CONQUER FEAR GROUP MANUAL

PROJECT GROUP

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INTRODUCTION TO THE CONQUERFEAR GROUP MANUAL

This Appendix is a therapist treatment manual for ConquerFear-Group, a psychological and educational intervention for fear of cancer recurrence (FCR) delivered in a group format. ConquerFear was originally developed by the PoCoG FCR Intervention Team in Australia as an individually delivered treatment[1]. It has since been adapted to a group format at Aarhus University and Aarhus University Hospital in Denmark in collaboration with the developers of the original ConquerFear. The adaptation process and the results of feasibility and pilot studies are described in Tauber et al. (2021)[2]. A randomized controlled trial evaluating the efficacy of ConquerFear-Group on women treated for breast cancer is expected to be published ultimo 2022. The purpose of the present manual is to inform therapists about delivering ConquerFear in a group setting.

HOW TO USE THIS MANUAL

This manual covers the content specifically relevant to the group format. Introduction to the concept of FCR and background information about the treatment program can be found in the manual for ConquerFear delivered in an individual format (p. 7-14). Background information on each session as well as trouble shooting notes can likewise be found in the original manual and is referred to throughout the group manual. While the group manual has been tested in a sample of women treated for breast cancer, the intervention is based on transdiagnostic approaches and can be used across the cancer population. This is in compliance with the original ConquerFear manual, which was developed for FCR in a mixed cancer population. The group intervention can be delivered either face-to-face or online. A blended approach is not recommended. The ideal number of participants in a group is eight (+/- two).

The manual is divided into six chapters, each representing one session. The first session is delivered individually, while the remaining five sessions are delivered in groups. All participants in one group should ideally complete the first individual session within a time-span of two weeks. The subsequent group sessions are recommended to be completed weekly. Client handouts and worksheets to be used in conjunction with this manual are included in the Appendix. It is recommended to provide each participant with a folder for organizing the handouts and worksheets provided during the treatment program. We recommend that all group sessions are led by two therapists.

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OUTLINE OF TREATMENT PROGRAM

Session 1 (Individually delivered): Assessment and Discussion of Vulnerability Factors (90 min)

- Clinical assessment.
- Introduction to the FCR model and explanation of the rationale for the therapy.
- Discussion of past experiences which may act as vulnerability factors.
- Case formulation.

Session 2 (Delivered in Group): Group Introduction and Clarification of Values (120 min)

- Introduction of group members and discussion of expectations.
- Introduction to the treatment program.
- Introduction to values and goals.

Session 3 (Delivered in Group): Introduction to Detached Mindfulness and Attention Training (120 min)

- Reviewing homework.
- Revisiting the FCR model and identification of triggers.
- Presentation of detached mindfulness.
- Introduction to the attention training technique.

Session 4 (Delivered in Group): Detached Mindfulness and Metacognitions (120 min)

- Reviewing homework.
- Continued discussion of Detached Mindfulness.
- Assessing and challenging metacognitive beliefs.

Session 5 (Delivered in Group): Worry Postponement and Education about Appropriate Follow-up Behavior (120 min)

- Reviewing homework.
- Revisiting worry postponement.
- Educating about and discussing appropriate follow-up behavior.

Session 6 (Delivered in Group): Treatment Summary and Relapse Prevention (120 min)

- Reviewing homework.
- Discussion about values and planning of future goals.
- Creating plan for dealing with FCR in future situations.
- Final group discussion.

SESSION 1: ASSESSMENT AND DISCUSSION OF VULNERABILITY FACTORS

1.1 SESSION MATERIAL

Timeframe: 90 minutes (individual session)

Session Goals

The goals of the initial individual session are to:

- Conduct a thorough biopsychosocial assessment.
- Gain a shared understanding of FCR.
- Present and explain the FCR Model.
- Provide the patients with an overview of the treatment and the rationale for its components.
- Guide the patients to gain insight into the relationship of past experiences of trauma, grief, and loss (where they exist) to current adjustment and fears of cancer recurrence.
- Reflect non-judgmentally on past experiences and "be with" the patients, modeling the capacity to bear pain and sadness rather than avoid it or displace it onto other things.
- Help patients juxtapose past experiences of helplessness and lack of control with their current situation where they can exercise choices about how to respond to fears and plan for their future.
- Provide a coherent case formulation of the presenting problem based on the FCR Model.

Handouts

- Handout 1.1. *How Fear of Cancer Recurrence Develops.*

PART 1: Clinical Assessment (45 minutes)

Objective: Obtain a thorough biopsychosocial assessment of the patients with particular emphasis on FCR. It is recommended that special focus be given to:

- Circumstances surrounding the initial diagnosis of cancer.
- The patient's views about completing treatment (how does this emotionally affect the patients).
- The patients' understanding of their *objective* risk of recurrence (i.e., what were they told about their risk of recurrence over 5 or 10 years) and views of their *perceived* risk of recurrence as a percentage (0-100%). If the perceived risk is higher than the objective risk – what are the reasons they feel more vulnerable?
- If the patients' perceived risk of recurrence fluctuates, what is the highest and lowest perceived risk (%)? The therapist should also explore reasons for why the perceived risk of recurrence fluctuates.
- The exact content and frequency of thoughts about FCR (including specific questions about any FCR-related imagery).

- The level of distress caused by FCR.
- Triggers.
- The functional impact of FCR (emotional, physical, financial, inter-personal, on life goals and future planning).
- The meaning of possible recurrence for self and others.
- Cognitive techniques for coping with FCR (e.g., suppression of thoughts or distraction).
- Other coping strategies for dealing with FCR (including specific questions about behavioral or emotional avoidance, e.g., alcohol use, avoidance of particular places, people, or situations).
- The current frequency of follow-up care appointments and routine medical investigations.
- Frequency of unplanned or unscheduled medical appointments and self-examinations because of concerns about recurrence.
- Career/family levels of FCR and degree of openness and communication about FCR. and
- Goals for FCR treatment.

An example of a completed assessment template can be found in the manual for individually delivered ConquerFear (p. 23-26).

It is recommended that the therapist use this template as a guide during the initial assessment session to help ensure that all areas pertinent to FCR are covered. It is also a useful place to summarize scores on pre-treatment standard measures.

PART 2: Presenting the FCR Model and Rationale for the Intervention (35 minutes)

Objective: Gaining a shared understanding of the nature of FCR and explaining the rationale for the therapy.

Gaining a shared understanding between therapist and patients of the nature of FCR and the factors which contribute to its development and maintenance is a very important component of the intervention which will improve patients' buy-in and motivation for treatment.

Brief Presentation of the FCR Model

Explain the FCR model (**Handout 1.1. *How Fear of Cancer Recurrence Develops***). The therapist should discuss each of the points below with the patients. Particular attention should be paid to the challenges of worrying too much or suppressing specific thoughts and to how certain life experiences (e.g., past losses) can make people more vulnerable to experiencing FCR.

Summary of the FCR Model

1) Fear of cancer recurrence (FCR) is the fear, worry or concern about cancer returning or progressing.[3]

2) It is very common and almost everyone with a diagnosis of cancer experiences it from time to time.

3) Research tells us that somewhere between 10-30% of people with a history of cancer (depending on their cancer type) experience moderate to severe problems with FCR and want professional help to manage it.

