

# Identification of features of fear of progression in people with advanced cancer and systemic treatment: an international modified Delphi study

Evie E.M. Kolsteren<sup>a</sup>, Linda Kwakkenbos<sup>b,c,d</sup>, Judith B. Prins<sup>a</sup>, Lucy Davis, Marije van der Lee<sup>e,f</sup>, Hanneke Poort<sup>a</sup>, Petra Servaes<sup>a</sup>, Louise Sharpe<sup>g</sup>, Sophie Lebel<sup>h</sup>, José A.E. Custers<sup>a</sup>, on behalf of the Delphi Study Participants

## Abstract

**Background:** The growing group of people with advanced cancer and systemic treatment faces psychosocial challenges, including fear of progression (FoP). This study aimed to identify features that characterize FoP in people with advanced cancer and systemic treatment.

**Methods:** An exhaustive list of possible FoP characteristics was generated based on literature, patient-reported outcome measures on FCR and FoP, interview data, and clinical expertise. Members of the International Psycho-Oncology Society (IPOS) Special Interest Group FORwards with expertise in FoP in people with advanced cancer and systemic treatment were invited to score features in a 2-round modified Delphi study. Features were scored on a 5-point Likert scale indicating their importance as a feature of FoP and reached consensus to be included or excluded if more than two-thirds applied the same score. A list of agreed features of FoP was generated.

**Results:** A total of 21 participants completed both Delphi rounds, including psychologists, researchers, nurses, and one psychiatrist. Of the 55 rated features, 31 features reached consensus to be features of FoP in advanced cancer, including items on fear, uncertainty, worry, loss, hopelessness, and interference with daily life.

**Conclusions:** Reaching expert consensus is a critical first step in identifying features of FoP in people with advanced cancer and systemic treatment, highlighting uncertainty and fear of death as unique challenges. Identifying features of FoP in advanced cancer is essential to guide future psycho-oncological research and clinical practice to improve psychosocial guidance with FoP for the growing group of people with advanced cancer and systemic treatment.

**Keywords:** fear of progression, advanced cancer, Delphi study, expert opinion, psycho-oncology

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<sup>a</sup> Department of Medical Psychology, Radboud University Medical Center, Nijmegen, the Netherlands, <sup>b</sup> Department of Clinical Psychology, Behavioural Science Institute, Radboud University, Nijmegen, the Netherlands, <sup>c</sup> Radboud University Medical Center, IQ Healthcare, Nijmegen, the Netherlands, <sup>d</sup> Department of Psychiatry, Radboudumc Center for Mindfulness, Radboud University Medical Center, Nijmegen, the Netherlands, <sup>e</sup> Department of Medical and Clinical Psychology, Tilburg University School of Social and Behavioral Sciences, Tilburg, the Netherlands, <sup>f</sup> Scientific Research Department, Centre for Psycho-Oncology, Helen Dowling Institute, Bilthoven, the Netherlands, <sup>g</sup> School of Psychology A18, The University of Sydney, Sydney, Australia, <sup>h</sup> School of Psychology, University of Ottawa, Ottawa, Canada

\* Corresponding author. Address: Department of Medical Psychology, Radboud University Medical Center, 6525 GC Nijmegen, the Netherlands. E-mail address: evie.kolsteren@radboudumc.nl (E. E. M. Kolsteren).

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Delphi study participants: Phyllis Butow, Leah Curran, Cristiane Decat Bergerot, Esther Deuning-Smit, Tania Estapé, Wendy Lam, Florence Lewis, Wendy Lichtenthal, Christine Maheu, Gozde Ozakinci, Emma Rheel, Lauren Rudy, Lahiru Russell, Josée Savard, Ben Smith.

