Effect of Life Review on Quality of Life in Terminal Patients: A Systematic Review and Meta-Analysis

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ABSTRACT

Background: Enhancing quality of life takes precedence in the terminal stage of a disease, when a cure is considered impossible and all alternative methods to prevent disease progression have been exhausted. Life review, involving appreciating accomplishments and resolving conflicts, is widely considered to be an effective approach to bringing peace to terminal patients.

Purpose: This study was conducted to assess the effects of life review on quality of life in terminal patients.

Methods: The Cochrane Library, PubMed, MEDLINE, CINAHL, CEPS, and ProQuest databases were searched for original studies published between 2007 and July 2018. Studies that used experimental designs to assess the effects of life review on quality of life in terminal patients, involved patients aged >18 years, and were published in English or Chinese were considered eligible for inclusion. Studies that measured quality of life in individuals other than patients as well as unpublished papers or data were excluded. The search terms used included “life review,” “end of life,” “terminal or terminally ill,” “advanced cancer,” “palliative,” “hospice,” and “quality of life.” The quality of each included study was assessed using the Downs and Black checklist.

Results: Six studies with 296 patients were included in the review. The participants in the included studies were from multiple countries. Life review was found to affect quality of life significantly (95% CI [0.147, 0.668], Z = 3.062, p < .05). The selected studies exhibited moderate heterogeneity (I² = 42.407, p > .1).

Conclusions: Life review was found to affect quality of life significantly in the participants in the included studies. The feasibility and safety of applying life review interventions should be considered for terminal patients, and implementers of these interventions should be trained and qualified. Only a few studies in the literature have evaluated the effects of life review therapy in terminal patients. Further studies that use stricter selection criteria are necessary to evaluate the efficacy of the life review intervention before its adoption in clinical practice.

Key Words: life review, terminal-stage patients, end-of-life care, quality of life, meta-analysis.

Introduction

The terminal stage of a disease is defined as the stage at which a patient’s disease is not amenable to cure, health progressively deteriorates, and survival is not expected by the healthcare professionals providing care. The main goal of end-of-life care is to provide the highest quality of life (QOL) to patients and their relatives (World Health Organization, 1990). End-of-life care strives to add “life to years” instead of years to life (Tang & McCorkle, 2002). The relationship between spiritual well-being and QOL in patients with cancer has been increasingly studied in recent years. Most healthcare researchers and clinicians suggest that QOL should consider symptoms, functioning, psychological and social well-being, and, to a lesser extent, meaning and fulfillment (Kaasa & Løge, 2003).

An approach that improves the QOL of patients who are facing problems related to life-threatening diseases and their families by controlling pain and other symptoms and satisfying their psychological, social, and spiritual needs is desirable (Bennett & Closs, 2008; Choi & Kim, 2017). Cohen and Mount (1992) strongly advocated that, in end-of-life care, QOL is not only a primary concern but also the main objective of every intervention. Kissane and Kelly (2000) described “demoralization syndrome” in patients with terminal illness as a triad of hopelessness, loss of meaning, and desire for death. Psychotherapeutic interventions designed for patients who desire death must reinforce meaning and purpose, thereby reducing the desire for death and overall suffering for these patients who experience hopelessness (Chochinov et al., 2004).

Life review is considered an effective psychospiritual intervention for people facing death (Leung et al., 2015). Therapeutic life review may assist people to cope with loss, guilt, conflict, and defeat and may enable them to discover meaning in their accomplishments (Haber, 2006). Therapeutic life
review is a procedure of recalling, evaluating, and integrating life experiences that aims to achieve ego integrity in the final stage of life (Trueman & Parker, 2006). The differences between life review and reminiscence must be emphasized because many researchers have conflated these concepts (Haight & Burnside, 1993). Reminiscence is a descriptive activity that involves thoughts about a patient’s life and recalls prominent events from the past. During reminiscence, memory is more an affective function than a cognitive function. It may be structured or unstructured and undertaken either individually or in a group setting (Haight & Burnside, 1993; Keall, Clayton, & Butow, 2015). By contrast, life review is typically structured around one or more life themes, with lifetime family experiences and work experiences being the most common (Haber, 2006). In contrast to reminiscence, life review is an appraisal activity that involves investigating and, if possible, resolving a specific conflict. Life review functions at a deeper level than reminiscence with a goal of helping patients seek meaning from life events. This may help patients face death through achieving a sense of peace through resolving conflicts and providing a feeling of achievement in life tasks (Haber, 2006). Aspects of the process of life review such as individuality, structure, and evaluation distinguish this process from reminiscence and give it therapeutic value, with evaluation being the most crucial aspect (Haight & Burnside, 1993).