4) For some people, FCR can have big impact on their mood, relationships, and ability to make plans for their future.

5) Certain beliefs, in particular those about the nature and importance of worry, can underlie a particular style of coping with worry which is problematic.

6) This problematic style of dealing with worry includes:
   a. rumination (e.g., repeatedly turning worries over and over in one's mind).
   b. attention towards threat-related information (e.g., like having a radar which is particularly attuned to detecting information about and signs of potential cancer recurrence).
   c. self-focused attention (e.g., being very aware of one's bodily sensations and thoughts).
   d. attempts to control, avoid or suppress thoughts about potential recurrence.

7) The above strategies may all increase the worry.

8) Furthermore, having cancer and worries about potential recurrence can change the way people see themselves (self-concept) and what they regard as important in life (values). FCR can make it difficult to plan the future, which may result in a feeling of meaninglessness and a lack of direction in life.

9) Certain life experiences, such as past losses (particularly those involving cancer), past traumatic life events, caring roles, and other sources of psychological stress can also make people more vulnerable to experiencing FCR.

10) Many people also lack information about how best to monitor their health and stay healthy after a cancer diagnosis.

Derived from the manual of ConquerFear delivered in an individual format, p. 30.

The rationale behind the treatment

Explain the rationale behind the treatment.

> ***Key point: The aim of the treatment is not to get rid of thoughts about recurrence completely – that is unlikely to happen and counterproductive to aim for – but to help patients assign these thoughts less importance and give them less attention than they currently do, and to develop goals for the future which will give their lives purpose, meaning, and direction.***

PART 3: Discussion of Past Experiences which may act as Vulnerability Factors

Objective: To help patients understand how past experiences can impact FCR for some people. The discussion aims to reflect non-judgmentally on past experiences and "be with" the patient by modeling the capacity to bear pain and sadness rather than avoid or displace it onto other things.

Background for the therapist and case vignettes can be found in the individually delivered ConquerFear manual, Session 2.

It might be helpful to introduce the discussion of past experiences by saying something like the following:

"We have found that past experiences can shape the meaning that people give to their cancer experience and can make fear of cancer recurrence worse. E.g., a person who has lost a relative to cancer may be more vulnerable to fear of cancer recurrence and, for example, be more convinced that the cancer will recur. Today, I want to spend a bit of time talking with you about this issue and trying to understand how your past experiences may have influenced your level of fear of cancer recurrence."

The therapist then asks the patient if she can see any connections between past experiences and her FCR. How do the patients think that her experience of (x, y, z) may have influenced her worrying about cancer coming back?

> ***Key point: The aim of discussing past events is to try to increase the patient's awareness of the way in which their past life events have informed their specific presentation of FCR.***

Allowing some time for elaboration of past relevant themes, the therapist must help the patients to move on to a focus on future action rather than dwelling on past issues. It should be presented gently to the patients that since we cannot change the past, it is essential to develop an accepting stance toward what has happened in the past as this will help reduce future suffering (see metaphors below).

Several metaphors may be used to explain these points.

Metaphor	Application
Hand of cards	Imagine that you are playing a card game and that you have been dealt a poor hand of cards. You cannot change your cards, so you have two choices about the remainder of the game. You can either walk away from the game and avoid losing but potentially miss out on the joy of playing cards, or you can choose to play the game as best as you can with the cards that you have, accepting that you do not know what the outcome will be.
Tug of war	Imagine you are playing tug of war with an “anxiety monster”. You are holding one end of the rope and the monster the other, and in between there is a bottomless pit. You can pull harder, but each time you do, so does the monster, or you can drop the rope. If you drop the rope, the anxiety monster is still there but you do not need to struggle with it.
Fish Hook	Sometimes we can be joined to our past like a person fishing who has a fish on the end of their hook. We can struggle with that fish for hours or just let go of it and focus on doing something else.
Struggle switch	Imagine that you have a switch in your head called the struggle switch. When it is switched on, you struggle against any emotional discomfort that you experience. You try your best to get rid of it or avoid it. Like, “Oh no! Here is that horrible feeling again. Why does it keep coming back? How do I get rid of it?” So now, I’ve got anxiety about my anxiety. In other words, my anxiety gets worse. I’m even more anxious and I might get angry about my anxiety. “It’s not fair; why does this keep happening?” Alternatively, you might get depressed: “Not again. Why do I always feel like this?” Suppose you are able to turn off your struggle switch. In this case, whatever feelings show up, no matter how unpleasant, you don’t struggle with them. If anxiety shows up, you don’t struggle, you just say, “Okay, here is that feeling again. Here is tightness in my chest. Here is a knot in my stomach. Here is my mind predicting bad things in the future again”. It is not what you would want to happen and it is still unpleasant, but you are not going to waste your energy and time struggling with it. Instead, you will take control and put your energy into doing something meaningful to you. When the switch is on, it is like an emotional amplifier. We can develop anxiety about our anxiety or depression or anger about our anxiety. With the struggle switch off, our anxiety levels still rise and fall. This is unavoidable and a normal part of life, but we are not wasting our time struggling with anxiety.

Derived from the individually delivered ConquerFear manual, p. 48. Reference: Harris, 2009. Adapted from Hayes et al., 1999

PART 4: Case formulation

The therapist presents a coherent case formulation based on the FCR Model. Specifically, the therapist summarizes how the patient's beliefs about worries, past experiences (including vulnerability factors), lack of or misinformation, and shift in values may impact their level of FCR.

HOMEWORK AND SESSION SUMMARY

- What do patients bring with them from today's session?
- Questions?
- No homework after Session 1.

1.2 SESSION 1 CHECKLIST

- ☐ Conduct a detailed psychosocial assessment paying particular attention to FCR related issues.
- ☐ Present the FCR Model and rationale for treatment.
- ☐ Explore the meaning and potential impact of relevant past life experiences on the patient's level of FCR.
- ☐ Present a coherent case formulation of the patient's experience of FCR.
- ☐ Summary of the session.
- ☐ Homework: No homework after Session 1.

SESSION 2: GROUP INTRODUCTION AND CLARIFICATION OF VALUES

2.1 SESSION MATERIAL

Timeframe: 120 minutes (group session)

Session Goals

The goals of session 2 are to:

- Introduce group members to each other.
- Discuss expectations and agree upon group rules.
- Elaborate on the rationale for the therapy.
- Explain that cancer can impact a person's values.
- Encourage patients to reflect upon value and goal changes from their perspective.
- Help patients to clarify their values and set goals.

Handouts

- Handout 2.1 *My Values – What is Important to Me?*
- Handout 2.2. *Examples of Values, Goals, and Actions*
- Handout 2.3. *Willingness and Commitment Worksheet*

PART 1: Group introduction and discussion of expectations (25 minutes)

Objective: To welcome the patients, introduce themselves to one another, and discuss expectations. In addition, the therapist inquires about/presents a set of rules that the group participants should adhere to and asks the participants whether they can agree to these. It is recommended that the following parts are included in the introduction:

- Welcome patients to the group and provide an overview of the day's session.
- Let patients introduce themselves, focusing on their cancer experience, how FCR burdens them, and what they expect to get out of the treatment.
- Discuss expectations and agree upon group rules:
  - Ask patients what is important to them concerning being part of a therapy group (e.g., openness, honesty, respect).
  - Stress the importance of full attendance: 1) each session focuses on different content, and 2) it is important for group cohesion.
- The therapist explains the treatment format:
  - Five two-hour group sessions, incl. 10 min break.
  - Sessions are based on alternating therapist presentations, exercises, and group discussions.

