (0.5x SD control at baseline, 1.76)
4 95% CI crosses 2 MIDs (0.5x SD control at baseline, 1.76)
5 95% CI crosses 1 MID (0.5x SD control at baseline, 1.39)
6 95% CI crosses 1 MID (FSFI MID = 2.1)

Table 11: Clinical evidence profile for comparison emotional awareness and expression interview as compared to treatment as usual for chronic urogenital pain

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interview Condition	Treatment as usual	Relative (95% CI)	Absolute		
Pain Severity (follow-up mean 6 weeks; Better indicated by lower values)												
Carty 2019	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	37	25	-	MD 1.21 lower (2.17 to 0.25 lower)	VERY LOW	CRITICAL
Pain Interference (follow-up mean 6 weeks; Better indicated by lower values)												
Carty 2019	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	37	25	-	MD 1.53 lower (2.87 to 0.19 lower)	VERY LOW	CRITICAL
Pelvic Floor Distress Inventory SF20 (follow-up mean 6 weeks; Better indicated by lower values)												
Carty 2019	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	37	25	-	MD 11.6 lower (18.65 to 4.55 lower)	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interview Condition	Treatment as usual	Relative (95% CI)	Absolute		
Depression (follow-up mean 6 weeks; Better indicated by lower values)												
Carty 2019	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	37	25	-	MD 0.4 lower (0.87 lower to 0.07 higher)	VERY LOW	IMPORTANT
Anxiety (follow-up mean 6 weeks; Better indicated by lower values)												
Carty 2019	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[6]	none	37	25	-	MD 0.33 lower (0.73 lower to 0.07 higher)	VERY LOW	IMPORTANT

CI: confidence interval; MD: mean difference
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 22 95% CI crosses 1 MID (0.5 x SD control at baseline, 0.82)
3 95% CI crosses 1 MID (0.5 x SD control at baseline, 1.60)
4 95% CI crosses 1 MID (0.5 x SD control at baseline, 7.12).
5 95% CI crosses 1 MID (0.5 x SD control at baseline, 0.53)
6 95% CI crosses 1 MID (0.5 x SD control at baseline, 0.44)

Table 12: Clinical evidence profile for mindfulness based stress reduction versus health enhancement program for urge urinary incontinence

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Mindfulness based stress reduction	Health enhancement program	Relative (95% CI)	Absolute		
Retention												
Felsted 2019	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[1]	none	11/13 (84.6%)	8/12 (66.7%)	RR 1.27 (0.8 to 2.02)	180 more per 1000 (from 133 fewer to 680 more)	LOW	IMPORTANT

CI: confidence interval; RR: relative risk
1 95% CI crosses 2 MIDs (0.8 and 1.25)

Table 13: Clinical evidence profile for hypnotherapy versus behavioural therapy for overactive bladder

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Hypnotherapy	Behavioural therapy	Relative (95% CI)	Absolute		
Mean change in OAB-SF, Distress score (Better indicated by lower values)												
Komesu 2011	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	10	10	-	MD 6.4 higher (11.64 lower to 24.44 higher)	VERY LOW	CRITICAL
Mean change in OAB-SF, QOL score (Better indicated by lower values)												
Komesu 2011	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	10	10	-	MD 14.4 higher (3.68 lower to 32.48 higher)	VERY LOW	CRITICAL
Mean change in number of voids (Better indicated by lower values)												
Komesu 2011	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	10	10	-	MD 1 higher (0.51 lower to 2.51 higher)	VERY LOW	CRITICAL

CI: confidence interval; MD: mean difference; OAB-SF: overactive bladder short form; QOL: quality of life
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 2 MIDs (OAB-q MID = 10)
3 95% CI crosses 1 MID (OAB-q MID = 10)
4 95% CI crosses 1 MID (0.5 x SD control at baseline, 1.35)

Table 14: Clinical evidence profile for comparison motivational interview support versus pelvic floor muscle training alone for pelvic floor dysfunction

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	MIVS	PFMT alone	Relative (95% CI)	Absolute		
Mean number of classes attended (Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	MIVS	PFMT alone	Relative (95% CI)	Absolute		
Osborne 2016	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	16	15	-	MD 1.42 higher (0.35 to 2.49 higher)	LOW	IMPORTANT

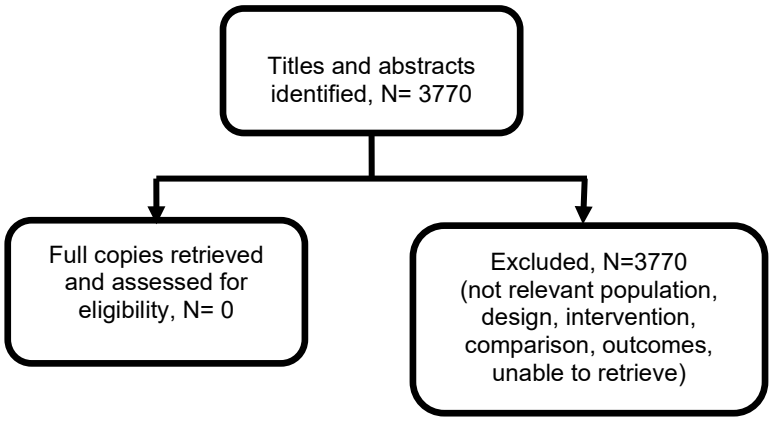
CI: confidence interval; MD: mean difference; MIVS: Motivational interview and value support; PFMT: pelvic floor muscle training
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (0.5 x SD control, 0.82)

Appendix G – Economic evidence study selection

Economic evidence study selection for review question: What is the effectiveness of psychological interventions for women with symptoms associated with pelvic floor dysfunction?

No economic evidence was identified which was applicable to this review question.

Figure 2: Study selection flow chart



Appendix H – Economic evidence tables

Economic evidence tables for review question: What is the effectiveness of psychological interventions for women with symptoms associated with pelvic floor dysfunction?

No evidence was identified which was applicable to this review question.

Appendix I – Economic evidence profiles

Economic evidence profiles for review question: What is the effectiveness of psychological interventions for women with symptoms associated with pelvic floor dysfunction?

No economic evidence was identified which was applicable to this review question.

Appendix J – Economic analysis

Economic evidence analysis for review question: What is the effectiveness of psychological interventions for women with symptoms associated with pelvic floor dysfunction?

No economic analysis was conducted for this review question.

Appendix K – Excluded studies

Excluded studies for review question: What is the effectiveness of psychological interventions for women with symptoms associated with pelvic floor dysfunction?

Clinical studies

Table 15: Excluded studies and reasons for their exclusion

Study	Reason for Exclusion
Abbasy, S. A., Michelfelder, A., Kenton, K., Mueller, E. R., FitzGerald, M. P., Home-based cognitive therapy for overactive bladder, Journal of Urology, 1), 561, 2009	Conference abstract
Adam, F., De Sutter, P., Day, J., Grimm, E., A Randomized Study Comparing Video-Based Mindfulness-Based Cognitive Therapy With Video-Based Traditional Cognitive Behavioral Therapy in a Sample of Women Struggling to Achieve Orgasm, Journal of Sexual Medicine, 06, 06, 2019	Population does not meet the inclusion criteria; no mention of sexual dysfunction caused by pelvic floor dysfunction
Addison, R., Establishing a user group in continence care, Nursing Times, 98, 60-1, 2002	Online brief report
Adelstein, S. A., Lee, U. J., The Role of Mindfulness in Urinary Urgency Symptoms, Current Bladder Dysfunction Reports, 11, 38-44, 2016	Narrative review
Aeyoung, So, De Gagne, Jennie C., Sunah, Park, Long-Term Effects of a Self-management Program for Older Women With Urinary Incontinence in Rural Korea: A Comparison Cohort Study, Journal of Wound, Ostomy & Continence Nursing, 46, 55-61, 2019	Intervention does not meet the inclusion criteria: intervention based on self-management and self-efficacy (behavioural and PFMT)
Albers-Heitner, P. C., Lagro-Janssen, T. A., Joore, M. M., Berghmans, B. L., Nieman, F. F., Venema, P. P., Severens, J. J., Winkens, R. R., Effectiveness of involving a nurse specialist for patients with urinary incontinence in primary care: results of a pragmatic multicentre randomised controlled trial, International Journal of Clinical Practice, 65, 705-712, 2011	Intervention does not meet the inclusion criteria, multi-component but no psychological aspect.
Althof, S. E., It was the best of times; it was the worst of times, Journal of Sex and Marital Therapy, 33, 399-403, 2007	Commentary paper
Anonymous, Continence Promotion and Care, Nursing Times, 6-6, 2019	Full text unavailable from the British Library
Anonymous, Erratum: Comparison of 2 transvaginal surgical approaches and perioperative behavioral therapy for apical vaginal prolapse: The OPTIMAL randomized trial (JAMA (2014) 311:10 (1023-1034) 10.1001/jama.2014.1719), JAMA - Journal of the American Medical Association, 313, 2287, 2015	Erratum
Anonymous, Manage vulvodynia using a multimodal and individualized approach, Drugs and Therapy Perspectives, 35, 612-617, 2019	Narrative review

Study	Reason for Exclusion
Anonymous, Mindfulness and sex therapy, Journal of Sexual Medicine, Conference: 22nd Congress of the World Association for Sexual Health, WAS 2015. Singapore. 12, 333, 2015	Conference abstract
Anonymous,, National association for continence launches nationwide support groups, Urologic nursing : official journal of the American Urological Association Allied, 20, 141, 2000	Narrative summary paper
Anonymous, Patient information page from the Hormone Health Network. Female sexual dysfunction, Journal of Clinical Endocrinology & Metabolism, 97, 39A-40A, 2012	Patient fact sheet
Anonymous, Pill-free treatment for urinary incontinence, Harvard Health Letter, 44, 8-8, 2019	Online news brief
Anonymous, Retraining an overactive bladder. Self-help strategies that can effectively treat an 'urgent' problem, Johns Hopkins Medical Letter, Health After 50Johns Hopkins Med Lett Health After 50, 24, 5-8, 2012	Narrative summary providing advice to those with overactive bladder
Anonymous, Treating UI with behavioural therapies, Canadian Nursing Home, 7, 11-18, 1996	Narrative summary of care
Anonymous, Treating urge incontinence, Nurses' Drug Alert, 32, 51-51, 2008	Conference abstract
Anonymous,, Behavior therapy and urge incontinence, Mayo Clinic health letter (English ed.), 21, 4, 2003	Abstract overview
Anonymous,, Female sexual dysfunction, International Journal of Impotence Research, 15, S22-S26, 2003	Short report on classification and prevalence of female sexual dysfunction
Arnouk, A., De, E., Rehfuss, A., Cappadocia, C., Dickson, S., Lian, F., Physical, Complementary, and Alternative Medicine in the Treatment of Pelvic Floor Disorders, Current Urology Reports, 18, 47, 2017	Narrative review (references checked)
Arulkumaran, S., Johnson, T. R. B., Contemporary issues in women's health, International Journal of Gynecology and Obstetrics, 83, 1-3, 2003	Narrative review
Asoglu, Mehmet, Beginoglu, Özlem, Demir, Mustafa, Çelik, Hakim, Fedai, Ülker, Akil, Öznur, Ayaydin, Hamza, Kilicaslan, Fethiye, Retrospective Analysis of Vaginismus Patients Referred to Psychiatric Outpatient Clinic in a University Hospital, Journal of Harran University Medical Faculty, 16, 569-572, 2019	Study design does not meet the inclusion criteria: Retrospective study
Ayeleke, R. O., Hay-Smith, E. J. C., Omar, M. I., Pelvic floor muscle training added to another active treatment versus the same active treatment alone for urinary incontinence in women, Cochrane Database of Systematic Reviews, 2015	Intervention does not meet the inclusion criteria, no psychological aspect. Maybe suitable for 8.1
Ayeleke, R., Hay-Smith, J., Omar, M., Pelvic floor muscle training added to another active treatment versus the same active treatment	Conference abstract