Several studies have investigated life review in older adults. Life review has been reported to pacify individuals through the process of life evaluation, which involves both appreciating accomplishments and resolving conflicts (Bohlmeijer, Smit, & Cuijpers, 2003). Moreover, the positive effects of life review interviews on depression (Haight, Michel, & Hendrix, 1998; Hanaoka & Okamura, 2004; Korte, Bohlmeijer, Cappeliez, Smit, & Westerhof, 2012; Pot et al., 2010) and self-esteem (Chiang, Lu, Chu, Chang, & Chou, 2008; Haight, Michel, & Hendrix, 2000) have been reported. However, few investigations or empirical studies on psychotherapeutic interventions for end-of-life patients have been published. Results from these previous studies provide critical underpinnings for psychotherapeutic approaches. The clinical effects of life review have been investigated in many practical studies. For example, one systematic review of the effects of therapeutic life review found that it is difficult to use therapeutic life review effectively with patients with life-threatening diseases (Keall et al., 2015). As the effects of using life review on terminal patients are inconsistent in the literature, this systematic review and meta-analysis of quantitative evaluations of life review interventions was conducted to improve the QOL domains in terminal patients.

### Methods

**Search Strategies and Screening Process**

A systematic review and meta-analysis was conducted to examine the effects of life review on QOL in terminally ill patients.

This study adopted the Preferred Reporting Items for Systematic Reviews and Meta-Analyses, and systematic database searches were conducted in August 2018. Five electronic databases covering the realms of biomedicine science, social science, and general references were screened, including Cochrane Library, PubMed, MEDLINE, CINAHL, CEPS, and ProQuest. The search terms used included “life review,” “end of life,” “terminal or terminally ill,” “advanced cancer,” “palliative,” “hospice,” and “quality of life.” The results were saved to a citation manager in Endnote X6. Figure 1 presents the flowchart of this systematic review according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (Moher, Liberati, Tetzlaff, & Altman, 2009).

The inclusion criteria were studies that (a) employed experimental designs that are suitable for assessing the effects of life review in terminally ill patients who lived for less than 6 months or received palliative care, (b) included terminally ill patients aged >18 years, (c) were original studies published in English or Chinese, (d) used life review as an intervention, and (e) used QOL as an outcome measure. Studies that assessed QOL in populations other than patients (e.g., patient caretakers or relatives) and unpublished papers or data were excluded from this study.

### Assessment of Study Quality

The quality of the included studies was assessed using the Downs and Black checklist, a quality index with high internal consistency, high retest reliability, and good interrater reliability (Downs & Black, 1998). This checklist consists of 27 items that are distributed over the five subscales of reporting, external validity, internal validity: bias, internal validity: confounding, and power. The Downs and Black checklist may be used to assess the methodological quality of both randomized controlled trials (RCTs) and nonrandomized studies, with scores greater than or equal to 20 considered good, between 15 and 19 considered fair, and 14 or below considered poor (Kennelly, 2011). Two investigators selected original studies on the basis of the inclusion criteria and reviewed the quality of each. Any disagreement between the two investigators regarding the extracted data was resolved through discussion. As study quality was the issue of concern, the score for each of the included studies should exceed 14.

### Meta-Analysis

After the eligible studies were identified, each study was analyzed using the Comprehensive Meta-Analysis software program. Heterogeneity was assessed using forest plots that used both $Q$ (a significant result that indicates statistical heterogeneity; Hwu & Lin, 2014) and $I^2$ (a significant result that indicates methodological heterogeneity) statistics. Values of 25%, 50%, and 75% indicate low, moderate, and high heterogeneity, respectively (Higgins, Thompson, Deeks, & Altman,
A fixed-effects model was adopted for analysis when $p > .1$ and $I^2 < 50\%$ (because of trial homogeneity), whereas a random-effects model was adopted when $p < .1$ and $I^2 \geq 50\%$. The magnitude and significance of the effects of life review on QOL were calculated and are presented as odds ratios with 95\% confidence intervals.