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## 1. Background

Progress in new treatment options in the past two decades has led to better survival rates in people with several types of advanced cancer. Approval of new standards of care, such as targeted therapy or immunotherapy, improved progression-free and overall survival outcomes significantly in, for example, metastatic lung cancer or metastatic melanoma.<sup>1,2</sup> Subsequently, the prevalence of people living longer with advanced cancer with an uncertain and poor prognosis while receiving systemic treatment has increased substantially.<sup>3</sup> People with advanced cancer receiving systemic treatment refers to patients with any type of metastatic or locally unresectable, solid, advanced, or incurable cancer and a poor and uncertain prognosis, receiving systemic treatment aimed at prolonging life, including chemotherapy, hormone therapy, immune therapy, or targeted therapy. The life expectancy of these patients remains poor and uncertain due to the complexity of prognostics aggravated by the rapid evolution of treatment options.<sup>4–7</sup> As reported in a recent scoping review, living longer with advanced cancer and systemic treatment has a serious psychosocial impact.<sup>6</sup> Fear, uncertainty, loss, hope, and the impact on social life and work were commonly reported themes. A prominent fear for patients is the fear of the cancer progressing, reflected by tumor growth or the cancer spreading to other body parts, inevitably leading to death. Fear of progression (FoP) has been previously reported as transdiagnostic construct, as the fear that the illness or cancer will recur, progress, or spread, in the same organ or in another part of the body,<sup>8–11</sup> and is strongly related to symptoms of depression and anxiety.<sup>12,13</sup> Fear of cancer recurrence (FCR) is defined as ‘fear, worry, or concern relating to the possibility that cancer will come back or *progress*’<sup>9</sup> and is considered to be one of the most frequent unmet needs among patients with cancer.<sup>10,14</sup> Some authors have argued that FoP and FCR are nearly identical, whereas others have argued that they are distinct<sup>15,16</sup> and that the definition by Lebel and colleagues<sup>9</sup> confounds them. Indeed, in 2015, an inclusive definition of FCR was proposed<sup>9</sup> that encompassed the possibility of cancer progressing along with recurring, because of its appeal and applicability to all patients with cancer. Research to date on FCR has been mostly focused on early-stage cancer survivors as opposed to patients most often defined as those still in active treatment. However, in the past decades, with the emergence of a new population of patients with cancer living longer with advanced cancer receiving systemic treatment, refining and disentangling FCR and FoP appear to be helpful in advancing research and care for these patients.<sup>17</sup> The experience of this new group of patients appears to be somewhat different from that of other patients with cancer, and they specifically report fearing that their treatment might stop being effective resulting in progression of cancer, stress, and fear regarding frequent scans (eg, every three months), referred to as scanxiety,<sup>18,19</sup> and an overall pervasive sense of uncertainty.<sup>5,6,12,15</sup> Since it is expected that a growing number of people lives longer with advanced cancer and systemic treatment, a considerable amount of people may experience (severe) FoP and could be in need of psychosocial support to cope with this.<sup>6,20</sup> Therefore, it is important and timely to identify features of FoP for this specific patient group and to explore how FoP levels can be assessed, to improve psychosocial outcomes. A significant first step would be to find consensus on the features of FoP in advanced cancer.<sup>21,22</sup> Hence, the objective of this study was to identify features of FoP in people with advanced cancer and systemic treatment with an international modified Delphi study.<sup>23</sup>

## 2. Methods

Delphi methodologies aim to develop and measure consensus among a group of professionals.<sup>22,24</sup> This modified Delphi study<sup>23</sup> consisted of four phases and the active involvement of a steering committee. The study was performed in accordance with the ethical standards as laid down in the 1964 Declaration of Helsinki and its later amendments. As determined by the research ethical committee, ethical approval was deemed unnecessary for this survey-based study as it did not involve human subject research with individuals undergoing research actions or subjected to rules of conduct.

### 2.1. Phase 1: participants

The overall process of this modified Delphi study was managed by the project team, of which members had experience in research on FoP in advanced cancer [E.K., J.C.] and performing Delphi studies [L.K.]. The project team was responsible for the development of the initial list of potential features of FoP, recruitment of participants, executing the Delphi rounds, and processing the findings. First, a steering committee was established. The steering committee consisted of seven international members [L.D., S.L., M.L., H.P., J.P., P.S., L.S.] with significant psychological clinical and research experience on FoP in people with advanced cancer and systemic treatment, including one patient representative with lived experience of metastatic cancer and comprehensive patient advocacy experience for many years. The steering committee was involved in all phases of the project, including creating the initial list of potential FoP features, recruiting participants for the Delphi rounds, and discussing the results.