- Inform the patients that the treatment content has been developed and tested with good results.
- Inform patients that they are still welcome in the group in the case of cancer recurrence. In such cases, the patient will be invited to an additional individual session with the purpose of clarifying the patient's needs. In addition, it will be emphasized that FCR also includes fear of progression.

PART 2: Introduction to the treatment program (20 minutes)

The therapist presents the treatment program's two parts: One part focuses on acquiring new skills to cope with FCR more adaptively, and a second part focuses on clarifying values and learning to live a meaningful life, despite fears and concerns about cancer recurrence.

1. Skills to cope with FCR

   This part of the treatment program aims to provide the patients with skills to break free from unhealthy thinking patterns and become less affected by FCR. The goal is not to eliminate or remove unpleasant thoughts about cancer recurrence but to provide the patients with the skills needed to respond differently to thoughts about cancer recurrence than their current reactions.

2. Living a meaningful life despite FCR

   Experiencing cancer and adapting to life after the end of treatment can be distressing and may result in 1) a change in values, 2) a lack of contact with one's values, or 3) becoming more aware of one's values. Therefore, the second part of the treatment program focuses on clarifying values, setting value-based goals, and planning specific steps to reach these goals. The aim is to become more aware that it is possible to let oneself be guided by one's values and live a meaningful life, despite fearing cancer recurrence.

Using a metaphor to introduce the treatment rationale

It is recommended that the therapist uses the following metaphor to supplement the more didactic explanation of the treatment.

> The metaphor below is based on the transcript found in the manual for individual delivered ConquerFear and is here adapted to a group format.
>
> *It is often quite hard to explain the rationale for this treatment program, so I would like to show you what it is all about by using a metaphor.*
>
> *I want you to imagine that your folder (*everyone should receive a folder for the handouts before beginning the session) *represents all the difficult thoughts and worries and feelings about potential cancer recurrence that you have been struggling with up until now.*

Now I would like you to hold it up in front of your face so that it is almost touching your nose. (The patients hold the folder up in front of their face, blocking the view of both the therapist and the other patients in the group).

Now, how would it be to continue talking to each other for the next hour or so when you are so caught up with these worries (making it difficult to connect and engage with each other)*? Notice how disconnected you are from others and the world around you. Notice too that while you hold on tightly to these worries, you cannot do the things that make your life work. Consider how difficult it would be to, for instance, drive a car, or hug someone, or cook dinner, type on a computer, or cuddle a baby while you are holding on tightly to this. Could you do it?*

Now stretch your arms and hold the folder as far as way from you as possible while still holding on to it. Imagine that you try to push your worrying thoughts away. How would it be to sit like this for the rest of the day´s session (exhausting, difficult to focus on talking to each other)*? Imagine how difficult it would be to concentrate about other issues when spending so much energy pushing away the thoughts about recurrence.*

OK, let us try something different now. Place the folder on your lap and just let it sit there. Now isn't that a lot less effort?

The thoughts about recurrence are still there. However, the difference here is that you are not caught up in your worries or trying to push the thoughts away. You are accepting their existence and acknowledging that they are here, without responding to them.

Now in an ideal world, I am sure this is what you would like to do (therapist mimes throwing the folder away on the floor). *But here is the thing, we cannot control our thoughts. Thoughts come and go. However, we can control how much attention we pay the thoughts, and we can choose to respond to them differently than by worrying or avoiding them.*

So, here is what this program is all about. We are going to help you to do this (therapist picks up folder and drops it in her lap and let's go of it, holding arms up in a gesture of freedom). *By living with those thoughts and giving them less attention you will be a lot more free to do what you really want to in life. We are going to learn some new skills called Attention Training and Detached Mindfulness that are going to help you pay less attention to these thoughts when they occur. We will also talk about how having cancer has impacted what is important to you and try to develop some concrete plans for the future so you can do what you really want to. Having this direction will help those worries seem less important. What we really want to help you do, is to create a rich and meaningful life while accepting the uncertainty that goes with it.*

Derived from the individually delivered ConquerFear manual, p. 31, and adapted for a group setting.

BREAK (10 minutes)

PART 3: Understanding the changes in values and goals (45 minutes)

The purpose of this section is to demonstrate that values can change, to assist in working out if and how the patient's values have indeed changed, and what is important to them now, and then to devise concrete ways of working towards living the life they want to lead.

The therapist introduces this part of the session by telling the patients which part of the FCR-model they will be focusing on. The therapist then explains that one's life can be affected in different ways when having experienced an upheaval of one's life, such as having had cancer.

- Some experience a radical change in their values (e.g., spending time with the family has now become more important than work).
- Some experience to be detached from or to have lost sight of their values (e.g., when fear or worry is blocking one from noticing and following one's values, or when someone, for instance, is exercising a lot because she feels this is what she *should* be doing in order to stay healthy – not because it feels meaningful to do so).
- Some become even more aware of what was already valued (e.g., setting time aside for oneself has always been important, and it has now become even more important).

The therapist should emphasize that all three aspects are normal. In common to all three is that *something* has changed. The therapist asks the group whether they can recognize themselves in these descriptions.

The therapist can then refer to the metaphor presented before the break and summarize that the goal of the treatment is *not* to eliminate or remove unpleasant thoughts but to come to *accept* their presence and *give them less attention*. The first step on the road for the patients to reach this goal is to become aware of what is important to them and to move towards a more meaningful life. The reason is that as long as life feels meaningful, and as long as the things we are dedicating our time and energy to feel important, we are much more prepared to face adversity in life, such as having to live with the fear of cancer recurrence.

The therapist should emphasize that values-clarification can take time, and one's perspective on one's values may even change throughout the treatment program. Understanding the changes in values and goals will therefore be the focus of the day's session and will be revisited in the last session.

The patients should now be invited to complete **Handout 2.1** ***My Values – What is Important to Me?*** and discuss it in the group afterwards.

Note: It may be difficult for the patients to identify their values. In the handout, the patients are therefore not explicitly asked to identify their values but to consider what they would like to make more room for in their lives because it feels important to them (focus is here on goals and behavior). In the following discussion, the therapist should help the patients translate this work into actual values.

Example:
Patient: *"I would like to spend more time with my grandchildren"* (goal).
Therapist: *"It sounds like an important value to you to be a caring and attentive grandmother*"
(value).

Committing to change: goals and actions

The therapist should now explain that goal setting is the building block we use to navigate towards our values, and in order to reach our goals, we will have to plan concrete actions. To help the patients distinguish between values, goals, and actions, the therapist can refer to **Handout 2.2. *Examples of Values, Goals and Actions*** and provide them with examples.

- The patients are then asked to reflect upon one or more goals they would like to set for the upcoming weeks. The therapist may add a couple of examples on the blackboard. Patients are given **Handout 2.3. *Willingness and Commitment Worksheet*** and asked to complete the handout at home.