**Results**

After searching and screening the literature, six original studies that had been published in international journals in English were included in this review. The characteristics of participants, research design, settings, outcome measurements, and quality were analyzed (Table 1). The six studies in this review included 296 participants in total and were conducted in Japan ($n = 1$), the United States ($n = 1$), Canada ($n = 1$), Hong Kong ($n = 1$), Australia ($n = 1$), and China ($n = 1$). An analysis of research design found that four of the studies used an RCT design (Studies 2–4 and 6) and that two used a one-group pretest–posttest design (Studies 1 and 5). An analysis of research settings revealed that the intervention periods were 1–3 weeks (Studies 2 and 4–6) and 24 weeks (Study 1), with the intervention period for Study 3 varied according to the physical and psychological capacities of each patient. Moreover, differences were observed in terms of numbers of sessions, with one study (Study 4), three studies (Studies 2 and 5–6), and two studies (Studies 1 and 3) involving two, three, and four sessions, respectively. The investigators in these studies included psychologists (Studies 1 and 3), nurses (Studies 5–6), and research assistants (Study 2). The specialist background of the investigators in Study 4 was not specified.

Furthermore, the outcome measurement instruments differed among the six studies. The questionnaires used

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**Figure 1.** Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow diagram. CINAHL = Cumulative Index to Nursing and Allied Health Literature; CEPS = Chinese Electronic Periodicals Service.
| Author (Year)/Country | Participant | Study Design | Delivery Personnel/Setting | Intervention Duration/Frequency/Complexity |
|-----------------------|-------------|--------------|----------------------------|------------------------------------------|
| 1. Ando, Tsuda, & Morita (2007)/Japan | 1. *n* = 12; participants who receive palliative care 2. Age: 63 years (avg) 3. Gender: female (10), male (2) 4. Diseases: no data | One-group pretest-posttest design (no control group) | Psychologist/palliative care unit patients | 1. No explanation how to perform four sessions and the duration 2. Four sessions 3. Span: 24 weeks |
| 2. Steinhauser et al. (2008)/United States | 1. *n* = 82 (includes lost to follow-up) palliative care or hospice setting patients 2. Age: range of 28–96; E = 26, relaxation = 26, C = 26 3. Gender: female (38), male (44) 4. Disease: cancer (48), heart disease (5), lung disease (10), other (19) | 1. Randomly assigned 2. Blinded to subjects’ intervention group assignment | Research assist/inpatient and outpatient | 1. 45 minutes to 1 hour 2. One session for 1 week/two sessions 3. Span: 3 weeks |
| 3. Henry et al. (2010)/Canada | 1. *n* = 24 (includes lost to follow-up) participants were diagnosed with advance ovarian cancer (Stage 3 or 4) within the last 2 months. 2. Age: no explanation (eligibility criteria: >18 years); E = 12, C = 12 3. Gender: no explanation | 1. Randomly assigned 2. Blind to data analysis | Psychologists | 1. 30–90 minutes 2. Individualized to respect the patient 3. Four sessions |
| 4. Mok, Lau, Lai, & Ching (2012)/Hong Kong | 1. *n* = 84 (includes lost to follow-up) 2. Age: no explanation (eligibility criteria: >18 years) 3. Gender: female (5), male (5) 4. Disease: cancer type: breast (5), prostate (4), lung (1) | Randomly assigned | No explanation | 1. First session span 2. 30–60 minutes, 15–30 minutes for the second session/2–3 days between sessions 3. Two sessions |
| 5. Keall, Butow, Steinhauser, & Clayton (2013)/Australia | 1. *n* = 14 (includes lost to follow-up) 2. Age: no explanation (eligibility criteria: >18 years) 3. Gender: female (5), male (5) 4. Disease: cancer type: breast (5), prostate (4), lung (1) | Quasi study one-group pretest-posttest design (no control group) | Experienced palliative care nurse | 1. 40–150 minutes 2. 1 week 3. Three sessions |
| 6. Xiao, Kwong, Pang, & Mok (2013)/China | 1. *n* = 80; Chinese patients with advanced cancer 2. Age: *E* = 40; 59.78 years (avg) 3. Gender: female (38), male (42) 4. Participants’ diseases: 50% gastrointestinal cancer | Randomized clinical trial/single blind (data collector) | Nurse/home-based hospital participants | 1. No explanation of duration for once life review 2. Three weekly life review program/three sessions 3. Span: 3 weeks |