Since this modified Delphi study aimed to explore the concept of FoP from a psychosocial perspective, the International Psycho-Oncology Society Special Interest Group on Fear of Cancer Recurrence (IPOS SIG FORwards), an international group of professionals with psychosocial clinical and/or research experience in FCR and FoP, was considered an eligible platform to reach out to key experts. Members were invited by email to participate. The invitation included information on the background, purpose, methods, and inclusion criteria of the study and a link to the first survey. Inclusion criteria were as follows: 1) having worked with people with advanced cancer and systemic treatment with FoP in clinical practice or research; 2) being able to read and write in English; 3) being able to fill in online surveys; and 4) willing to provide an email address to participate in both Delphi rounds. A consent form was presented in the first online survey of Delphi round 1, before study participation. Participants provided consent by clicking “Agree.” By the method of snowballing, invitees were asked to forward the invitation email to other potential participants who met inclusion criteria. The aim was to include a minimum of 20 participants to achieve valid results.<sup>25</sup>

### 2.2. Phase 2: list of potential FoP features

First, an initial list including 38 potential features of FoP was developed by the project team. Features were derived from the literature,<sup>6</sup> existing patient-reported outcome measures on FoP or FCR (CWS<sup>26</sup>, FCRI<sup>27</sup>, FoP-Q-SF<sup>28</sup>), and preliminary results on FoP in advanced cancer from semistructured interviews exploring psychosocial aspects of living with advanced cancer and systemic treatment from the perspectives of patients, their partners, and health care professionals.<sup>29</sup> Second, the steering committee was consulted to comment on this list from their clinical expertise. 1 feature was

adjusted, and 7 features were added, resulting in a list of 45 features including cognitive, emotional, social, and behavioral features (Supplementary File I, Table I, <http://links.lww.com/OR9/A59>).

### 2.3. Phase 3: Delphi study

This modified Delphi study consisted of two rounds and was conducted using online software Qualtrics (2022). First, participants read an explanation about the study, and those who agreed to participate completed demographic and personal data. Then, participants were asked to complete the first survey within two weeks,<sup>22</sup> and a reminder was sent approximately one week before survey closure (in both Delphi rounds).

**2.3.1. Delphi round 1.** In the first round, participants individually scored each item of the initial list of 45 FoP features created in phase 2 on a 5-point Likert scale, indicating their estimation of the importance of the item as a feature of FoP in advanced cancer (1 = very low; 2 = low; 3 = moderate; 4 = high; 5 = very high). With each feature, feedback and suggestions for item edits could be provided in open comment boxes. At the end of the survey, suggestions for additional features could be provided as well. Scores were summarized as follows: 1–2 indicated a low score, meaning the feature was not considered to be an important/essential feature of FoP; 3 indicated a moderate score, meaning the feature needed additional discussion; and 4–5 indicated a high score, meaning the feature was considered an important or essential feature of FoP. Features rated in the same-score category (ie, low and high) by more than two-thirds (66%) of the participants were deemed to meet “consensus.”<sup>24</sup> Literature indicates a lack of consensus regarding the agreement rate to use in Delphi studies, with serious variation observed across different studies.<sup>30</sup> In this study, a fairly lenient agreement rate was chosen, as to not be too restrictive in this first step to identify features of FoP in a relatively new patient group. The results of the first round were analyzed by the project team and presented in a summary report demonstrating the distribution of scores and aggregate group results (mean score and percentage ratings of 1–5 scores) and the comments provided per feature (Table I, Supplementary File I, <http://links.lww.com/OR9/A59>). This resulted in one of the following outcomes for each feature: 1) consensus without substantial participant feedback—the feature will be excluded from, or included in the consensus shortlist of FoP features, and not presented in round 2; 2) no consensus and no substantial participant feedback—the feature will be scored again in round 2; 3) consensus on inclusion but with substantial participant feedback—feedback to be discussed by the steering committee and the (revised) feature will be presented in round 2 without scoring but with an open comment box for feedback on the revision; 4) no consensus and substantial participant feedback—feedback to be discussed by the steering committee and the (revised) feature will be scored again in round 2 with an open comment box for feedback on the revision. The outcomes for each feature were discussed by the steering committee in an online meeting, as well as any modifications and suggestions for additional features made by participants, resulting in an amended list of potential FoP features in advanced cancer to be scored in round 2.