Study	Reason for Exclusion
alone for urinary incontinence in women: Cochrane systematic review, International Urogynecology Journal and Pelvic Floor Dysfunction, 1), S177-S178, 2014	
Backman, H., Widenbrant, M., Bohm-Starke, N., Dahlof, L. G., Combined physical and psychosexual therapy for provoked vestibulodynia-an evaluation of a multidisciplinary treatment model, Journal of Sex Research, 45, 378-85, 2008	Population does not meet the inclusion criteria, women do not have pelvic floor dysfunction
Baker, J., Costa, D., Guarino, J. M., Nygaard, I., Comparison of mindfulness-based stress reduction versus yoga on urinary urge incontinence: a randomized pilot study. with 6-month and 1-year follow-up visits, Female Pelvic Medicine & Reconstructive Surgery, 20, 141-6, 2014	No relevant outcome reported
Baker, J., Costa, D., Nygaard, I., Mindfulness-based stress reduction for treatment of urinary urge incontinence: a pilot study, Female Pelvic Medicine & Reconstructive Surgery, 18, 46-9, 2012	study design does not meet the inclusion criteria: Single arm study, no comparator group
Baker, J., Nygaard, I., Costa, D., Comparison of mindfulness based stress reduction (MBSR) vs yoga on urgency incontinence: A randomized pilot study, Female Pelvic Medicine and Reconstructive Surgery, 19, S76, 2013	Conference abstract
Bakes, Emma, Pelvic Floor Physiotherapy and Psychological Support: Why Do Patients Fail to Complete Their Rehab?, Journal of Pelvic, Obstetric & Gynaecological Physiotherapy, 78-79, 2018	Full text unavailable from the British Library
Balk, E. M., Adam, G. P., Corsi, K., Mogul, A., Trikalinos, T. A., Jeppson, P. C., Adverse Events Associated with Nonsurgical Treatments for Urinary Incontinence in Women: a Systematic Review, Journal of General Internal Medicine, 34, 1615-1625, 2019	Systematic review, references checked - interventions included not relevant
Balk, E. M., Rofeberg, V. N., Adam, G. P., Kimmel, H. J., Trikalinos, T. A., Jeppson, P. C., Pharmacologic and Nonpharmacologic Treatments for Urinary Incontinence in Women: A Systematic Review and Network Meta-analysis of Clinical Outcomes, Annals of Internal Medicine, 170, 465-479, 2019	Systematic review, references checked - interventions included not relevant
Balk, E., Adam, G. P., Kimmel, H., Rofeberg, V., Saeed, I., Jeppson, P., Trikalinos, T., Nonsurgical Treatments for Urinary Incontinence in Women: A Systematic Review Update [Internet]., Agency for Healthcare Research and Quality (US), 08, 2018	Systematic review, references checked - interventions included not relevant
Banerjee, S., Srivastav, A., Palan, B. M., Hypnosis and self-hypnosis in the management of nocturnal enuresis: A comparative study with imipramine therapy, American Journal of Clinical Hypnosis, 36, 113-119, 1993	Population does not meet the inclusion criteria: children aged 5 to 16 years

Study	Reason for Exclusion
Barber, M. D., Visco, A. G., Wyman, J. F., Fantl, J. A., Bump, R. C., Continence Program for Women Research, Group, Sexual function in women with urinary incontinence and pelvic organ prolapse, Obstetrics & Gynecology, 99, 281-9, 2002	Intervention does not meet the inclusion criteria; drug and behavioural therapy intervention, no psychological aspect
Barnes, J., Bowman, E. P., Cullen, J., Biofeedback as an adjunct to psychotherapy in the treatment of vaginismus, Biofeedback & Self Regulation, 9, 281-9, 1984	Study design does not meet the inclusion criteria: Case series - single arm intervention, no comparator group
Barnes, J., Primary vaginismus (part 2): Aetiological factors, Irish Medical Journal, 79, 62-65, 1986	Study design does not meet the inclusion criteria, study groups women according to aetiology, no intervention is given
Beck, J. Gayle, Vaginismus, 381-397, 1993	Book chapter
Benoit-Piau, J., Bergeron, S., Brassard, A., Dumoulin, C., Khalife, S., Waddell, G., Morin, M., Fear-avoidance and Pelvic Floor Muscle Function are Associated With Pain Intensity in Women With Vulvodynia, Clinical Journal of PainClin J Pain, 34, 804-810, 2018	Population does not meet the inclusion criteria, women do not have pelvic floor dysfunction
Bergeron, S., Lord, M., The integration of pelvi-perineal re-education and cognitive behavioural therapy in the multidisciplinary treatment of the sexual pain disorders...Reprinted from Sexual and Relationship Therapy, Vol. 18, No. 2, 2003, 135-141, Sexual & Relationship Therapy, 25, 299-305, 2010	Narrative review
Bergeron, S., Morin, M., Lord, M., Integrating pelvic floor rehabilitation and cognitive-behavioural therapy for sexual pain: what have we learned and where do we go from here?, Sexual & Relationship Therapy, 25, 289-298, 2010	Narrative review
Bergeron, Sophie, Lord, Marie-Josee, The integration of pelvi-perineal re-education and cognitive-behavioural therapy in the multidisciplinary treatment of the sexual pain disorders, Sexual and Relationship Therapy, 18, 135-141, 2003	Narrative review
Bernard, S., Boucher, S., McLean, L., Moffet, H., Mobile technologies for the conservative self-management of urinary incontinence: a systematic scoping review, International Urogynecology Journal., 2019	Systematic review, references checked - interventions included not relevant
Bernorio, R., Di Santo, S., Mori, G., Prunas, A., The effectiveness of body-mind connection therapy in the treatment of lifelong vaginismus, Journal of Sexual Medicine, 1), 11, 2014	Conference abstract
Björk, Anna-Bell, Sjöström, Malin, Johansson, Eva E., Samuelsson, Eva, Umefjord, Göran, Women's Experiences of Internet-Based or Postal Treatment for Stress Urinary Incontinence, Qualitative Health Research, 24, 484-493, 2014	Study design does not meet the inclusion criteria: Qualitative study

Study	Reason for Exclusion
Black, P. A., Urinary incontinence: a many faceted problem, Professional Nurse, 5, 378-84, 1990	Summary paper
Borello-France, D., Burgio, K. L., Goode, P. S., Markland, A. D., Kenton, K., Balasubramanyam, A., Stoddard, A. M., Urinary Incontinence Treatment, Network, Adherence to behavioral interventions for urge incontinence when combined with drug therapy: adherence rates, barriers, and predictors, Physical Therapy, 90, 1493-505, 2010	Intervention does not meet the inclusion criteria. Maybe suitable for 8.1 or 11.1
Borello-France, D., Burgio, K. L., Goode, P. S., Ye, W., Weidner, A. C., Lukacz, E. S., Jelovsek, J. E., Bradley, C. S., Schaffer, J., Hsu, Y., Kenton, K., Spino, C., Pelvic Floor Disorders, Network, Adherence to behavioral interventions for stress incontinence: rates, barriers, and predictors, Physical Therapy, 93, 757-73, 2013	Intervention does not meet the inclusion criteria.
Borrie, M. J., Bawden, M., Speechley, M., Kloseck, M., Interventions led by nurse continence advisers in the management of urinary incontinence: A randomized controlled trial, Cmaj, 166, 1267-1273, 2002	Population does not meet the inclusion criteria, both men and women included in the study, no separate data on women
Borrie, M., Bawden, M., Speechley, M., Kloseck, M., Rigby, D., Roe, B., Nurse-led behavioural and lifestyle counselling may reduce incontinence, Evidence-Based Healthcare, 6, 143-144, 2002	Conference abstract
Brady, L., Prompted voiding yields results. CNAs are key to the success of a pilot study that reduced urinary incontinence for residents of one Illinois facility, Provider, 35, 41-4, 2009	Narrative summary paper
Brady, M., Fitzgerald, C. M., Adams, W., Brubaker, L., Mueller, E. R., Brincat, C., Patient preparedness for pelvic floor physical therapy: Standard counseling vs video, Female Pelvic Medicine and Reconstructive Surgery, 23 (5 Supplement 1), S13-S14, 2017	Conference abstract
Braun, E. J., Wise, M. E., Jansen, S. M., Myers, S., Sampene, E., Li, Z., Moberg, D. P., Rogers, R. G., Mahoney, J., Brown, H. W., Mind over matter; Healthy bowels, healthy bladder: an individually randomized group treatment trial, Female Pelvic Medicine & Reconstructive Surgery, 24, S51-S52, 2018	Intervention does not meet the inclusion criteria, no psychological aspect.
Braun, E. J., Wise, M. E., Jansen, S., Myers, S., Sampene, E., Li, Z., Moberg, D. P., Rogers, R. G., Mahoney, J. E., Brown, H. W., Best in category prize prevention and public health: mind over matter; healthy bowels, healthy bladder: an individually randomized group treatment trial, Neurourology and Urodynamics, 37, S319-S320, 2018	Conference abstract
Brotto, L. A., Basson, R., Group mindfulness-based therapy significantly improves sexual desire in women, Behaviour Research and Therapy, 57, 43-54, 2014	Doesn't specify that sexual dysfunction is associated with pelvic floor dysfunction