Note. *n* = number; avg = average; Sig = significant; NS = nonsignificant improvements; E = experimental group; C = control group; QOL = quality of life; SELT-M = Skalen zur Erfassung von Lebensqualität bei Tumorkranken—Modified version; QOLC-E = Quality-of-Life Concerns in the End-of-Life; QUAL-E = Quality of Life at the End of Life; MQOL = McGill Quality of Life Questionnaire.
| Outcome Measure and Follow-Up Frequency | Result | Quality Assessment Score | Reason for Dropout | Drop Rate |
|----------------------------------------|--------|--------------------------|--------------------|-----------|
| 1. Pretest/posttest (immediately)      | Overall QOL: pretest-posttest, \( p = .013 \) | 20 | Nine participants withdrew | 42.86% (9/21) |
| 2. Overall QOL (one item) is a part of SELT-M | | | Reason: unexpectedly deteriorated \((n = 7)\), inappropriate candidates for life review interviews due to the obsessive and compressive reminiscence type \((n = 1)\), and serious depression \((n = 1)\). | |
| Pretest/posttest 1 week later/ posttest 2 weeks later/QUAL-E | QUAL-E: NS in all measurements | 16 | 40 participants withdrew | 48.78% (40/82) |
| Pretest/posttest 1 month/ posttest 3 months/MQOL | MQOL total: NS in all measurements | 22 | Four participants withdrew | 14.29% (4/28) |
| Pretest/posttest 1 day later/ posttest 2 weeks later | QOLC-E total \( p = .025 \) | 21 | 26 participants withdrew | 30.95% (26/84) |
| Pretest/posttest 1 week later | QUAL-E: end-of-life preparation subscale \( \text{NS in all measurements} \) QUAL-E: life completion \( \text{NS in all measurements} \) | 21 | Four participants withdrew | 28.57% (4/14) |
| Pretest/posttest (baseline and immediately after the program and at a 3-week follow-up)/ overall QOL | Overall QOL: C and E at posttest \( p < .001 \) and follow-up \( p < .001 \) | 25 | 30 participants withdrew | 37.50% (30/80) |
| | | | Reason: physical discomfort \((n = 10)\), death \((n = 15)\), cognitive impairment \((n = 5)\) | |
included the overall Quality of Life scale (Studies 1 and 6), Quality of Life at the End of Life scale (Studies 2 and 5), McGill Quality of Life Questionnaire total scale (Study 3), and Quality-of-Life Concerns in the End-of-Life scale (Study 4). Three of the six studies (Studies 1, 4, and 6) found that life review improved QOL ($p < .05$). Furthermore, the attrition rate in these studies ranged from 14% to 49%, and scores on the quality index checklist ranged between 16 and 25 (Table 1).

These six studies exhibited moderate heterogeneity ($I^2 = 42.407, p > .1$). No harmful effects of the life review intervention were identified on the reported outcome measures. The six studies all found a significantly improved QOL in the intervention group over the control group (95% CI $[0.147, 0.668]$, $Z = 3.062, p < .05$; Table 2). Because of the wide variation in posttest duration, only data from the first posttest were considered in this review to distinguish between immediate and prolonged effects and to avoid the high participant dropout rates over time.