**2.3.2. Delphi round 2.** Participants who completed round 1 were invited to participate in round 2, to rescore features for which consensus was not reached, and to provide feedback on modified features. Participants received the summary report of round 1 to consider the responses from other Delphi respondents and the

outcomes of the steering committee discussion. The features presented in round 2 were scored on a 5-point Likert scale as previously described for round 1. Again, after closing the survey, the results were analyzed and presented in a summary report by the project team and discussed by the steering committee in an online meeting, resulting in one of the following outcomes: 1) consensus without substantial participant feedback—the feature is excluded from or included in the consensus shortlist of features of FoP; 2) no consensus and no substantial participant feedback—the feature is discussed by the steering committee for inclusion in or exclusion from the shortlist; 3) consensus and substantial participant feedback—the feature is discussed by the steering committee and the revised feature will be included in the shortlist; 4) no consensus and substantial participant feedback—the feature is discussed by the steering committee to be included in or excluded from the shortlist. After finalizing round 2, the participants received the summary report with results of round 2.

### 2.4. Phase 4: shortlist of FoP features

All features that did not reach consensus in the Delphi exercise and those with substantial comments from participants and any suggestions made in round 2 for additional features were discussed by the steering committee in a third online meeting. Based on participants' scores and feedback and expert opinion from steering committee members, a final decision was reached based on consensus among members on inclusion or exclusion. This led to a final shortlist of features of FoP in advanced cancer.

## 3. Results

### 3.1. Participants

In total, 22 participants registered and completed the first-round survey. All participants indicated to have clinical and/or research experience on working with people with advanced cancer and systemic treatment. Participants were predominantly female (95.5%) and represented multiple countries (Table 1).

### 3.2. Delphi round 1

Of the initial list of 45 potential features of FoP in advanced cancer, 19 (42%) reached consensus to be included in round 1 and one feature (2%) reached consensus to be excluded (Supplementary file I: Table I, <http://links.lww.com/OR9/A59>). The included items covered six features regarding worry, five features regarding fear, and three features regarding uncertainty, and the included single features were “hypervigilance to bodily symptoms,” “difficulties with the prospect of dying,” “existential issues,” “loss of control,” and “functional impairment.” The feature “feeling impatient/being in a hurry” was excluded with consensus. Based on participant feedback and subsequent steering committee discussion, 13 features were modified, of which one feature was split into two. 9 participant suggestions for other features were added. Altogether, this resulted in 35 features being scored (anew) in round 2. In addition, 5 features that reached consensus to be included in round 1 were presented again for participant feedback on modifications from round 1, without scoring (see Supplementary file II: Summary report Delphi round 1, <http://links.lww.com/OR9/A60>).

### 3.3. Delphi round 2

All but one participant completing the first Delphi round, completed the second-round survey (n = 21; response rate:

**Table 1**  
Delphi study participant characteristics.

N	22
Age (mean (min-max)) <sup>a</sup>	46.6 (27–66)
Female (n (%))	21 (95.5%)
Country (n)	Australia (5) Netherlands (5) Canada (4) Belgium (2) Brazil (1) China (1) Japan (1) Spain (1) United Kingdom (1) United States (1)
Profession <sup>b</sup>	Psychologist and researcher (7) Psychologist (7) Researcher (5) Nurse (2) Psychiatrist (1) Student (psychology) (1)

<sup>a</sup> Missing data for one participant.

<sup>b</sup> Participants could select more than one option.