Study	Reason for Exclusion
Brown, Claire, The TOPSY trial, Journal of Pelvic, Obstetric & Gynaecological Physiotherapy, 95-96, 2018	Full text unavailable from the British Library (likely a conference abstract)
Brown, J., Thomas, E., Continence. Help is only a call away, Nursing Times, 85, 81, 1989	Full text unavailable from the British Library
Brown, J., Thomas, E., Continence. Hot lines, Nursing Times, 91, 61-2, 1995	Full text unavailable from the British Library
Brown, J., Thomas, E., White, H., McCallum, A., An incontinence helpline service, Nursing Standard, 5, 25-7, 1991	Narrative summary paper
Burgio, K. L., Goode, P. S., Locher, J. L., Umlauf, M. G., Roth, D. L., Richter, H. E., Varner, R. E., Lloyd, L. K., Behavioral training with and without biofeedback in the treatment of urge incontinence in older women: A randomized controlled trial, Journal of the American Medical Association, 288, 2293-2299, 2002	Intervention does not meet the inclusion criterial; is not a psychological therapy
Burgio, K. L., Goode, P. S., Locher, J. L., Umlauf, M. G., Roth, D. L., Richter, H. E., Varner, R. E., Lloyd, L. K., Waetjen, L. E., Biofeedback did not improve the results of behavioural training for urge urinary incontinence in older women, Evidence-based Obstetrics and Gynecology, 5, 84-85, 2003	Intervention does not meet the inclusion criteria: intervention based on behaviour not psychology
Burgio, K. L., Influence of behavior modification on overactive bladder, Urology, 60, 72-6; discussion 77, 2002	Interventions not psychological
Burgio, K. L., Kraus, S. R., Borello-France, D., Chai, T. C., Kenton, K., Goode, P. S., Xu, Y., Kusek, J. W., Urinary Incontinence Treatment, Network, The effects of drug and behavior therapy on urgency and voiding frequency, International Urogynecology Journal, 21, 711-9, 2010	Intervention does not meet the inclusion criterial; is not a psychological therapy
Burgio, K. L., Kraus, S. R., Menefee, S., Borello-France, D., Corton, M., Johnson, H. W., Mallett, V., Norton, P., FitzGerald, M. P., Dandreo, K. J., Richter, H. E., Rozanski, T., Albo, M., Zyczynski, H. M., Lemack, G. E., Chai, T. C., Khandwala, S., Baker, J., Brubaker, L., Stoddard, A. M., Goode, P. S., Nielsen-Omeis, B., Nager, C. W., Kenton, K., Tennstedt, S. L., Kusek, J. W., Chang, T. D., Nyberg, L. M., Steers, W., Urinary Incontinence Treatment, Network, Behavioral therapy to enable women with urge incontinence to discontinue drug treatment: a randomized trial, Annals of Internal Medicine, 149, 161-9, 2008	Intervention does not meet the inclusion criterial; is not a psychological therapy
Burgio, K. L., Locher, J. L., Goode, P. S., Combined behavioral and drug therapy for urge incontinence in older women, Journal of the American Geriatrics Society, 48, 370-4, 2000	Intervention does not meet the inclusion criterial; is not a psychological therapy
Burgio, K. L., Locher, J. L., Goode, P. S., Hardin, J. M., McDowell, B. J., Dombrowski, M., Candib, D., Behavioral vs drug treatment for urge urinary incontinence in older women: a	Intervention does not meet the inclusion criterial; is not a psychological therapy

Study	Reason for Exclusion
randomized controlled trial, JAMA, 280, 1995-2000, 1998	
Burgio, K. L., Locher, J. L., Roth, D. L., Goode, P. S., Psychological improvements associated with behavioral and drug treatment of urge incontinence in older women, Journals of Gerontology - Series B Psychological Sciences and Social Sciences, 56, P46-P51, 2001	Intervention does not meet the inclusion criterial; is not a psychological therapy
Burton, J. R., Pearce, K. L., Burgio, K. L., Engel, B. T., Whitehead, W. E., Behavioral training for urinary incontinence in elderly ambulatory patients, Journal of the American Geriatrics Society, 36, 693-8, 1988	Intervention does not meet the inclusion criterial; is not a psychological therapy
Byrne, C. M., Solomon, M. J., Rex, J., Young, J. M., Heggie, D., Merlino, C., Telephone vs. face-to-face biofeedback for fecal incontinence: Comparison of two techniques in 239 patients, Diseases of the Colon and Rectum, 48, 2281-2288, 2005	Population includes men and cannot separate out data on women
Callif, Debbie, Mindfulness in Pelvic Floor Dysfunction, Biofeedback, 46, 21-24, 2018	Study design does not meet the inclusion criteria: case reports of three women
Carey, Michael P., Cognitive-behavioral treatment of sexual dysfunctions, 251-280, 1998	Book chapter
Carone Craig, A. R., Psychological counseling in enuretic patients, Urodinamica, 11, 19-24, 2001	Population does not meet the inclusion criteria, study only includes children
Carrión Pérez, F., Rodríguez Moreno, M. S., Carnerero Córdoba, L., Romero Garrido, M. C., Quintana Tirado, L., García Montes, I., Telerehabilitation to treat stress urinary incontinence. Pilot study, Medicina clinica, 144, 445-448, 2015	Intervention does not meet the inclusion criterial; is not a psychological therapy
Carty, J., Lumley, M., Holmes, H., Tomakowsky, J., Schubiner, H., Dove-Medows, E., Peters, K., The effects of a stress and emotion interview for women with urogenital pain: A randomized trial, Journal of Pain, 1), S103, 2016	Conference abstract
Chelvanayagam, S., Stern, J., Using therapeutic groups to support women with faecal incontinence, British Journal of Nursing, 16, 214-8, 2007	Outcome data does not meet the inclusion criteria
Chelvanayagam, S., Stern, J., Using therapeutic groups to support women with faecal incontinence, British Journal of Nursing, 16, 214-8, 2007	Narrative review
Cichowski, S. B., Dunivan, G. C., Rogers, R. G., Murrietta, A. M., Komesu, Y. M., Standard compared with mnemonic counseling for fecal incontinence: a randomized controlled trial, Obstetrics & Gynecology, 125, 1063-70, 2015	Conference abstract
Cichowski, S. B., Dunivan, G., Komesu, Y., Rogers, R. G., Standard vs mnemonic counseling for fecal incontinence: A randomized controlled trial, International Urogynecology Journal and Pelvic Floor Dysfunction, 1), S12-S13, 2014	Conference abstract

Study	Reason for Exclusion
Colling, J., Owen, T. R., McCreedy, M., Newman, D., The effects of a continence program on frail community-dwelling elderly persons, Urologic Nursing, 23, 117-22, 127-31, 2003	Intervention does not meet the inclusion criteria: behavioural training study
Continence Promotion and Care, Nursing Times, 6-6, 2019	Full text unavailable from the British Library
Cook, T., Group treatment of female urinary incontinence: Literature review, Physiotherapy, 87, 226-234, 2001	Not a systematic review. RCTs checked
Cornelius, C., Monsour, M., Noursalehi, M., PeriCoach clinical study and real-world data insights, Female Pelvic Medicine and Reconstructive Surgery, 25 (5 Supplement 1), S287, 2019	Conference abstract
Crowley, T., Goldmeier, D., Hiller, J., Diagnosing and managing vaginismus, BMJ (Online), 339, 225-229, 2009	Clinical review paper
da Maia Lima, Claudia Feio, Pereira Caldas, Célia, Correa Trotte, Liana Amorim, Oliveira Ferreira, Antônio Milton, Corrêa da Silva, Bárbara Martins, Behavioral therapy for the urinary incontinence of elderly woman, Journal of Nursing UFPE / Revista de Enfermagem UFPE, 9, 8762-8770, 2015	Study design does not meet the inclusion criteria; single arm study. Additionally, the intervention is unclear
Demain, S., Smith, J. F., Hiller, L., Dziedzic, K., Comparison of group and individual physiotherapy for female urinary incontinence in primary care, Physiotherapy, 87, 235-242, 2001	Intervention does not meet the inclusion criteria
Demain, S., Smith, J. F., Hiller, L., Dziedzic, K., Comparison of group and individual physiotherapy for female urinary incontinence in primary care: pilot study, Physiotherapy, 87, 235-242, 2001	Intervention does not meet the inclusion criteria; the intervention compared bladder training to pelvic floor muscle training in a group or individually
Diokno, A. C., Newman, D. K., Low, L. K., Griebling, T. L., Maddens, M. E., Goode, P. S., Raghunathan, T. E., Subak, L. L., Sampselle, C. M., Boura, J. A., Robinson, A. E., McIntyre, D., Burgio, K. L., Effect of Group-Administered Behavioral Treatment on Urinary Incontinence in Older Women: A Randomized Clinical Trial, JAMA Internal Medicine, 178, 1333-1341, 2018	Intervention does not meet the inclusion criterial; is not a psychological therapy
Diokno, A. C., Ocampo, M. S., Jr., Ibrahim, I. A., Karl, C. R., Lajiness, M. J., Hall, S. A., Group session teaching of behavioral modification program (BMP) for urinary incontinence: a randomized controlled trial among incontinent women, International Urology & Nephrology, 42, 375-81, 2010	Intervention does not meet the inclusion criterial; is not a psychological therapy
Diokno, A. C., Sampselle, C. M., Herzog, A. R., Raghunathan, T. E., Hines, S., Messer, K., Karl, C., Leite, M. C., Prevention of urinary incontinence by behavioral modification program: a randomized, controlled trial among older women in the community, Journal of Urology, 171, 1165-71, 2004	Intervention does not meet the inclusion criterial; is not a psychological therapy