**Discussion**

The studies included in this review found that life review enhanced QOL in terminal patients. QOL is affected by the overall self-assessment of her or his life, whereas life review is a procedure of recalling, evaluating, and integrating life experiences with the goal of achieving ego integrity (Trueman & Parker, 2006). Life review intervention assists participants to identify and examine past experiences and achievements to find meaning, resolve conflicts, make amends with friends and family, and finish incomplete work. Life review is consistent with Erickson’s developmental theory, which culminates in resolving the conflict between integrity and despair in the last stage of life. Life review provides an evaluative opportunity to achieve life integrity (Haight & Burnside, 1993) and facilitates acceptance of a single life cycle with few or no regrets. Furthermore, life review enables individuals to integrate memories into a meaningful whole and achieve satisfaction.

The meta-analysis conducted in this review of six studies showed crucial and direct results of life review for terminal patients. Four of these studies were compared with another meta-analysis, which found the posttest effect on QOL to be significant (Wang, Chow, & Chan, 2017). In addition, two other meta-analyses found that life review interventions are often flexible and incorporate individualized performance settings. According to Keall et al. (2015), assessing the effectiveness of life reviews in patients with advanced life-threatening diseases is difficult. Differences among studies in terms of implementers, procedures, and the format of meetings employed in the life reviews may influence the effectiveness of the review. However, this meta-analysis overcame these potential problems. Life review is primarily an assessment activity that investigates issues and, when possible, resolves conflicts. It requires profound reflection, and participants seek meaning in their life events. Because of the risks of negative effects, life review should not be considered a harmless approach because it may affect the resilience of participants and foster feelings of victimization during the review process (Korte, Bohlmeijer, & Smit, 2009). In other words, the implementing researcher should be an expert who is able to guide participants to reflect while being aware of potential harm. Wang et al. (2017) completed a rigorously designed systematic review of RCTs that set strict criteria for the testing method, including a large scale, distinct definitions, multicenter samples, and sensitive measurements.

**Limitations**

This review was affected by several limitations. First, studies published only in English or Chinese were included. Second, only the short-term effects of life review were considered. Third, although the included studies applied a variety of operative processes for life review, the study

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**TABLE 2.**

| Study (Year)          | Std Diff in Means | SE  | Variance | Lower Limit | Upper Limit | Z     | p    | Std Diff in Means and 95% CI |
|-----------------------|-------------------|-----|----------|-------------|-------------|-------|------|-----------------------------|
| Xiao et al. (2013)    | 0.240             | 0.240| 0.058    | −0.231      | 0.710       | 0.997 | .319 |
| Steinhauer et al. (2008) | −0.177         | 0.350| 0.122    | −0.862      | 0.508       | −0.506| .613 |
| Ando et al. (2007)    | 1.219             | 0.445| 0.198    | 0.348       | 2.091       | 2.743 | .006 |
| Henry et al. (2010)   | 0.167             | 0.388| 0.151    | −0.594      | 0.927       | 0.430 | .667 |
| Mok et al. (2012)     | 0.755             | 0.271| 0.073    | 0.224       | 1.286       | 2.788 | .005 |
| Keall et al. (2013)   | 0.484             | 0.420| 0.176    | −0.339      | 1.307       | 1.152 | .249 |
| Total (95% CI)        | 0.407             | 0.133| 0.018    | 0.147       | 0.668       | 3.062 | .002 |

Note. CI = confidence interval; Std Diff = standard difference.
design did not assess which process was the most effective and suitable for terminal patients. Fourth, although the search term “life review” was used, other related terms such as “storytelling” and “forgiveness” were not used because of considerations of method consistency. Thus, some otherwise eligible studies may not have been identified and included in this review.

Conclusions

Few studies have evaluated the effect of life review therapy in terminal patients. Because of the low probability of survival, life review therapy may best be used as a short-term procedure in this patient population. However, more studies are required to confirm its efficacy. Furthermore, many practical studies have employed different session regimes, periods, and therapy durations, future studies should conduct comparisons of different operative methods. Nurses are in an ideal position to offer life review because of their qualities of leadership, creativity, and empathy, which are essential to providing psychosocial care to terminal patients. However, greater consideration should be given to the psychological and emotional needs of terminal patients.

Author Contributions

Study conception and design: MHH, HHW
Data collection: MHH, HHW
Data analysis and interpretation: All authors
Drafting of the article: MHH, HHW
Critical revision of the article: All authors

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*Reference marked with an asterisk indicate studies included in the meta-analysis.

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