95.5%). Of the presented 35 features, another six features reached consensus to be included in round 2, resulting in 25 features with participant consensus on being included after two Delphi rounds (see Supplementary file II: Summary report Delphi round 2, <http://links.lww.com/OR9/A60>). These six features were “fear to depend on others,” “fear of pain due to progression,” “loss of future perspective,” “loss of autonomy,” “feeling hopeless(ness)/experiencing no hope,” and “feeling desperate.”

### 3.4. Features of FoP in people with advanced cancer and systemic treatment

For the remaining 29 features without consensus to be included or excluded after Delphi round 2, the steering committee participated in an online meeting for a third and final discussion of the Delphi study results to reach consensus on all features (phase 4), resulting in a final shortlist of features of FoP (Table 2). Therefore, the steering committee considered the scores and participant feedback per feature to propose inclusion or exclusion in the second online meeting. This resulted in another six features being included, leading to a final shortlist of 31 of a total of 55 rated features of FoP in advanced cancer (56%). The six additional features included “fear of doctors missing out on signs of disease progression,” “uncertainty about treatment options,” “difficulties to plan,” “avoidance of triggers of fear,” “loss of identity,” and “loss of hope.” The first four items reached a consensus rate of 65% in Delphi round 2. Although the consensus rate for direct inclusion was 66% or more, the steering committee unanimously proposed to include these items based on their high ratings. The items “loss of identity” and “loss of hope” had lower consensus rates (50% in Delphi round 2). Based on the high ratings of other items regarding loss (eg, loss of future perspectives and loss of autonomy), indicating ‘loss’ is regarded to be an important theme in FoP in advanced cancer, the steering committee decided to include both features, taking their own clinical experiences into account. The remaining items had varying rates and no indicative feedback for inclusion or exclusion and were consequently not included. In Delphi round 1, thirteen items had minor textual revisions. For example, the item “fear of dying” was adjusted into “fear of the process of dying,” to clarify the distinction between

**Table 2**  
Shortlist of features of FoP in people with advanced cancer and systemic treatment.

Shortlist of features of FoP in people with advanced cancer and systemic treatment	Consensus rates for inclusion (%)
1. Fear of death	Round 1: 91
2. Hypervigilance to bodily symptoms	Round 1: 91
3. Intrusive thoughts	Round 1: 91
4. Worry	Round 1: 86
5. Loss of control	Round 1: 86
6. Preoccupation	Round 1: 86
7. Uncertainty	Round 1: 86
8. Fear of the process of dying	Round 1: 82
9. Worry about impact of disease on loved ones	Round 1: 82
10. Functional impairment due to fear (social, work)	Round 1: 81
11. Fear of pain due to progression <sup>a</sup>	Round 1: NA; round 2: 80
12. Existential issues	Round 1: 77
13. Fear of running out of treatment options	Round 1: 77
14. Rumination	Round 1: 77
15. Worry about impact of dying on loved ones (leaving behind loved ones)	Round 1: 77
16. Feeling hopeless(ness)/experiencing no hope	Round 1: 32; round 2: 75
17. Fear to depend on others <sup>a</sup>	Round 1: NA; round 2: 75
18. Loss of future perspective	Round 1: 43; round 2: 75
19. Uncertainty about the future	Round 1: 75
20. Loss of autonomy	Round 1: 59; round 2: 74
21. Fear relating to scan or test results	Round 1: 73
22. Feeling desperate	Round 1: 23; round 2: 68
23. Difficulties with prospect of dying	Round 1: 68
24. Feeling anxious	Round 1: 68
25. (In)tolerance of uncertainty	Round 1: 68
26. Fear of doctors missing out on signs of disease progression <sup>a,b</sup>	Round 1: NA; round 2: 65
27. Uncertainty about treatment options <sup>b</sup>	Round 1: 59; round 2: 65
28. Difficulties to plan <sup>b</sup>	Round 1: 55; round 2: 65
29. Avoidance of triggers of fear <sup>b</sup>	Round 1: 36; round 2: 65
30. Loss of identity <sup>b</sup>	Round 1: 59; round 2: 50
31. Loss of hope <sup>b</sup>	Round 1: 32; round 2: 50

<sup>a</sup> Items that were suggested as additional features by one of the participants in Delphi round 1 and, therefore, presented and rated for the first time in Delphi round 2.