Study	Reason for Exclusion
Donohoe, G., Sensitivity can break the taboo. Female sexual problems and treatment approaches, Professional Nurse, 7, 304-8, 1992	Narrative review
Dougherty, M. C., Dwyer, J. W., Pendergast, J. F., Boyington, A. R., Tomlinson, B. U., Coward, R. T., Duncan, R. P., Vogel, B., Rooks, L. G., A randomized trial of behavioral management for continence with older rural women, Research in nursing & health, 25, 3-13, 2002	Intervention does not meet the inclusion criterial; is not a psychological therapy
Dow, Michael G., A controlled comparative evaluation of conjoint counselling and self-help behavioural treatment for sexual dysfunction, Dissertation Abstracts International Section C: Worldwide, 75, No Pagination Specified, 2018	Thesis, no published article identified
Dowd, T., Dowd, E. T., A cognitive therapy approach to promote continence, Journal of Wound, Ostomy, & Continence Nursing, 33, 63-8, 2006	Narrative review
Dowd, T., Kolcaba, K., Steiner, R., Using cognitive strategies to enhance bladder control and comfort, Holistic Nursing Practice, 14, 91-103, 2000	Population includes men and cannot separate out the data on women
Due, U., Brostrom, S., Lose, G., Lifestyle advice with or without pelvic floor muscle training for pelvic organ prolapse: a randomized controlled trial, International Urogynecology Journal, 27, 555-63, 2016	Intervention does not meet the inclusion criterial; is not a psychological therapy
Dufour, S., Fedorkow, D., Fang, Q., The use of mobile health technology to support post-partum pelvic health: A randomized mixed methods pilot study, Neurourology and Urodynamics, 37 (Supplement 5), S70-S71, 2018	Conference abstract
Dufour, S., Fedorkow, D., Kun, J., Deng, S. X., Fang, Q., Exploring the impact of a mobile health solution for postpartum pelvic floor muscle training: Pilot randomized controlled feasibility study, Journal of Medical Internet Research, 21 (7) (no pagination), 2019	Intervention does not meet the inclusion criterial; is not a psychological therapy
Dyer, K. Y., Xu, Y., Brubaker, L., Nygaard, I., Markland, A., Rahn, D., Chai, T. C., Stoddard, A., Lukacz, E., Urinary Incontinence Treatment, Network, Minimum important difference for validated instruments in women with urge incontinence, Neurourology & Urodynamics, 30, 1319-24, 2011	Intervention does not meet the inclusion criterial; is not a psychological therapy
Elder, J. S., Bladder rehabilitation, the effect of a cognitive training programme on urge incontinence, Journal of Urology, 158, 1642, 1997	Abstract and editorial comment
Elliott, V., De Bruin, E. D., Dumoulin, C., Virtual reality as a treatment approach for older women with mixed urinary incontinence: A feasibility study, Neurourology and Urodynamics, 31 (6), 940-941, 2012	Conference abstract
Engel, B. T., Burgio, L. D., McCormick, K. A., Hawkins, A. M., Scheve, A. A., Leahy, E.,	Intervention does not meet the inclusion criteria; intervention based on toilet training

Study	Reason for Exclusion
Behavioral treatment of incontinence in the long-term care setting, Journal of the American Geriatrics Society, 38, 361-3, 1990	
Farnam, F., Janghorbani, M., Raisi, F., Merghati-Khoei, E., Compare the effectiveness of PLISSIT and sexual health models on women's sexual problems in Tehran, Iran: A randomized controlled trial, Journal of Sexual Medicine, 11, 2679-2689, 2014	Doesn't specify that sexual dysfunction was associated with pelvic floor dysfunction
Felsted, K. F., Supiano, K. P., Mindfulness-Based Stress Reduction Versus a Health Enhancement Program in the Treatment of Urge Urinary Incontinence in Older Adult Women: A Randomized Controlled Feasibility Study, Research in Gerontological Nursing, 12, 285-297, 2019	Outcome data does not meet the inclusion criteria
Fera, P., Lelis, M. A., Glashan, R. Q., Nogueira, M. P., Bruschini, H., Behavioral interventions in primary enuresis: experience report in Brazil, Urologic nursing : official journal of the American Urological Association Allied, 22, 257-262, 2002	Population do not meet the inclusion criteria; children aged 6 to 13 years
Fera, P., Lelis, M. A., Glashan, R. Q., Pereira, S. G., Bruschini, H., Desmopressin versus behavioral modifications as initial treatment of primary nocturnal enuresis, Urologic Nursing, 31, 286-289, 2011	Population does not meet the inclusion criteria; Children under 12
Fireman, G., Nocturnal enuresis: Psychological correlates and behavior therapy, Children's Hospital Quarterly, 1, 349-352, 1989	Population does not meet the inclusion criteria; children only included
Freeman, R. M., Baxby, K., Hypnotherapy for incontinence caused by the unstable detrusor, British Medical Journal Clinical Research Ed.Br Med J (Clin Res Ed), 284, 1831-4, 1982	Study design does not meet the inclusion criteria; single arm study, no comparator group
Freeman, R., A psychological approach to detrusor instability incontinence in women, Stress Medicine, 3, 9-14, 1987	Study design does not meet the inclusion criteria; single arm study, no comparator group
Friberg Felsted, K., Supiano, K. P., What is the feasibility and prelimimary efficacy of mindfulness-based stress reduction to treat symptoms of urinary incontinence in older adult women?, Journal of the American Geriatrics Society, 67 (Supplement 1), S227, 2019	Conference abstract
Garley, A., Unwin, J., A case series to pilot cognitive behaviour therapy for women with urinary incontinence, British Journal of Health Psychology, 11, 373-86, 2006	Study design does not meet the inclusion criteria: non-randomised case series
Garner, Ginger, Garner, Laverne, Yoga and Geriatric Pelvic Health, Notes, 27, 11-14, 2020	Full text unavailable from the British Library
Gaylord, S. A., Whitehead, W. E., Coble, R. S., Faurot, K. R., Palsson, O. S., Garland, E. L., Frey, W., Mann, J. D., Mindfulness for irritable bowel syndrome: protocol development for a controlled clinical trial, BMC Complementary & Alternative Medicine, 9, 24, 2009	No results, protocol paper
Gezginci, E., Iyigun, E., Yilmaz, S., Aydur, E., Comparative effectiveness of three different	Conference abstract

Study	Reason for Exclusion
teaching methods in behavioural therapy program for female overactive bladder: A randomized controlled trial, European Urology, Supplements, 14 (2), e263-e263a, 2015	
Gezginci, E., Iyigun, E., Yilmaz, S., Aydur, E., Comparative effectiveness of three different teaching methods in behavioral therapy program for female overactive bladder: A randomized controlled trial, Journal of Urology, 1), e572, 2015	Conference abstract
Gezginci, E., Iyigun, E., Yilmaz, S., Comparison of 3 Different Teaching Methods for a Behavioral Therapy Program for Female Overactive Bladder: A Randomized Controlled Trial, Journal of Wound, Ostomy, & Continence Nursing, 45, 68-74, 2018	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention
Gezginci, Elif, Iyigun, Emine, Yilmaz, Sercan, Comparison of 3 Different Teaching Methods for a Behavioral Therapy Program for Female Overactive Bladder: A Randomized Controlled Trial, Journal of Wound, Ostomy & Continence Nursing, 45, 68-74, 2018	Intervention does not meet the inclusion criteria
Golder, J., Treatment of enuresis. A personal approach in general practice, Australian family physician, 15, 1413, 1416, 1986	Narrative review
Gomelsky,A., Dmochowski,R.R., Treatment of mixed urinary incontinence in women, Current Opinion in Obstetrics and Gynecology, 23, 371-375, 2011	Narrative review
Goode, P. S., Burgio, K. L., Locher, J. L., Umlauf, M. G., Lloyd, L. K., Roth, D. L., Urodynamic changes associated with behavioral and drug treatment of urge incontinence in older women, Journal of the American Geriatrics Society, 50, 808-16, 2002	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention
Gray, M., Beitz, J. M., Counseling patients undergoing urinary diversion: Does the type of diversion influence quality of life?, Journal of Wound, Ostomy and Continence Nursing, 32, 7-15, 2005	Systematic review; review on a surgical interventions, and therefore not relevant
Gulewitsch, M. D., Schlarb, A. A., Comparison of gut-directed hypnotherapy and unspecific hypnotherapy as self-help format in children and adolescents with functional abdominal pain or irritable bowel syndrome: a randomized pilot study, European journal of gastroenterology & hepatology, 29, 1351-1360, 2017	Population includes males and children under 12, cannot separate out the data on women
Gunzler, Cindy, Berner, Michael M., Efficacy of psychosocial interventions in men and women with sexual dysfunctions-A systematic review of controlled clinical trials: Part 2-The efficacy of psychosocial interventions for female sexual dysfunction, Journal of Sexual Medicine, 9, 3108-3125, 2012	Systematic review, references checked for relevance
Hagen, S., McClurg, D., Bugge, C., Hay-Smith, J., Dean, S. G., Elders, A., Glazener, C., Abdel-Fattah, M., Agur, W. I., Booth, J., et al.,,	Intervention not psychological. Maybe suitable 8.1

Study	Reason for Exclusion
Effectiveness and cost-effectiveness of basic versus biofeedback-mediated intensive pelvic floor muscle training for female stress or mixed urinary incontinence: protocol for the OPAL randomised trial, BMJ Open, 9, 2019	
Hall, C., Advising on continence, Community Outlook Community Outlook, 38-43, 1990	Full text unavailable from the British Library
Hamid, N., Dehghanizadeh, Z., Firuzi, A. A., Effects of cognitive - behavioral therapy on sexual function in women with vaginismus disorder, Iranian Journal of Obstetrics, Gynecology and Infertility, 15, 2012	Publication not in English, only available in Farsi
Harrison,J.D., Young,J.M., Solomon,M.J., Butow,P.N., Secomb,R., Masya,L., Randomized pilot evaluation of the supportive care intervention "CONNECT" for people following surgery for colorectal cancer, Diseases of the Colon and Rectum, 54, 622-631, 2011	Population does not meet the inclusion criteria, majority male population
Hesnan, K., ET nurses expanding our practice. Behavioral interventions for incontinence, Ostomy Wound Management, 38, 12, 14-6, 17 passim, 1992	Full text unavailable from the British Library
Hill, L. A., Fereday-Smith, J., Credgington, C., Woodward, A. F., Knight, J. C., Williams, A. J., Doughty, G., Lamb, S. E., Pepper, J., Lall, R., Clarke, M., Bladders behaving badly: a randomized controlled trial of group versus individual interventions in the management of female urinary incontinence, Journal of the Association of Chartered Physiotherapists in Women's Health, 30-36, 2007	Intervention does not meet the inclusion criteria: group education (include for 6.2)
Hiller, J., Psychotherapy works, Sexual & Relationship Therapy, 21, 385-389, 2006	Narrative review
Hocking, J., Continence problems: how to tackle reticence of patients, Nursing Times, 95, 56-8, 1999	Narrative review
Hu, T. W., Kaltreider, D. L., Igou, J. F., Yu, L. C., Rohner, T. J., Cost effectiveness of training incontinent elderly in nursing homes: a randomized clinical trial, Health Services Research, 25, 455-77, 1990	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention
Hucker, A., McCabe, M. P., Incorporating Mindfulness and Chat Groups Into an Online Cognitive Behavioral Therapy for Mixed Female Sexual Problems, Journal of Sex Research, 52, 627-639, 2015	No reference to pelvic floor dysfunction
Hunt, J., Psychological approaches to the management of sensory urgency and idiopathic detrusor instability, British Journal of Urology, 77, 339-41, 1996	Narrative review
Igbedioh, Carlene, Williams, Andrew B., Schizas, Alexis, Introducing a pelvic floor telephone assessment service, Journal of Community Nursing, 28, 59-65, 2014	Intervention does not meet the inclusion criteria; study tests a telephone triage for assessment of patients
Irwin, B., User support groups in continence care, Nursing Times, 96, 24, 2000	Descriptive summary of a support service