HOMEWORK AND SESSION SUMMARY (20 minutes)

- The purpose of discussing and clarifying values is to become aware that we can move towards a more meaningful life despite fears of recurrence or worries about the future in general.
- Patients are asked to complete **Handout 2.3. *Willingness and Commitment Worksheet*** and bring the worksheet to the following session.
- What do the patients take home from today's session?
- Questions?

2.2 SESSION 2 CHECKLIST

- ☐ Introduce the patients to each other and to the treatment program
- ☐ Set up group rules
- ☐ Present the goal and rationale for the treatment
- ☐ Discuss and clarify values and plan goals and actions

HOMEWORK

- ☐ Complete **Handout 2.3. *Willingness and Commitment Worksheet*** and bring the worksheet to the following session

SESSION 3: INTRODUCTION TO DETACHED MINDFULNESS AND ATTENTION TRAINING

3.1 SESSION MATERIAL

Timeframe: 120 minutes (group session)

Session Goals

The goals of session 3 are to:

- Review Homework for Session 2
- Revisit the FCR-model focusing on how thoughts related to cancer can activate the Cognitive Attentional Syndrome (CAS) and result in heightened FCR.
- Present the rationale for detached mindfulness (DM) as an alternative to worry and avoidance.
- Identify triggers.
- Demonstrate detached mindfulness.
- Introduce attention training.

Handouts

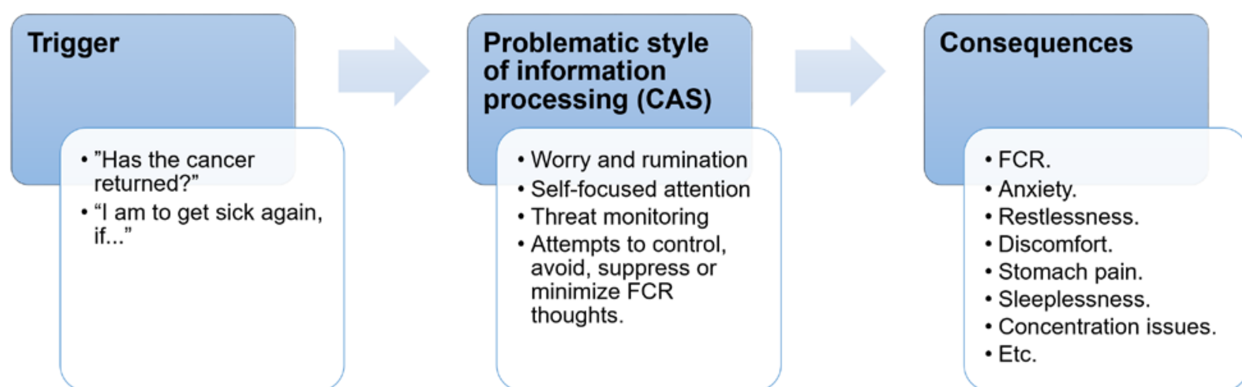
- Handout 2.3. *Willingness and Commitment Worksheet* (completed at home)
- Handout 3.1. *Detached Mindfulness*
- Handout 3.2. *Self-Attention Rating Scale*
- Handout 3.3. *Attention Training*
- Handout 4.1. Metacognitions (MCQ-HA)

PART 1: Review Homework (20 minutes)

The therapist should ask the patients whether they have reflected upon their values and what they specifically can do (goals and actions) to live in accordance with these values (**Handout 2.3. *Willingness and Commitment Worksheet***). The therapist should summarize the main points from the last session's discussion about values if relevant.

PART 2: FCR Model and Identification of Triggers (30 minutes)

The therapist indicates which part of the FCR-model they will be focusing on: Intrusive thoughts and images about cancer recurrence that trigger CAS, which results in unpleasant emotions and negative consequences, such as heightened FCR. It might be helpful to present a simplified model on a blackboard, such as the one below.



The therapist can then say something like the following :

- *We have previously discussed how a particular thinking pattern, including worrying, self-focused attention, threat monitoring, and attempts to control, avoid, suppress or minimise FCR-related thoughts, may result in heightened FCR.*
- *Often this thinking pattern is triggered by thoughts or images, physical sensations, or feelings.*
- *It is not the trigger thoughts themselves that result in heightened or unpleasant emotions and discomfort, but rather our way of responding to these triggers, e.g., by worrying or attempting to suppress or avoid unpleasant thoughts.*
- *In this treatment program, we invite you to practice skills that will enable you to become better at observing your trigger thoughts by letting them come and go without responding to them using a skill called detached mindfulness.*

Identify triggers

In this part of the session, the therapist should ask the patients what may trigger their worries about cancer recurrence. The therapist should provide the patients with some examples and write down some of the patient's triggers on the blackboard.

BREAK (10 minutes)

PART 2: Presentation of Detached Mindfulness

After the break, the therapist explains that the patients in this part of the session will learn a technique called detached mindfulness (DM) as an alternative way of responding to trigger thoughts rather than worrying about or avoiding these thoughts. As detached mindfulness is best understood by experiencing this state, rather than simply talking about it, any further rationale for DM should not be presented until the patients have experienced DM through at least two in-session exercises, e.g., the:

- Free-Association Task

- Thought Suppression Experiment

Descriptions of the exercises can be found in the individually delivered ConquerFear manual on p. 66 – 69.

Based on the patient's experiences from these exercises, the patients are now more likely to understand what DM entails and how they can apply DM to their trigger thoughts. The rationale should now be elaborated, preferably rooted in and following up upon the patients' statements.

The rationale for Detached Mindfulness

The therapist now explains what DM entails. To clarify it further, it is also recommended to use a metaphor, e.g., the Passenger Train Metaphor (see p. 68 in the individually delivered ConquerFear manual).

As the name 'detached' mindfulness suggests, it is about:

- Being more aware or more mindful of your thinking.
- Stepping back from your thoughts and becoming an observer of your own thoughts.
- Learning that the self is much greater than just the content of our thoughts.
- Learning to see thoughts as just one form of passing internal events.
- Accepting your thoughts for what they are and observing them without engaging with them, reacting to them, or trying to get rid of them.

Explain to patients that we know that trying to get rid of worries about cancer recurrence by distraction or avoidance is not a particularly effective strategy. The aim of detached mindfulness is not to get rid of thoughts about cancer recurrence but to help you learn to get less caught up in them. If you learn to view your thoughts more objectively as passing internal events, like leaves floating down a stream or clouds passing in the sky, they can cause less distress, or the distress can be much shorter.

Optional introduction to worry postponement

To some patients, it may be difficult to accept the idea that they should refrain from responding to trigger thoughts. Therefore, it may be suitable to introduce worry postponement immediately after presenting DM. Worry postponement is about not trying to get rid of, suppress or distract oneself from thoughts, but rather about noticing thoughts when they occur and promising oneself to return to them later at a designated, more appropriate time. See further details in Session 5.

- Worry postponement may be a helpful way of validating the patients' concerns about a possible cancer recurrence. The goal is not that the patients should refrain from relating to the consequences of a potential cancer recurrence. Instead, the patients should be in control of *when* and for *how long* it is relevant to reflect upon it.
- Worry postponement can make it easier to apply DM to trigger thoughts, as this allows one to reflect upon something at a later set time.

A handout on worry postponement is included in the Appendix of this manual for this session (**Handout 5.1. *Postpone your worry***).