<sup>b</sup> Items that did not reach consensus to be included or excluded in the two Delphi rounds, which were included by the steering committee based on participant ratings and the feedback provided.

this item and the item “fear of death.” Table I (Supplementary file I, <http://links.lww.com/OR9/A59>) gives an overview of the results of Delphi rounds 1 and 2 and the decisions of the steering committee. Summary reports of Delphi rounds 1 and 2 include all ratings, feedback, and descriptions of decisions made (Supplementary files I and II, <http://links.lww.com/OR9/A59>, <http://links.lww.com/OR9/A60>).

## 4. Discussion

This modified Delphi study was the first structured attempt to identify features of FoP in people with advanced cancer receiving systemic treatment. Thirty-one features reached consensus, including items on fear, uncertainty, worry, loss, hopelessness, and interference with daily life. Although previous studies defining FCR and FoP in cancer did not specifically focus on patients with advanced cancer, we compared these study results with the results of our Delphi study and found a few similarities and differences.<sup>9,10,31</sup> In a single Delphi study defining clinical FCR to differentiate from normative FCR, the specific clinical characteristics were defined as 1) persistent high levels of preoccupation; 2) persistent high levels of worry; and 3) hypervigilance to bodily symptoms.<sup>21</sup> Although in this Delphi

study, we did not identify explicitly *clinical* features, the overlap in features of FoP with identified clinical characteristics of FCR is evident. Fear, worry, preoccupation, and hypervigilance to bodily symptoms are aspects that people with cancer in general are concerned with and constituted both features of FCR and FoP in advanced cancer. However, remaining features of FoP, such as fears regarding treatment options, scan results or death (intolerance of), uncertainty, loss in several domains of life, and hopelessness (Table 2), seem to be central psychosocial aspects of living longer with advanced cancer. Features regarding uncertainty included in this Delphi study were uncertainty in general, (in)tolerance of uncertainty, uncertainty about the future, and uncertainty about treatment options. These results are consistent with recent literature findings indicating uncertainty to be prominent throughout the entire disease trajectory of living with advanced cancer and systemic treatment.<sup>4-6</sup> These findings are also in line with a study exploring the main fears across patients with cancer, chronic arthritis, or diabetes mellitus, which found that specifically the unpredictability of disease progression and the fear of dying were most prominent for patients with cancer.<sup>28,32</sup> Patients with diabetes or arthritis expressed other nuances of fear of progression, which adds to the idea of FoP being a transdiagnostic concept with disease-specific aspects, revealing specific features or expressions of FoP in different disease populations.

In this Delphi study, fear of dying (and death) reached consensus while these items were not included in previous FCR or FoP definitions and might, therefore, be a central feature of FoP in advanced cancer. Unlike in settings where cancer is treated with curative intent, in advanced cancer, cancer progression is inevitable and treatment is no longer with curative intention. Disease progression and a subsequent death can, therefore, be more realistic and obtrusive outcomes for people with advanced cancer. For people treated with curative intent, the connection between a less certain cancer recurrence and a subsequent death is less direct, and fear of death was not included in the definition of FCR. A recent study by Coutts-Bain and colleagues (2022) showed a stronger association of death anxiety with FoP than with FCR in people with breast or ovarian cancer.<sup>16</sup> Furthermore, features regarding worry in this Delphi study identified “worry about the impact of the disease on loved ones” and “worry about the impact of dying on loved ones,” indicating a person’s permanent state of living with the inevitability of death due to advanced disease.