Study	Reason for Exclusion
Jacobson, A. F., Winslow, E. H., Treatment for nocturnal enuresis, The American journal of nursing, 99, 22, 1999	Population does not meet the inclusion criteria; children with enuresis
Janeway, Megan, Baum, Neil, Smith, Ryan, Sexual dysfunction in older women, Clinical Geriatrics, 20, 16-20, 2012	Narrative review
Johnson, A. K., Johnson, A. J., Barton, D., Elkins, G., Hypnotic Relaxation Therapy and Sexual Function in Postmenopausal Women: Results of a Randomized Clinical Trial, International Journal of Clinical and Experimental Hypnosis, 64, 213-224, 2016	Sexual dysfunction not completely due pelvic floor dysfunction
Johnson, Aimee K., Johnson, Alisa J., Barton, Debra, Elkins, Gary, Hypnotic Relaxation Therapy and Sexual Function in Postmenopausal Women: Results of a Randomized Clinical Trial, International Journal of Clinical & Experimental Hypnosis, 64, 213-224, 2016	Population does not meet the inclusion criteria; healthy women were recruited
Johnson, C., Accentuate the positive, Nursing Times, 95, 81, 1999	Personal experience
Jones, G., Brennan, V., Jacques, R., Wood, H., Dixon, S., Radley, S., Evaluating the impact of a 'virtual clinic' on patient experience, personal and provider costs of care in urinary incontinence: A randomised controlled trial, PLoS ONE, 13 (1) (no pagination), 2018	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention
Jones, L. M., McCabe, M. P., The effectiveness of an Internet-based psychological treatment program for female sexual dysfunction, Journal of Sexual Medicine, 8, 2781-92, 2011	Pelvic floor dysfunction not the cause of all sexual dysfunction
Jones, L. M., McCabe, M. P., The effectiveness of an Internet-based psychological treatment program for female sexual dysfunction, Journal of Sexual Medicine, 8, 2781-92, 2011	Population does not meet the inclusion criteria; women did not have pelvic floor dysfunction
Kabakci, E., Batur, S., Who benefits from cognitive behavioral therapy for vaginismus?, Journal of Sex & Marital Therapy, 29, 277-88, 2003	Study design does not meet the inclusion criteria; single arm study, no comparator group included
Kangchai, W., Srisuphun, W., Kompayak, J., Charoenyooth, C., Jitapunkul, S., Efficacy of self-management promotion program for elderly women with urinary incontinence, Thai Journal of Nursing Research, 6, 101-114, 2002	Full text unavailable from the British Library
Karimi, Farzaneh, Babazadeh, Raheleh, Asgharipour, Negar, Esmaily, Habibollah, Roudsari, Robab Latifnejad, The Effectiveness of Counseling using PLISSIT Model on Depression, Anxiety and Stress, among Postpartum Women with Sexual Dysfunction: A Randomized Trial, Journal of Midwifery & Reproductive Health, 7, 1912-1920, 2019	Population does not meet the inclusion criteria; women do not have pelvic floor dysfunction
Keachie, J., Continence. Island life, Nursing Times, 89, 72, 74, 76, 1993	Full text unavailable from the British Library
Kenton, K., Barber, M., Wang, L., Hsu, Y., Rahn, D., Whitcomb, E., Amundsen, C., Bradley, C. S.,	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention

Study	Reason for Exclusion
Zyczynski, H., Richter, H. E., Pelvic Floor Disorders, Network, Pelvic floor symptoms improve similarly after pessary and behavioral treatment for stress incontinence, Female Pelvic Medicine & Reconstructive Surgery, 18, 118-21, 2012	
Kilinc, M. F., Doluoglu, O. G., Yildiz, Y., Yuceturk, C. N., Hascicek, A. M., Using a checklist to increase the effectiveness of behavioral therapy for overactive bladder: A prospective randomized controlled trial, Neurourology & Urodynamics, 38, 1152-1159, 2019	Population includes men and cannot separate out the data on women
Kilmann, P. R., Boland, J. P., Norton, S. P., Davidson, E., Caid, C., Perspectives of sex therapy outcome: a survey of AASECT providers, Journal of Sex & Marital Therapy, 12, 116-38, 1986	Narrative review
Kincade, J. E., Dougherty, M. C., Busby-Whitehead, J., Carlson, J. R., Nix, W. B., Kelsey, D. T., Smith, F. C., Hunter, G. S., Rix, A. D., Self-monitoring and pelvic floor muscle exercises to treat urinary incontinence, Urologic nursing : official journal of the American Urological Association Allied, 25, 353-363, 2005	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention
Kingsberg, S. A., Lecture 4: Clinical approaches to women's sexual dysfunctions, International Journal of Impotence Research, 13, S44-S46, 2001	Narrative review and presentation
Kinman, C. L., Meriwether, K. V., Powell, C. M., Hobson, D. T. G., Gaskins, J. T., Francis, S. L., Use of an iPadTM application in preoperative counseling for pelvic reconstructive surgery: a randomized trial, International Urogynecology Journal, 29, 1289-1295, 2018	No usable data
Klijn, A. J., Uiterwaal, C. S., Vijverberg, M. A., Winkler, P. L., Dik, P., de Jong, T. P., Home uroflowmetry biofeedback in behavioral training for dysfunctional voiding in school-age children: a randomized controlled study, Journal of Urology, 175, 2263-8; discussion 2268, 2006	Population do not meet the inclusion criteria, study includes children and data cannot be separated out
Knauf, K., A good poop, The journal of pastoral care & counseling : JPCC, 59, 139-140, 2005	Commentary paper
Komesu, Y. M., Rogers, R. G., Sapien, R. E., Schrader, R. M., Simmerman-Sierra, T., Mayer, A. R., Ketai, L. H., Methodology for a trial of brain-centered versus anticholinergic therapy in women with urgency urinary incontinence, International Urogynecology Journal, 28, 865-874, 2017	Protocol paper - no data reported
Komesu, Y. M., Rogers, R. G., Sapien, R., Hypnotherapy for treatment of overactive bladder: A pilot study, Journal of Pelvic Medicine and Surgery, 2), S86, 2010	Conference abstract
Komesu, Y. M., Schrader, R. M., Rogers, R. G., Sapien, R. E., Mayer, A. R., Ketai, L. H., Hypnotherapy or medications: a randomized	Comparison does not meet the inclusion criteria, comparator arm receives medication

Study	Reason for Exclusion
noninferiority trial in urgency urinary incontinent women, American Journal of Obstetrics & Gynecology, 23, 23, 2019	
Komesu, Y. M., Schrader, R., Rogers, R. G., Sapien, R., Ketai, L. H., Hypnotherapy or pharmacotherapy for urgency urinary incontinence treatment in women. the hyp-hop randomized clinical trial, Female Pelvic Medicine and Reconstructive Surgery, 24 (5 Supplement 1), S4, 2018	Conference abstract
Kristmanson, D., Wen, S., White, R., Black, A., Schachter, J., Effectiveness of a motivational interviewing workshop in decreasing decisional conflict in women with pelvic floor disorders: A randomized trial, Neurourology and Urodynamics, 36 (Supplement 3), S393-S394, 2017	Conference abstract
Lackner, J. M., Quigley, B. M., Gudleski, G. D., Radziwon, C., Krasner, S. S., Hamilton, F. A., Ruminski, K. A., Brenner, D. M., Firth, R. S., Vargovich, A., Global Ibs Symptom Improvement in Cognitive-Behavioral Therapy-Treated Patients Is Associated with Clinically Important Changes in Abdominal Pain and Stool Consistency across All Bowel Types, Gastroenterology, 156 (6 S1), S-1062, 2019	Conference abstract
Lavelle, E. S., Zyczynski, H. M., Stress Urinary Incontinence. Comparative Efficacy Trials, Obstetrics and Gynecology Clinics of North America, 43, 45-57, 2016	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention
Lee, P. S., Reid, D. W., Saltmarche, A., Linton, L., Measuring the psychosocial impact of urinary incontinence: the York Incontinence Perceptions Scale (YIPS), Journal of the American Geriatrics Society, 43, 1275-8, 1995	Intervention does not meet the inclusion criteria; behavioural therapy
Lekan-Rutledge, D., Colling, J., Urinary incontinence in the frail elderly: even when it's too late to prevent a problem, you can still slow its progress, American Journal of Nursing, Suppl, 36-46, 2003	Narrative review
Leong, B. S., Mok, N. W., Effectiveness of a new standardised Urinary Continence Physiotherapy Programme for community-dwelling older women in Hong Kong, Hong Kong Medical Journal, 21, 30-7, 2015	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention
Long, J. E., Khairat, S., Chmelo, E., Palmer, M. H., Mind over bladder: Women, aging, and bladder health, Geriatric Nursing, 39, 230-237, 2018	Study design does not meet the inclusion criteria, non-comparative study
MacNeill, C., Dyspareunia, Obstetrics and Gynecology Clinics of North America, 33, 565-577, 2006	Narrative review of prevalence and diagnosis
Manchester, J., Psychogenic urine retention: a graded approach, Nursing Mirror, 151, 48-49, 1980	Unable to access full text article from the British Library