PART 4: Attention Training Technique (ATT)

Rationale

The therapist presents Attention Training as a method to strengthen our brain's ability to control our attention more flexibly (e.g., when we go to the fitness to become fitter, we train the brain to become more flexible).

With a metacognitive model of FCR in mind, the rationale for ATT must emphasize that the technique is not intended to achieve a 'blank mind' free from intrusive thoughts or inner experiences. Similarly, the rationale discourages the use of active thought suppression. It is emphasized that the technique teaches people to deal with thoughts or inner experiences, which intrude into consciousness, as 'noise,' which should not be resisted.

Potentially unrealistic expectations and assumptions about the technique should be discussed prior to practicing the technique. A common misconception is that the technique should 'block out' unwanted thoughts or feelings. The therapist should emphasize that the goal of the exercise is to be aware of thoughts or experiences but for attention to be directed away from them as instructed in the task, even though the patient is fully aware of the presence of painful thoughts or experiences. This technique differs from thought avoidance, which usually involves efforts to block out or suppress unwanted thoughts. In contrast, during ATT, the client remains fully aware of the presence and content of any unwanted thoughts. However, these thoughts are not given attention because they are viewed as a transient mental experience in an array of thoughts that may come and go throughout the practice.

Credibility Check

It is helpful to check with the client how useful they believe it could be to learn ATT.

Following the manual for individually delivered ConquerFear, the therapist could use a numerical rating scale of 0-100 to evaluate a sense of credibility or gauge this through discussions of patients' belief in the rationale presented. Low levels of credibility (Wells recommends 40 or below) should be discussed further.

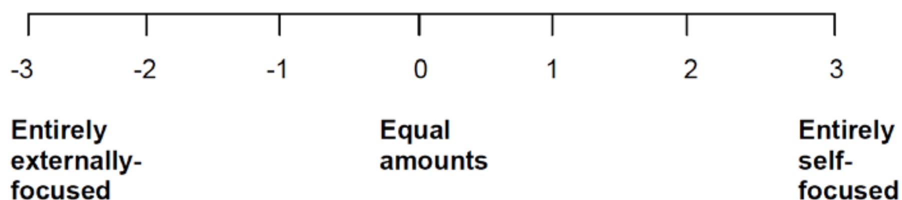
A common concern for patients may be that learning to focus attention away from bodily sensations may be "inviting trouble," placing them at increased risk of recurrence because they will learn to ignore bodily sensations. In the event of patients expressing this concern, the therapist should emphasize that ATT is not about ignoring new pain or new bodily sensations. It is about learning to give less attention to persistent thinking about particular pains or bodily sensations that keep on occurring, despite having been checked. It should also be emphasized that an important part of this treatment program is learning how to deal with regular check-ups and follow-

up investigations and aches and pains. A whole session will be devoted to this topic in Session 5.

Self-Attention Rating Scale

The Self-Attention Rating Scale is an index of the effectiveness of the procedure in counteracting CAS. The scale is shown below, and a handout of the scale is reproduced in the Appendix.

“At this moment in time, how much is your attention focused on yourself (i.e., internal states such as thoughts, emotions, and sensations) versus your external environment (e.g., sounds and visual inputs from the surroundings)? Please indicate by giving me a number on the scale”:



For further information regarding:

- The rationale.
- Credibility Check.
- Instructions for ATT.
- Homework.
- Troubleshooting.

See the individually delivered ConquerFear manual, Session 2, p. 50 – 54.

NB: It is recommended to consider postponing the introduction of ATT to Session 4 as Session 3 covers much content.

HOMEWORK AND SESSION SUMMARY (10 minutes)

A crucial component of ATT is the consistent practice of the technique as homework. Consistent practice is also likely to strengthen the patients’ ability to apply DM to trigger thoughts. The patients should be asked to practice ATT twice a day. In reality, most patients only manage to do this once a day. The patients should rate their focus of attention before and after each practice and register it in **Handout 3.2. *Self-Attention Rating Scale***. **Handout 3.3. *Attention Training*** is given as a reminder of how to practice.

The patients are asked to apply DM to thoughts that trigger worries about cancer recurrence as often as possible. The patients should be encouraged to write down examples of situations in

which they applied DM to trigger thoughts. **Handout 3.1** ***Detached Mindfulness*** is given to remind what DM is and how to practice it. The therapist should ask the patients about the extent to which they expect to be able to apply DM to trigger thoughts (in percent).

Handout 4.1. ***Metacognitions (MCQ-HA)*** should be completed before session 4.

What do patients take home from today's session?

Questions?

3.2 SESSION 2 CHECKLIST

- Review homework.
- Present FCR-model and identify triggers.
- Introduce Detached Mindfulness (DM) using experiential techniques and metaphors.
- Introduce and practice the Attention Training Technique (ATT) in the session.

HOMEWORK

- Practice ATT twice a week and rate focus of attention before and after each practice.
- Apply DM to trigger thoughts.
- Complete Handout 4.1. Metacognitions (MCQ-HA)

SESSION 4: DETACHED MINDFULNESS AND METACOGNITIONS

4.1 SESSION MATERIAL

Timeframe: 120 minutes (group session)

Session Goals

The goals of session 4 are to:

- Review ATT homework.
- Discuss the application of DM.
- Support and reinforce the application of DM.
- Identify and challenge possible metacognitions underlying worry, threat-monitoring, and avoidance.

Handouts

- Handout 4.1. Metacognitions (MCQ-HA)

PART 1: Review ATT home practice (20 minutes)

Home practice of ATT is discussed, including failure to practice, misuse of ATT as distraction or safety behavior, or motivation to continue FCR worry and rumination. See Session 2, p. 54 – 52, in the individually delivered ConquerFear manual.

PART 2: Continued Discussion of Detached Mindfulness (30 minutes)

The therapist should first summarize the defining features of DM: Observing one's thoughts without responding to them any further. The goal is not to get rid of thoughts about cancer recurrence but to get less caught up in them. It may be helpful to refer to a metaphor, e.g., the passenger train metaphor.

Review homework:

- Review the range of thoughts to which DM was applied.
- The therapist should take care to note that DM should not be inappropriately applied as a coping strategy to prevent exposure to perceived threats.
- What was difficult in applying DM?
- If the patients still struggle to grasp the idea of DM, it may be helpful to go through one of the designated exercises, e.g., the daydreaming exercise.