Other features of FoP in advanced cancer concerned “loss”: “loss of a future perspective,” “loss of control,” “loss of autonomy,” “loss of identity,” and “loss of hope.” Although loss is not part of current FCR and FoP definitions, it is eminent that patients with cancer in general experience loss in several life domains. However, for people with advanced cancer, loss might be distinctive in its accumulative and sometimes irreversible nature compared with patients with cancer being curatively treated.<sup>5,6</sup>

In a next step, the 31 included features of FoP in advanced cancer identified in this modified Delphi study could be clustered in subthemes, taking into consideration categorization of determinants, core features, or consequences of FoP. Our attempt to identify features of FoP encompassed specific facets within broader themes, aimed at exploring FoP nuances in advanced cancer. Several ‘specific’ features under one overarching theme (eg, uncertainty) reached (high) consensus. Yet, additional investigation is essential to cluster these similar or potentially overlapping items to attain a more precise understanding of FoP in advanced cancer receiving systemic treatment. This modified Delphi study marks a first step in identifying features of FoP in

patients with advanced cancer receiving systemic treatment, potentially serving as an example for similar research across other illnesses. Comparing results across diseases could pinpoint what features of FoP are transdiagnostic and which are disease-specific. This will facilitate future (comparative) research and clinical care to address FoP in generic and tailored programs.

#### 4.1. Strengths and limitations

Since face-to-face contact is not crucial for a Delphi study to be successful,<sup>22</sup> we were able to involve an international group of committed experts to participate in the steering committee and the Delphi rounds. Although three rounds are considered to be optimal, this modified Delphi study consisted of two rounds, followed by a steering committee discussion.<sup>22</sup> Scoring of features without consensus in round 1 was consistent with results of the second round. After finishing the second round, the steering committee decided on those features left without consensus, taking into account previous scoring and comments, and based on the indicative results after two Delphi rounds, a final shortlist could be established. While a valid number of participants completed both Delphi rounds,<sup>25</sup> results should be interpreted with care. Group consensus does not automatically mean that these are the only right or the best results. Through our sampling method (IPOS SIG FORwards group), we aimed to include participants in our study who are key experts who currently work on FoP in patients with advanced cancer undergoing systemic treatment. However, there were also limitations to this method. Specifically, there was limited variation in demographic characteristics. Participants were mostly psychologists and/or researchers, and 96% were female. While professionals from all over the world enrolled, members from Australia, Canada, and the Netherlands were strongly represented. While we sent an inclusive invitation including a request to invitees to share the Delphi study within their networks, this has not resulted in participation of individuals with more diverse demographic characteristics (eg, men, other nationalities, or other professions such as doctors or nurses). Whether the results would have differed with participants with other demographics remains uncertain. An important strength of the study was the inclusion of a patient representative in the steering committee with a lived experience of advanced cancer and systemic treatment, as well as extensive patient advocacy experience. However, additional elaboration on the study results would benefit from increased patient input and collaboration of other disciplines.

#### 4.2. Clinical implications

Given the changing landscape with rapid developments in systemic cancer treatments and the growing group of people with advanced cancer receiving systemic treatment, additional elaboration on FoP is needed.<sup>33</sup> Without an accurately described construct, assessment of FoP and subsequently the development of new interventions and adaptation of existing instruments targeting FoP remain a challenge. Reaching consensus among experts on the features of FoP in advanced cancer was a significant first step in identifying those in need of psychological support, to help them navigate a prolonged but uncertain disease trajectory. The list of FoP features established in this Delphi study is a solid foundation that could be used and verified in empirical research and to enhance additional research on theoretical models including antecedents and consequences of FoP in advanced cancer. In addition, it could also form the foundation for

identifying people with significant or ‘clinical’ FoP in the future, to provide tailored support.

#### 4.3 Conclusions

This modified Delphi study was a first structured attempt to identify features of FoP in people with advanced cancer receiving systemic treatment. These results provide the foundation of additional investigation to determine whether FoP in advanced cancer differs significantly from FoP across other diseases. In advanced cancer, features resembling fear, uncertainty, worry, loss, hopelessness, and interference with daily life reached agreement as part of FoP. Hence, uncertainty, loss, and death anxiety could be specific targets for future screening instruments and interventions for those in need of psychosocial support with elevated levels of FoP in patients with advanced cancer receiving systemic treatment.

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