Study	Reason for Exclusion
Mantle, F., Hypnosis in the treatment of enuresis, Paediatric Nursing, 11, 33-36, 1999	Narrative review of enuresis in children
Margolis,M.K., Fox,K.M., Cerulli,A., Ariely,R., Kahler,K.H., Coyne,K.S., Psychometric validation of the overactive bladder satisfaction with treatment questionnaire (OAB-SAT-q), Neurourology and Urodynamics, 28, 416-422, 2009	Population does not meet the inclusion criteria, males included and no separate analysis conducted on women
Marti, B. G., Valentini, F. A., Robain, G., Contribution of behavioral and cognitive therapy to managing overactive bladder syndrome in women in the absence of contributive urodynamic diagnosis, International Urogynecology Journal, 26, 169-73, 2015	Narrative review
Maseroli, Elisa, Scavello, Irene, Rastrelli, Giulia, Limoncin, Erika, Cipriani, Sarah, Corona, Giovanni, Fambrini, Massimiliano, Magini, Angela, Jannini, Emmanuele A., Maggi, Mario, Vignozzi, Linda, Outcome of medical and psychosexual interventions for vaginismus: A systematic review and meta-analysis, Journal of Sexual Medicine, 15, 1752-1764, 2018	Systematic review, references checked for relevance (all RCTs included)
Maß, Reinhard, Briken, Peer, Evaluation of the Hamburg model of couple therapy in the treatment of low sexual desire and vaginismus. A prospective group comparison, Sexual & Relationship Therapy, 32, 46-57, 2017	Study design does not meet the inclusion criteria, single arm study - no comparison group
McClurg, D., Pollock, A., Campbell, P., Hazelton, C., Elders, A., Hagen, S., Hill, D. C., Conservative interventions for urinary incontinence in women: An Overview of Cochrane systematic reviews, Cochrane Database of Systematic Reviews, 2016 (9) (no pagination), 2016	Protocol paper
McDowell, B. J., Engberg, S., Sereika, S., Donovan, N., Jubeck, M. E., Weber, E., Engberg, R., Effectiveness of behavioral therapy to treat incontinence in homebound older adults, Journal of the American Geriatrics Society, 47, 309-318, 1999	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention
McFall, S. L., Yerkes, A. M., Cowan, L. D., Outcomes of a small group educational intervention for urinary incontinence: episodes of incontinence and other urinary symptoms, Journal of Aging & Health, 12, 250-67, 2000	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention
McFall, S. L., Yerkes, A. M., Cowan, L. D., Outcomes of a small group educational intervention for urinary incontinence: health-related quality of life, Journal of Aging & Health, 12, 301-17, 2000	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention
McFall, Stephanie L., Yerkes, Adeline M., Cowan, Linda D., Outcomes of a small group educational intervention for urinary incontinence: Health-related quality of life, Journal of Aging and Health, 12, 301-317, 2000	Intervention does not meet the inclusion criteria, the intervention based on bladder training
Meadow, R., Nocturnal enuresis, Prescribers' Journal, 35, 206-211, 1995	Population does not meet the inclusion criteria, a narrative summary on children

Study	Reason for Exclusion
Meek, D., Thorne, P., Luker, A., Support groups for older women, Nursing Times, 85, 71-3, 1989	Full text unavailable from the British Library
Melles, R. J., ter Kuile, M. M., Dewitte, M., van Lankveld, J. J., Brauer, M., de Jong, P. J., Automatic and deliberate affective associations with sexual stimuli in women with lifelong vaginismus before and after therapist-aided exposure treatment, Journal of Sexual Medicine, 11, 786-99, 2014	Outcomes not relevant; paper is looking at reaction times. Population is the same as Ter Kuile (included study 2013/2015).
Miller, E., "Don't make me laugh: comedy bursts the continence taboo", Nursing Times, 109, 11, 2013	Study design does not meet the inclusion criteria, not a randomised controlled trail
Moossdorff-Steinhauser, H. F. A., Bols, E. M. J., Spaanderman, M. E. A., Dirksen, C. D., Weemhoff, M., Nieman, F. H. M., Berghmans, B., Long-term effects of motherfit group therapy in pre-(MOTHERFIT1) and post-partum women (MOTHERFIT2) with stress urinary incontinence compared to care-as-usual: Study protocol of two multi-centred, randomised controlled trials, Trials, 20 (1) (no pagination), 2019	Study Protocol, no results
Moriarty, M. B., The NIH puts the spotlight on incontinence, RNRn, 52, 44-5, 1989	Narrative summary paper
Morley, R., The future of SUI management ... a shift in emphasis?, Health Service Journal, 114, suppl 14-5 following 54, 2004	Narrative summary paper
Mosalanejad, F., Afrasiabifar, A., Zoladl, M., Investigating the combined effect of pelvic floor muscle exercise and mindfulness on sexual function in women with multiple sclerosis: a randomized controlled trial, Clinical Rehabilitation, 32, 1340-1347, 2018	Does not specify that sexual dysfunction is associated with pelvic floor dysfunction
Muller, N., Continence coach: telehealth to the bladder's rescue, Ostomy Wound Management, 59, 14, 2013	Study design does not meet the inclusion criteria, not a randomised controlled trail
Muller, N., Proliferating hope, Ostomy Wound Management Ostomy Wound Manage, 55, 18, 2009	Editorial
Myers, E. M., Robinson, B. L., Geller, E. J., Wells, E., Matthews, C. A., Fenderson, J. L., Crane, A. K., Jannelli, M., Connolly, A., Randomized trial of a web-based tool for prolapse: impact on patient understanding and provider counseling, International Urogynecology Journal, 25, 1127-32, 2014	Not Validated questionnaire
Myers, E. M., Robinson, B. L., Geller, E. J., Wells, E., Matthews, C. A., Fenderson, J. L., Crane, A. K., Jannelli, M., Connolly, A., Interactive web-based tool for pelvic organ prolapse: Impact on patient understanding and provider counseling, Journal of Minimally Invasive Gynecology, 1), S57, 2013	Conference abstract
Myers, E. M., Robinson, B., Geller, E., Wells, E., Matthews, C., Fenderson, J., Crane, A., Jannelli, M., Connolly, A., Interactive web-based patient/provider counseling and pelvic organ	Conference abstract

Study	Reason for Exclusion
prolapse: Do patients better understand and do providers better counsel?, International Urogynecology Journal and Pelvic Floor Dysfunction, 24, S87, 2013	
Myers, E., Robinson, B. L., Geller, E. J., Wells, E., Matthews, C. A., Fenderson, J. L., Crane, A. K., Jannelli, M., Connolly, A., Interactive web-based tool for pelvic organ prolapse: Impact on patient understanding and provider counseling, Female Pelvic Medicine and Reconstructive Surgery, 19, S131-S132, 2013	Conference abstract
Ng, M. L., Vaginismus - A disease, symptom or culture-bound syndrome?, Sexual and Marital Therapy, 14, 9-13, 1999	Commentary paper
Nicol, A. R., Research on psychological therapies, Current Opinion in Psychiatry, 1, 444-449, 1988	Review, not systematic
Norton, C., Chelvanayagam, S., Wilson-Barnett, J., Redfern, S., Kamm, M. A., Randomized controlled trial of biofeedback for fecal incontinence, Gastroenterology, 125, 1320-9, 2003	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention
Norton, C., Coping with incontinence, Geriatric Nursing & Home Care, 7, 16-9, 1987	Study design does not meet the inclusion criteria, not a randomised controlled trail
Norton, C., Dibley, L. B., Hart, A., Duncan, J., Emmanuel, A., Knowles, C. H., Stevens, N., Terry, H., Verjee, A., Kerry, S., Hounsome, N., Faecal incontinence intervention study (FINS): self-management booklet information with or without nurse support to improve continence in people with inflammatory bowel disease: study protocol for a randomized controlled trial, Trials, 16, 2015	IBS not Pelvic Floor Dysfunction
Norton, C., Winder, A., Continence. Target practice, Nursing Times, 89, 66, 68, 70, 1993	Full text unavailable from the British Library
Oakley, S. H., Ghodsi, V. C., Crisp, C. C., Estanol, M. V., Westermann, L. B., Novicki, K. M., Kleeman, S. D., Pauls, R. N., Effects of physical therapy on pelvic floor symptoms and quality of life in postpartum women following severe perineal trauma: a randomized controlled trial, Female pelvic medicine & reconstructive surgery, 21, S18, 2015	Conference
O'Connell, H. E., MacGregor, R. J., Russell, J. M., Female urinary incontinence. Management in primary care, Medical Journal of Australia, 157, 537-44, 1992	Study design does not meet the inclusion criteria, not a randomised controlled trail
Oh, H. S., Kim, M. K., Seo, W. S., Effectiveness of a behavioral intervention program for urinary incontinence in a community setting, Taehan Kanho Hakhoe chi, 35, 1476-1484, 2005	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention
Oh-oka, H., Usefulness of long-term dietary manipulation for female patients with painful bladder syndrome/interstitial cystitis, Neurourology and urodynamics, 37, S115-S116, 2018	Conference

Study	Reason for Exclusion
Osborne, L. A., Reed, P., A Review of Hypnotherapy for Overactive Bladder, International Journal of Clinical & Experimental Hypnosis, 67, 278-296, 2019	Narrative review, RCTs checked
Osborne, L. A., Whittall, C. M., Emanuel, R., Emery, S., Reed, P., Randomized Controlled Trial of the Effect of a Brief Telephone Support Intervention on Initial Attendance at Physiotherapy Group Sessions for Pelvic Floor Problems, Archives of Physical Medicine and Rehabilitation, 98, 2247-2252, 2017	Intervention does not meet the inclusion criteria; the intervention is a phone call to increase attendance, not to give psychological support
Osborne, L. A., Whittall, C. M., Hanratty, H., Emanuel, R., Emery, S., Reed, P., Patient health value strength predicts compliance, but internalised health values predict outcome, in physiotherapy treatment for pelvic floor dysfunction, Physiotherapy, 102 (Supplement 1), e271, 2016	Conference abstract
Osborne, Lisa A., Reed, Phil, A Review of Hypnotherapy for Overactive Bladder, International Journal of Clinical & Experimental Hypnosis, 67, 278-296, 2019	Narrative review
Osborne, Lisa A., Whittall, C. Mair, Emanuel, Ruth, Emery, Simon, Reed, Phil, Randomized Controlled Trial of the Effect of a Brief Telephone Support Intervention on Initial Attendance at Physiotherapy Group Sessions for Pelvic Floor Problems, Archives of Physical Medicine & Rehabilitation, 98, 2247-2252, 2017	Intervention does not meet the inclusion criteria; not a psychological intervention
Palmer, M. H., Marquez, C. S., Li, Y., Hawkins, S. Y., Smith, F., Busby-Whitehead, J., A Feasibility Study for a Posthospital Intervention for Lower Urinary Tract Symptoms in Adults With Heart Failure, Journal of wound, ostomy, and continence nursing : official publication of The Wound, Ostomy and Continence Nurses Society, 42, 539-546, 2015	Population includes males, can't separate out females
Palsson, O. S., Heymen, S., Busby-Whitehead, J., Twist, S., Whitehead, W. E., Six-Week Internet Self-Help Intervention Reduces Symptom Episodes by 50% or More in the Majority of Individuals with Fecal Incontinence: A Pilot Study, Gastroenterology, 154 (6 Supplement 1), S-184, 2018	Conference
Peters, N., Eliminate the negative, Nursing times, 95, 78, 1999	Personal experience
Peters, S., Yao, C. K., Shepherd, S., Philpott, H., Yelland, G., Muir, J. G., Gibson, P. R., Gut-directed hypnotherapy and a low fodmap diet are similarly efficacious in patients with irritable bowel syndrome: A randomised controlled non-inferiority trial, Gastroenterology, 1), S487-S488, 2015	Conference abstract
Pitia, A. P., Saskia Tavares, J., Teixeira, B., Teles, A., Lemos, A., Nogueira, A., Brasil, C., Lordelo, P., The effectiveness of cbt in the sexual function and quality of life of women with	Conference abstract