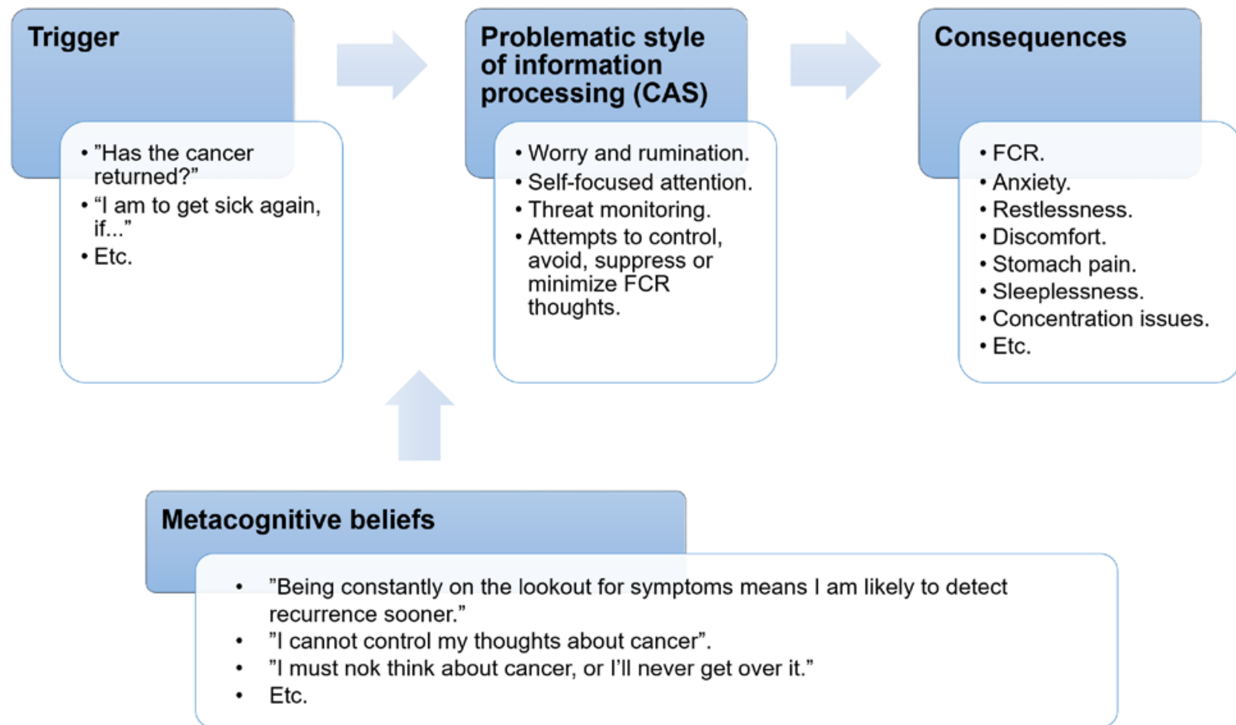
BREAK (10 minutes)

PART 3: Assessing and Challenging Metacognitive Beliefs (50 minutes)

Assessing Metacognitive Beliefs

This part of the session should begin with reintroducing the metacognitive part of the FCR-model. The therapist should explain how trigger thoughts activate the CAS and that activation of CAS results in unpleasant emotions and consequences, such as heightened FCR.

Once again, it may be helpful to present the simplified model on a blackboard:



The therapist can then say something like the following

- *Do you remember this model from last week's session? We talked about that when a thought triggers unhelpful thinking patterns such as sustained worrying, self-focused attention, threat-monitoring, or attempts to control or avoid cancer-related thoughts, this is likely to result in negative emotions such as prolonged anxiety discomfort and FCR. We also discussed that DM is an alternative skill that can help you refrain from reacting to the trigger thought with unhelpful strategies such as worry or rumination, thereby reducing the impact of FCR.*
- *Some people are more prone to engage in problematic thinking patterns such as worrying about or avoiding FCR-triggers because they believe it is helpful, harmful, or uncontrollable. Such beliefs are called metacognitive beliefs.*

The therapist should then give the patients examples of positive and negative metacognitive beliefs and ask them if they can relate to some of the beliefs. See the manual for individually delivered ConquerFear, Session 4, p. 75, for further information and examples of metacognitive beliefs. Any other metacognitive beliefs should be explored in the group and added to the blackboard. If the patients find it challenging to identify any metacognitive beliefs, the therapist can refer to **Handout 4.1. *Metacognitive Beliefs (MCQ-HA)***, which the patients have completed at home, to find inspiration. See the manual for individually delivered ConquerFear, Session 4, p. 84, for further information about MCQ-HA. The therapist may help the patients distinguish between positive and negative metacognitive beliefs by writing examples in two columns on the blackboard.

Challenging Metacognitive Beliefs

When several metacognitive beliefs have been identified and discussed in the group, the therapist should stress that metacognitive beliefs can be challenged. First, the therapist provides the patients with some examples. Next, the patients are invited to reflect upon the metacognitive beliefs listed on the blackboard and challenge them. See the individually delivered ConquerFear manual, Session 4, p. 86, for examples of questions to challenge metacognitive beliefs.

HOMEWORK AND SESSION SUMMARY (15 minutes)

The patients should be encouraged to continue applying DM to FCR trigger thoughts and continue the home practice of Attention Training.

What do patients take home from today's session?

Questions?

4.2 SESSION 2 CHECKLIST

- ☐ Review homework regarding ATT.
- ☐ Continue discussion and application of DM.
- ☐ Assess and challenge metacognitive beliefs.

HOMEWORK

- ☐ Continue the daily practice of ATT
- ☐ Practice the use of DM to trigger thoughts.

SESSION 5: WORRY POSTPONEMENT AND EDUCATION ABOUT APPROPRIATE FOLLOW-UP CARE

5.1 SESSION MATERIAL

Timeframe: 120 minutes (group session)

Session Goals

The goals of session 5 are to:

- Review DM and metacognitive beliefs.
- Introduce worry postponement.
- Normalize some threat-monitoring as an adaptive way to avoid danger.
- Discuss the impact of excessive threat-monitoring or avoidance on FCR in light of the treatment model.
- Provide education about the manifestations of threat-monitoring and avoidance behaviors in FCR.
- Assess compliance with recommended follow-up care and self-examination practices.
- Establish some agreed-upon behaviors around self-examination and threat-monitoring (i.e., consistent with the patient's medical advice).

Via bibliotherapy (Homework reading)

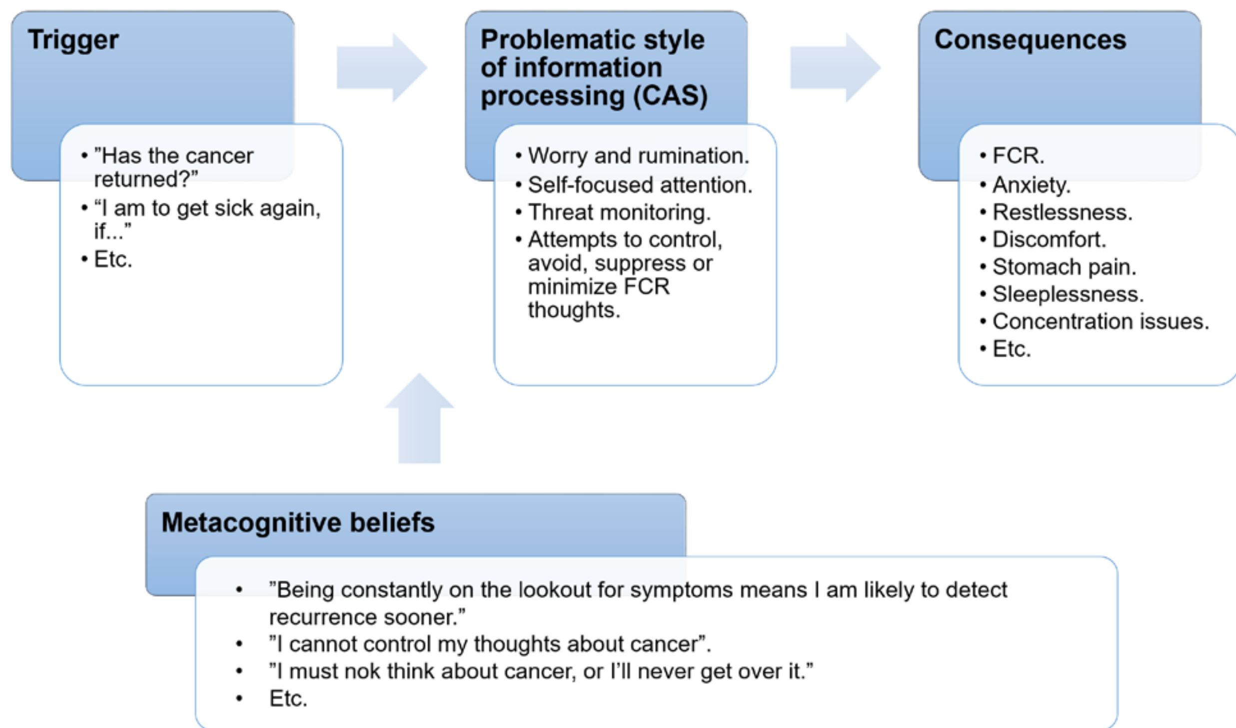
- Provide general education about the nature and role of follow-up care.
- Provide general education about lifestyle behaviors that may help to reduce the overall risk of developing a cancer recurrence.

Handouts

- Handout 5.1. *Postpone your worry*.
- Handout 5.2. *Your knowledge about follow-up care.*
- Handout 5.3. *Checking your symptoms sensibly.*
- Handout 5.4. *Follow-up care and lifestyle changes.*

PART 1: Review homework (20 minutes)

Review the concept of metacognition and the rationale for detached mindfulness. When doing so, it may be helpful to reintroduce the simplified FCR model described in the previous sessions.



In addition, the therapist should continue to explore:

1. The extent to which the patients are able to apply DM to their trigger thoughts and troubleshoot when necessary.
2. The extent to which the patients are aware of their own metacognitive beliefs and whether they are able to challenge them.

PART 2: Worry postponement (20 minutes)

An additional skill that may be of benefit to patients is worry postponement. Postponing worries to a later designated time point may help the patients refrain from responding to the thoughts immediately, thereby facilitating detached mindfulness and their control of *when* and *how long* to think about something. The therapist should inform the patients about worry postponement using the following instruction (derived from the manual for individually delivered ConquerFear).

Instruction for Worry Postponement

- Worry postponement is not trying to get rid of or suppress thoughts. We know that trying to ignore troubling thoughts simply does not work. The more we try to put something out of our minds, the more it comes back.
- Worry postponement is about noticing thoughts when they occur and promising oneself to return to them later at a designated time.

- Encourage the patients to recognize trigger thoughts and say to themselves something like this when they occur *"Here I am starting to worry again. I am just going to leave this thought alone and not deal with it now. I will deal with it later".*
- Worry-time is not a mandatory element. If the client does not feel the need to worry about things later or if the issue is no longer a concern at the worry time, that is fine (and a relevant discovery in and of itself).
- Once worry is postponed, encourage patients to make a concerted effort to bring their full attention back to the present moment and get on with some engaging activity.
- Postponing worries to a later designated time may also make it easier to apply DM to trigger thoughts, i.e., notice the thought and leave it without further action.
- The patients should be instructed to set aside 10-20 minutes of the day, preferably late in the day, but at least two hours before bedtime, to think about any worries that arise during the day.
- The patients should be encouraged to actively worry and problem-solve all the worry thoughts they had during the day in this designated time slot.
- If the patients experience much worry during the day, they may wish to write them down to help remember them later.
- Keeping the worry-time limited and sticking to the chosen limit is vital.
- If worrying thoughts occur after the designated worry period, they should be dealt with the same way the next day.

The patients are then asked to discuss in pairs at what time of the day and how many minutes they plan to set aside to worry. A handout on worry postponement is included in the Appendix (**Handout 5.1. *Postpone your worry***).

BREAK (10 minutes)

PART 3: Teaching and discussing appropriate follow-up behavior (55 minutes)

Threat monitoring and avoidance An important issue for health professionals working with people with cancer is to encourage alertness to the possibility of recurrent disease without exacerbating distress to a level that impairs daily functioning. However, many patients with excessive fears of recurrence become preoccupied with detecting signs of possible cancer recurrence and report excessive personal checking behaviors, such as conducting frequent bodily self-examinations or frequent visits to their cancer unit or general practitioners. Furthermore, while some people with a history of cancer may be aware of cancer-related cues and information, their anxiety about cancer recurrence manifests itself as avoidance of appropriate medical surveillance in follow-up care or avoidance of appropriate self-examination in an attempt to minimize or suppress worry. The existence of a bias towards threat-related information appears to be a feature of all anxiety conditions. In our model of FCR, excessive threat monitoring and behavioral and cognitive avoidance are central features of Cognitive Attentional Syndrome (CAS) and, as such, deserve specific attention in this treatment program. Threat monitoring usually takes the form of increased attention to signals of potential recurrence to reduce the risk of danger. Some degree of threat-monitoring in the presence of a history of life-threatening disease is adaptive and to be encouraged. However, excessive threat-monitoring (over and above medical recommendations) may contribute to heightened FCR and maintain and exacerbate the ongoing cycle of worry. Threat monitoring in FCR can range from those patients who say they are simply more aware of their bodies to those who keep an active lookout for new symptoms to those who frequently self-examine their bodies or present for frequent medical examinations (well over and above standard follow-up care practices). The latter group is most likely to suffer from FCR.

Derived from the manual for individually delivered ConquerFear, p. 73.

The therapist teaches about threat monitoring and avoidance behavior:

- Normalize threat monitoring as an adaptive way to avoid danger.
- Point out that while some people tend to engage in excessive threat monitoring, others are more likely to demonstrate avoidance behaviors.
- Excessive threat monitoring and avoidance behaviors can negatively impact many aspects of life, both physically, socially, and emotionally. See the individually delivered ConquerFear manual, p. 74-75 & 77-78, for further information.

Patients engaging in excessive threat monitoring

- Are likely to be highly aware of bodily sensations.
- May conduct excessive self-examinations.
- May experience worsened physical symptoms (e.g., tenderness of the breast due to frequent self-examinations).
- May have additional tests or frequently visit GP or oncologists.
- May spend much time searching for information on the internet.

Patient with avoidance behavior

- May avoid responding to bodily sensations and symptoms.
- May avoid conducting self-examinations.
- May stay away from follow-up appointments and other health-related consultations.
- May attempt to avoid cancer-related thoughts, places, certain people, or topics associated with cancer, as they may induce anxiety and worry.

Although the behavior mentioned above may temporarily reduce FCR, it is important to stress that such behavior, in the long run, is likely to maintain or worsen the impact of FCR. At this point, it is helpful to re-introduce the treatment model by showing patients the diagram of the model and explaining how excessive threat monitoring and avoidance (both cognitive and behavioural) are central features of the problematic information processing style that we believe contributes to maintaining FCR. It is also worth highlighting again how unhelpful metacognitions fit into the model.