Study	Reason for Exclusion
sexual dysfunction: A comparative study, Neurourology and Urodynamics, 37 (Supplement 5), S232-S233, 2018	
Pitia, A. P., Tavares, J., Teixeira, B., Brasil, C., Lemos, A., Campos, R., Nogueira, A., Sodre, D., Mascarenhas, I., Lordelo, P., The influence of cognitive-behavioral psychotherapy on the sexual function and quality of life of women with sexual dysfunction: Preliminary results: Of the randomized clinical trial using quantitative and qualitative metrics, Neurourology and Urodynamics, 37 (Supplement 5), S415-S416, 2018	Conference abstract
Plymat, K. R., Turner, S. L., In-home management of urinary incontinence, Home Healthcare Nurse Home, 6, 30-4, 1988	Commentary paper
Pottle, B., Continence. Action plans, Nursing Times, 89, 78, 1993	Full text unavailable from the British Library
Pottle, B., Continence. Reformed role, Nursing Times, 89, 63-4, 1993	Full text unavailable from the British Library
Powell, M., Nurses' hidden work, Nursing Times, 98, 53, 2002	Study design does not meet the inclusion criteria, not a randomised controlled trail
Rajalaxmi, V., Varalakshmi, S., Suresh, V. H., Kumar, G. M., Kamatchi, K., Vaishnavi, G., Muthukumaran, N., Efficacy of pelvic floor muscle training, yoga and cognitive behavioural therapy for urinary incontinence in diabetic women - a randomized controlled double blinded study, Research Journal of Pharmacy and Technology, 12, 4618-4622, 2019	Conference abstract
Rao, S. S. C., Valestin, J. A., Xiang, X., Hamdy, S., Bradley, C. S., Zimmerman, M. B., Home-based versus office-based biofeedback therapy for constipation with dyssynergic defecation: a randomised controlled trial, The Lancet Gastroenterology and Hepatology, 3, 768-777, 2018	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention
Richter, H. E., Burgio, K. L., Brubaker, L., Nygaard, I. E., Ye, W., Weidner, A., Bradley, C. S., Handa, V. L., Borello-France, D., Goode, P. S., Zyczynski, H., Lukacz, E. S., Schaffer, J., Barber, M., Meikle, S., Spino, C., Pelvic Floor Disorders, Network, Continence pessary compared with behavioral therapy or combined therapy for stress incontinence: a randomized controlled trial, Obstetrics & Gynecology, 115, 609-17, 2010	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention
Rigby, D., Continence. Face to face support, Nursing Times, 92, 84, 1996	Full text unavailable from the British Library
Rogers, J., Cognitive bladder training in the community, Paediatric Nursing, 8, 18-20, 1996	Population does not meet the inclusion criteria, children
Roja, Inara, Roja, Zenija, Use of cognitive hypnotherapy and couples therapy for female patients with psychogenic vaginismus, Contemporary Hypnosis, 27, 88-94, 2010	Full text unavailable from the British Library

Study	Reason for Exclusion
Rollins, G., Behavior management improves urinary incontinence in older women living at home, Report on medical guidelines & outcomes research, 13, 7-9, 2002	Outcome data does not meet the inclusion criteria
Rose, J., Making contact, Nursing Times, 95, 78, 81, 1999	Full text unavailable from the British Library
Rosenbaum, Talli Y., An integrated mindfulness-based approach to the treatment of women with sexual pain and anxiety: promoting autonomy and mind/body connection, Sexual & Relationship Therapy, 28, 20-28, 2013	Study design does not meet the inclusion criteria, not a randomised controlled trial
Safarzadeh, A., Navidian, A., Dastyar, N., The effect of assertiveness-based sexual counselling on sexual function among married female students, International Journal of Women's Health and Reproduction Sciences, 6, 342-349, 2018	Does not specify if sexual function is associated with pelvic floor dysfunctions
Sampselle, C. M., Behavioral interventions in young and middle-age women: simple interventions to combat a complex problem, The American journal of nursing, Suppl, 9-19, 2003	Review but no mention of psychological therapies,
Sampselle, C. M., Messer, K. L., Seng, J. S., Raghunathan, T. E., Hines, S. H., Diokno, A. C., Learning outcomes of a group behavioral modification program to prevent urinary incontinence, International Urogynecology Journal, 16, 441-446, 2005	Incorrect population (preventative intervention, population is symptom free)
Sampselle, C. M., Miller, J. M., Herzog, A. R., Diokno, A. C., Behavioral modification: group teaching outcomes, Urologic Nursing, 16, 59-63, 1996	Study design does not meet the inclusion criteria, not a randomised controlled study
Samuelsson, E., Nystrom, E., Soderstrom, L., Treatment for stress urinary incontinence with the support of a mobile application is effective when implemented for free use, Neurourology and Urodynamics, 35 (Supplement 4), S92-S94, 2016	Conference abstract
Schnelle, J. F., Traughber, B., Morgan, D. B., Embry, J. E., Binion, A. F., Coleman, A., Management of geriatric incontinence in nursing homes, Journal of Applied Behavior Analysis, 16, 235-41, 1983	Population includes males, can't separate females
Schnyder, U., Schnyder-Luthi, C., Ballinari, P., Blaser, A., Therapy for vaginismus: in vivo versus in vitro desensitization, Canadian Journal of Psychiatry - Revue Canadienne de Psychiatrie Can J Psychiatry, 43, 941-4, 1998	No outcome data provided. The paper does not provide data per intervention group
Schover,L.R., Yuan,Y., Fellman,B.M., Odensky,E., Lewis,P.E., Martinetti,P., Efficacy trial of an Internet-based intervention for cancer-related female sexual dysfunction, Journal of the National Comprehensive Cancer Network, 11, 1389-1397, 2013	Not Pelvic Floor Dysfunction, related to cancer
Scott, M. A., Stigleman, S., What is the best hypnotic for use in the elderly?, Journal of Family Practice, 52, 976-978, 2003	Summary paper

Study	Reason for Exclusion
Seabrook, J. A., Gorodzinsky, F., Freedman, S., Treatment of primary nocturnal enuresis: A randomized clinical trial comparing hypnotherapy and alarm therapy, Paediatrics and Child Health, 10, 609-610, 2005	Incorrect population (60% male, mean age 9.1 years)
Seo, J. T., Choe, J. H., Lee, W. S., Kim, K. H., Efficacy of functional electrical stimulation-biofeedback with sexual cognitive-behavioral therapy as treatment of vaginismus, Urology, 66, 77-81, 2005	Study design does not meet the inclusion criteria, not a randomised controlled trial
Shapiro, S. R., Enuresis: treatment and overtreatment, Pediatric nursing, 11, 203-207, 214, 1985	Population does not meet the inclusion criteria; Children
Sharma, V., Saito, Y., Amit, S., Mind-body medicine and irritable bowel syndrome: a randomized control trial using stress reduction and resiliency training, Journal of alternative and complementary medicine (New York, N.Y.), 20, A94, 2014	Conference abstract
Shultz, J. M., Rethink urinary incontinence in older women, Nursing, 42, 32-40; quiz p.40-1, 2012	Study design does not meet the inclusion criteria, not a randomised controlled study
Shultz, J. M., Urinary incontinence, Nursing, 40, 33, 2010	Study design does not meet the inclusion criteria, not a randomised controlled study
Simon, M. A., Bueno, A. M., Efficacy of Biofeedback Therapy in the Treatment of Dyssynergic Defecation in Community-Dwelling Elderly Women, Journal of Clinical Gastroenterology, 51, e90-e94, 2017	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention
Singh, H., Singh, D., Jain, B. K., Enuresis updated, Indian Pediatrics, 31, 611-618, 1994	Population does not meet the inclusion criteria; children
Sjostrom, M., Lindholm, L., Samuelsson, E., Mobile App for Treatment of Stress Urinary Incontinence: A Cost-Effectiveness Analysis, Journal of medical Internet research, 19, e154, 2017	Health Economic study
Sjostrom, M., Umefjord, G., Stenlund, H., Carlbring, P., Andersson, G., Samuelsson, E., Internet-based treatment of stress urinary incontinence: 1- and 2-year results of a randomized controlled trial with a focus on pelvic floor muscle training, BJU International, 116, 955-64, 2015	Intervention not psychological, suitable for 8.1
Sjostrom, M., Umefjord, G., Stenlund, H., Carlbring, P., Andersson, G., Samuelsson, E., Internet-based treatment of stress urinary incontinence: A randomised controlled study, Neurourology and Urodynamics, 31 (6), 734-736, 2012	Conference abstract
Sjostrom, M., Umefjord, G., Stenlund, H., Carlbring, P., Andersson, G., Samuelsson, E., Internet-based treatment of stress urinary incontinence: A randomised controlled study with focus on pelvic floor muscle training, BJU international, 112, 362-372, 2013	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention

Study	Reason for Exclusion
Skelton, N., Meeting the challenge, Nursing Times, 95, 82, 1999	Full text unavailable from the British Library
Stephan, E., Hajjar, R. R., Urinary incontinence in older adults, Journal Medical Libanais, 60, 220-227, 2012	Study design does not meet the inclusion criteria, not a randomised controlled study
Stephenson, K. R., Kerth, J., Effects of Mindfulness-Based Therapies for Female Sexual Dysfunction: A Meta-Analytic Review, Journal of Sex Research J Sex Res, 54, 832-849, 2017	Systematic review, references checked for relevance, no reference to pelvic floor dysfunction
Stephenson, Kyle R., Kerth, Jonathan, Effects of mindfulness-based therapies for female sexual dysfunction: A meta-analytic review, Journal of Sex Research, 54, 832-849, 2017	Systematic review, references checked for relevance, no reference to pelvic floor dysfunction
Stewart, M., Continence. Preparing for the future, Nursing Times, 81, 62-3, 1985	Commentary paper
Stravynski, A., Gaudette, G., Lesage, A., Arbel, N., Bounader, J., Lachance, L., Clerc, D., Fabian, J., Lamontagne, Y., Langlois, R., Lipp, O., Sidoun, P., The treatment of sexually dysfunctional women without partners: A controlled study of three behavioural group approaches, Clinical Psychology and Psychotherapy, 14, 211-220, 2007	No mention of pelvic floor dysfunction
Subak, L. L., Quesenberry, C. P., Posner, S. F., Cattolica, E., Soghikian, K., The effect of behavioral therapy on urinary incontinence: a randomized controlled trial, Obstetrics & Gynecology Obstet Gynecol, 100, 72-8, 2002	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention
Sudol, N. T., Garg, N., Adams-Piper, E., Jacobs, S., Lane, F. L., Upgrades in patient education: Assessing the utility of an iPad application in pelvic organ prolapse comprehension and counseling satisfaction, American Journal of Obstetrics and Gynecology, 218 (2 Supplement 2), S928-S929, 2018	Conference abstract
Sudol, N. T., Garg, N., Adams-Piper, E., Jacobs, S., Lane, F. L., 56: Upgrades in patient education: Assessing the utility of an iPad application in pelvic organ prolapse comprehension and counseling satisfaction, American Journal of Obstetrics & Gynecology, 218, S928-S929, 2018	Conference abstract
Supiano, K. P., Felsted, K. F., Treating urge urinary incontinence in older adult women with complementary therapies: A feasibility and randomized controlled trial utilizing MBSR and hep, Global Advances in Health and Medicine, 7, 223, 2018	Conference abstract
Tak, E. C., van Hespen, A., van Dommelen, P., Hopman-Rock, M., Does improved functional performance help to reduce urinary incontinence in institutionalized older women? A multicenter randomized clinical trial, BMC Geriatrics, 12, 51, 2012	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention

Study	Reason for Exclusion
ter Kuile, M. M., Both, S., van Lankveld, J. J., Cognitive behavioral therapy for sexual dysfunctions in women, Psychiatric Clinics of North America, 33, 595-610, 2010	Summary of treatments paper
Ter Kuile, M. M., Melles, R. J., Tuijnman-Raasveld, C. C., de Groot, H. E., van Lankveld, J. J., Therapist-Aided Exposure for Women with Lifelong Vaginismus: Mediators of Treatment Outcome: A Randomized Waiting List Control Trial, Journal of Sexual Medicine, 12, 1807-19, 2015	Same study population, and outcomes as in Ter Kuile 2013 (included study)
ter Kuile, M. M., van Lankveld, J. J. D. M., Groot, E. d, Melles, R., Neffs, J., Zandbergen, M., Cognitive-behavioral therapy for women with lifelong vaginismus: Process and prognostic factors, Behaviour Research and Therapy, 45, 359-373, 2007	Outcomes not relevant; paper is comparing responders and non-responders not intervention and control, and unable to determine which arm participants were originally enrolled in. Population the same as van Lankveld 2006 (included study).
ter Kuile, Moniek, van Lankveld, Jacques J., de Groot, Ellen, Melles, Reinhilde, Neffs, Janneke, Zandbergen, Maartje, Cognitive-behavioral therapy for women with lifelong vaginismus: Process and prognostic factors, Behaviour Research and Therapy, 45, 359-373, 2007	Outcomes not usable - for outcome measures paper is comparing responders and non-responders not intervention and control. Population the same as van Lankveld 2006.
Teunissen, T. A., de Jonge, A., van Weel, C., Lagro-Janssen, A. L., Treating urinary incontinence in the elderly - -conservative therapies that work: a systematic review, Journal of Family Practice, 53, 25-30, 32, 2004	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention
Thyer, B. A., Curtis, G. C., Furosemide as an adjunct to exposure therapy of psychogenic urinary retention, Perceptual and Motor Skills, 59, 114, 1984	No relevant outcome data
Vaishnav, Mrugesh, Saha, Gautam, Mukherji, Abir, Vaishnav, Parth, Principles of Marital Therapies and Behavior Therapy of Sexual Dysfunction, Indian Journal of Psychiatry, 62, S213-S222, 2020	Study design does not meet the inclusion criteria, not a randomised controlled study
Vakili, B., Chesson, R. R., Behavioral therapy for urinary incontinence and nonsurgical management of pelvic organ prolapse, Journal of Pelvic Medicine and Surgery, 11, 105-127, 2005	Intervention does not meet the inclusion criteria
Van Den Heuvel, E., Tannenbaum, C., Wagg, A., Fritel, X., Lavoie, M., Dorais, J., Continence across continents to upend stigma and dependency (CACTUSD): feasibility of an international randomized controlled trial of a continence promotion intervention, Neurourology and Urodynamics, 34, S207, 2015	Conference abstract
Velez, J. B., Behavior therapy for urge incontinence in older women, Journal of Family Practice, 48, 168-9, 1999	Narrative review
Walker, C. Eugene, Milling, Leonard S., Bonner, Barbara L., Incontinence disorders: Enuresis and encopresis, 363-397, 1988	Book chapter

Study	Reason for Exclusion
Weidner, A. C., Barber, M. D., Markland, A. D., Rahn, D. D., Hsu, Y., Mueller, E. R., Jakuswaldman, S., Dyer, K. Y., Warren, L. K., Gantz, M., et al.,, Perioperative behavioral therapy & pelvic muscle strengthening does not improve quality of life after apical prolapse surgery: a randomized controlled trial, International Urogynecology Journal and Pelvic Floor Dysfunction, 26, S59-S60, 2015	Patients receiving surgery
Weidner, A. C., Barber, M. D., Markland, A. D., Rahn, D. D., Hsu, Y., Mueller, E. R., Jakus-Waldman, S., Dyer, K. Y., Warren, L. K., Gantz, M., et al.,, Perioperative behavioral therapy & pelvic muscle strengthening does not improve quality of life after apical prolapse surgery: a randomized, controlled trial, Female Pelvic Medicine & Reconstructive Surgery Female pelvic med, 21, S67-S68, 2015	Patients received surgery
Weidner, A. C., Barber, M. D., Markland, A., Rahn, D. D., Hsu, Y., Mueller, E. R., Jakus-Waldman, S., Dyer, K. Y., Warren, L. K., Gantz, M. G., Meikle, S., Perioperative Behavioral Therapy and Pelvic Muscle Strengthening Do Not Enhance Quality of Life After Pelvic Surgery: Secondary Report of a Randomized Controlled Trial, Physical therapy, 97, 1075-1083, 2017	Patients received surgery
Weiss, L., Meadow, R., Group treatment for female sexual dysfunction, Arizona Medicine Ariz Med, 40, 626-8, 1983	Study design does not meet the inclusion criteria, not a randomised controlled study
Wells, M., White, H., Continence. Self-starters, Nursing Times, 87, 64, 1991	Full text unavailable from the British Library
White, H., Continence. Read all about it, Nursing Times, 90, 62-4, 1994	Full text unavailable from the British Library
Wolz-Beck, M., Reisenauer, C., Kolenic, G. E., Hahn, S., Brucker, S. Y., Huebner, M., Physiotherapy and behavior therapy for the treatment of overactive bladder syndrome: a prospective cohort study, Archives of Gynecology & Obstetrics, 295, 1211-1217, 2017	Intervention does not meet the inclusion criteria, not psychological maybe suitable for 11.1
Wyman, J. F., Fantl, J. A., McClish, D. K., Harkins, S. W., Uebersax, J. S., Ory, M. G., Quality of life following bladder training in older women with urinary incontinence, International Urogynecology Journal, 8, 223-229, 1997	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention
Wyman,J.F., Fantl,J.A., McClish,D.K., Bump,R.C., Comparative efficacy of behavioral interventions in the management of female urinary incontinence. Continence Program for Women Research Group, American Journal of Obstetrics and Gynecology, 179, 999-1007, 1998	Intervention does not meet the inclusion criteria; no psychological aspect to the intervention
Wynne, H., Carty, S., Rees, J., What can be done for the elderly patient who is incontinent of urine?, Reviews in Clinical Gerontology, 7, 213-227, 1997	Summary paper

Economic studies

No economic evidence was identified for this review.

Appendix L – Research recommendations

Research recommendations for review question: What is the effectiveness of psychological interventions for women with symptoms associated with pelvic floor dysfunction?

Research question

How effective are psychological interventions (either on their own or combined with other interventions) at improving symptoms of pelvic floor dysfunction?

Why this is important

There is clinical experience that women with PFD experience high levels of psychological symptoms, such as depression and anxiety. There is also some evidence suggesting that the presence of these psychological symptoms reduces the efficacy of less invasive interventions for PFD such as PFMT. This suggests that some women may not be benefiting from conservative management programmes, and are being referred for operations that could be avoided if some support was available for them during their conservative treatment. This has potential to save NHS resources. However, there are currently very few RCT studies examining this issue.

Table 16: Research recommendation rationale

Research question	**What is the effectiveness of psychological interventions either as stand-alone or as an additional therapy to improve symptoms of PFD?**
Why is this needed	
Importance to 'patients' or the population	Psychological conditions, such as depression and anxiety, are suggested to be associated with PFD, and to reduce the impact of conservative treatment regimens like PFMT. However, there is very limited evidence to guide suggestions about the best form of psychological support to offer for PFD, the impact of offering this support on PFD symptoms, and whether this support may need to differ for different aspects of PFD. Without this information, it is unclear what suggestions to make, to which patients.
Relevance to NICE guidance	The relative absence of evidence regarding this topic currently restricts NICE guidance from making strong and detailed recommendations regarding this support. The outcome of this research would allow such recommendations to be developed and become part of the NICE guidance.
Relevance to the NHS	Psychological support and/or intervention can be relatively low cost, and may reduce the need for interventions with higher cost impacts on the NHS (like surgery). It may be that the recommendations for psychological support could be combined with existing advice.
National priorities	Improved access to psychological services is a national priority.
Current evidence base	Although there is some evidence that psychological support improves attendance at

Research question	What is the effectiveness of psychological interventions either as stand-alone or as an additional therapy to improve symptoms of PFD?
	PFMT, there is limited evidence regarding whether psychological support and/or intervention improves PFD symptoms. Moreover, there is very little evidence about whether such support would work for all individuals, and whether the same support would be effective for all symptoms.
Equality	Can psychological support be effective by all groups of individuals (for example those with learning disabilities)?
Feasibility	Can appropriate psychological support/interventions be offered as part of primary and secondary care consultations regarding PFD, or does it require extra resources and training?
Other comments	The relative absence of evidence regarding this topic currently restricts NICE guidance from making recommendations regarding the most effective way of providing psychological support for reducing PFD symptoms. The outcome of this research would allow such recommendations to be developed further.

PFD: pelvic floor dysfunction: PFMT pelvic floor muscle training

Table 17: Research recommendation modified PICO table

Criterion	Explanation
Population	Women with PFD over 12 years old.
Intervention	Psychological support and interventions such as (but not restricted to); CBT, counselling, motivational programmes
Comparator	Alternative treatment, or no support. Give consideration to equating time input across groups.

Outcomes	• Engagement in intervention
	• PFD symptoms (validated subjective reports).
	• Psychological outcomes:
	  ○ distress
	  ○ anxiety
	  ○ depression
	  ○ mood
	  ○ motivation

Study design	Longitudinal RCT
Timeframe	6 months – 1 years, with 5 year follow-up.
Additional information	Include analysis of any predictors of the effectiveness, such as type of PFD, type of psychological conditions, age, and socio-economic status.

CBT: cognitive behavioural therapy; PFD: pelvic floor dysfunction: PFMT pelvic floor muscle training