Check here:

a) That the patients understand this relationship.

b) How credible the rationale for the session seems to them.

c) Whether they have any questions before proceeding.

Exercise: Assessing compliance with recommended follow-up care and self-examination practices

Once the patients have a thorough understanding of the rationale for reducing excessive threat-monitoring and avoidance, their degree of compliance with recommended follow-up care and self-examination practices should be assessed using the following writing exercise:

- The patients are asked to complete **Handout 5.2. *Your knowledge about follow-up care*.** In this worksheet, the patients are asked to write down what they know and what they do not know about recommended follow-up care and self-examination practices. Note: If the patients express that they have not been given any information about follow-up care, it is essential to emphasize that they should consult their oncologist to clarify any uncertainties.
- After completing the handout, the therapist asks the patients, "Are there any discrepancies between what you do and what you have been instructed to do?" Notably, the following discussion should not be focusing on the specific content of what the patients have been instructed to do, as this may to some extent differ from one person to another. Instead, the discussion should focus on *the discrepancies between what they do and what they are supposed to do and the consequences of deviating from the recommended follow-up care*.
- Furthermore, in cases where patients do not follow the recommended follow-up care, the therapist should ask the patients how they would react if they were to conduct self-examinations. Would they visit their GP more or less often. Would such changes in behavior result in, e.g., more worries? If so, how should they cope with such worries? The therapist should here discuss DM and worry postponement as possible skills for coping with worry.
- If necessary, the therapist should recommend that the patients develop a written agreement about self-examination and medical surveillance using **Handout 5.3. *Checking your symptoms sensibly*** (Note: This is only relevant for patients engaging in *excessive* threat monitoring or avoidance behavior).
- Finally, the therapist should emphasize that recommended follow-up care and self-examination may vary from one person to another. However, some general guidelines do apply. The therapist should elaborate upon these based on the national guidelines.
- **Handout 5.4 *Follow-up care and lifestyle changes*** is given as home reading. The handout provides information about recommended follow-up care and lifestyle changes. It is important to emphasize that the reading may trigger FCR-related thoughts. Therefore, the reading should be seen as an opportunity to apply DM to trigger thoughts and to use worry postponement.

HOMEWORK AND SESSION SUMMARY (15 minutes)

The patients should be encouraged to continue the home practice of Attention Training Technique (ATT), apply Detached Mindfulness (DM) to FCR trigger thoughts, and use worry postponement.

What do patients take home from today's session?

Questions?

5.2 SESSION 2 CHECKLIST

- Review homework.
- Introduce worry postponement.
- Introduce the concept of threat-monitoring and avoidance.
- Assess and discuss compliance with recommended follow-up care and self-examination practices using **Handout 5.2.** ***Your knowledge about follow-up care***.

HOMEWORK

- Apply DM to trigger thoughts.
- Practice use of DM and worry postponement.
- If relevant, consult with medical staff, and complete the handout 5.3. *Guidelines for Checking Your Symptoms Sensibly*.
- Read **Handout 5.4.** ***Follow-up care and lifestyle changes***.

SESSION 6: TREATMENT SUMMARY AND RELAPSE PREVENTION

6.1 SESSION MATERIAL

Timeframe: 120 minutes (group session)

Session Goals

The goals of session 6 are to:

- Review homework.
- Resume the discussion about values and committed action.
- Review and discuss what the patients' have learned and their perceived progress.
- Develop a plan for dealing with FCR in future situations – complete **Handout 6.1. *Plan for Dealing with FCR in the Future.***

Handouts

- Handout 6.1. *Plan for Dealing with Fear of Cancer Recurrence in the Future.*

PART 1: Review homework (20 minutes)

Continue to discuss the application of DM to triggers and use of worry postponement. Discuss at-home reading about follow-up care (**Handout 5.2. *Your knowledge about follow-up care***). Repeat that the reading material focuses on general guidelines, and individual differences may apply. Encourage the patients to consult their oncologist when in doubt.

PART 2: Discussion about values and planning of future goals

The purpose of this part of the session is not to focus on the values and goals planned in the initial discussion in Session 2 but rather to reflect upon current values and set new goals for the future to come. With the newly acquired skills to cope with FCR, they should now be better positioned to pursue a value-based living. In addition, their values may have changed since Session 2, and some of the patients may have been unable to reach their initially planned goals. Instead of dwelling on failures, it is therefore important to make the patients aware that they are now in a better position to follow their values and set realistic goals.

- The therapist may refer to the metaphor with the folder/book from Session 2 and emphasize that the patients have acquired a new set of skills during the treatment program. Using these skills will make paying less attention to their worries about cancer recurrence easier. This also allows them to live a more value-based living.
- The patients are then asked to reflect upon the following:
    - What is important to make more room for in your life?

- Are there any obstacles in doing so?
- What can be done to overcome these obstacles?

BREAK (10 minutes)

PART 3: Create Plan for Dealing with FCR in Future Situations (30 minutes)

The therapist explains that the level of FCR and anxiety can fluctuate. Therefore, it is important to make plans for how to deal with FCR in future situations, even if the patient does not endorse high levels of current FCR. The therapist then summarizes the consequences of responding with worry, rumination, threat monitoring, and avoidance and emphasizes that the patients have acquired alternative, more adaptive skills, including controlling and shifting attention, applying detached mindfulness, postponement of worry, and becoming aware of and challenging metacognitive beliefs.

The therapist then invites each individual to reflect upon what they have learned from the treatment program and complete **Handout 6.1. *Plans for Dealing with FCR in the Future.***

On this worksheet, the patients first write down what they have learned about:

1. Their attention.
2. Their behavior.
3. Their thoughts.

The patients then write down what they in future triggering situations plan to do concerning:

1. Their attention.
2. Their behavior.
3. Their thoughts.

The completed worksheet is discussed in the group, and the therapist encourages the patients to continue to practice the skills acquired throughout the treatment program.

PART 4: Final Group Discussion (25 minutes)

In this last part of the session, the patients' experiences with the treatment program are discussed. The group discussion may focus on how it has been to be part of the group. Let the patients exchange contact information if desired.

6.2 SESSION 2 CHECKLIST

- ☐ Review DM, worry postponement, and home reading.
- ☐ Reflect upon and discuss current values and goals. Note: their values and goals may have changed since the beginning of the treatment program.

- Discuss what the patients have learned throughout the treatment program.
- Develop a plan for dealing with FCR in the future.

HOMEWORK

- The patients should be encouraged to continue the daily practice of ATT, DM, and worry postponement as needed.

References

1. Butow PN, Turner J, Gilchrist J, Sharpe L, Smith AB, Fardell JE, et al. Randomized trial of ConquerFear: A novel, theoretically based psychosocial intervention for fear of cancer recurrence. J Clin Oncol. 2017;35(36):4066–77.

2. Tauber NM, Zachariae R, Jensen AB, Thewes B, Skyt I, Elkjaer E, et al. ConquerFear-group: Feasibility study with pilot results of a psychological intervention for fear of cancer recurrence delivered in groups. Psychooncology. 2022 Jan;31(1):30–8.

3. Lebel S, Ozakinci G, Humphris G, Mutsaers B, Thewes B, Prins J, et al. From normal response to clinical problem: definition and clinical features of fear of cancer recurrence. Support Care Cancer. 2016;24(8):3265–8.