

REVIEW

Life Goal Domains, Traits, and Setting Process in the Collaboration between Healthcare Professionals and Cancer Survivors: A Scoping Review

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Objectives: This study aimed to describe the classification of goal domains, goal traits, and the goal-setting process as revealed by previous life goal-setting practices of healthcare professionals collaborating with cancer survivors. **Methods:** The design was a scoping review. The MEDLINE, Academic Search Premier, and CINAHL databases were searched and mapped for papers with descriptions of goal domains, goal traits, and the goal-setting process. Goal domains were classified as life goals that were health-related, psychological, social, achievement-related, and leisure goals. Goal traits were classified based on specific, measurable, achievable, relevant, and timed (SMART) criteria. The goal-setting process was classified based on the frameworks of goal-setting phases (preparation, formulation, follow-up) and their components. **Results:** In total, 229 papers were identified, and 24 papers were included in the final analysis. All papers included health-related goals, followed by psychological and social goals. All goal domains were included in 41.7% of the papers. Relevant goals were the most common and timed goals were the least common. All papers included either of the components that comprise the preparation or formulation phases. We found that 12.5% of papers did not include any of the three components of the follow-up phase. **Conclusions:** The life goals collaboratively set between cancer survivors and healthcare professionals were characterized by the following: psychological and social goal domains, numerous goal domains, more relevant goals and fewer timed goals, low proportion of patient education in the preparation phase, and high proportion of evaluation of progress or achievement in the follow-up phase.

Key Words: cancer rehabilitation; cancer survivorship; goal setting; mapping review

INTRODUCTION

The global cancer burden is expected to reach 28.4 million cases by 2040, which is a 47% increase from 2020.¹⁾ Many cancer survivors have fair or poor health status, physical and psychological disabilities, and limitations in activities of daily living or instrumental activities of daily living, which may be a late consequence of cancer and its treatment.²⁾ The provision of early support, such as survivorship care³⁾ and occupational therapy,⁴⁾ for cancer survivors has become a global concern because these individuals are constrained to

live with the persistent effects of cancer and its treatment.

Life goals give meaning to a person's life, are an important part of developing one's identity, and are defined as internal representations of the desired states that motivate behavior.⁵⁾ As a potentially life-threatening illness, cancer negatively influences one's life goals, in addition to introducing physical and mental disabilities. For example, cancer survivors report fewer achievement-related and leisure goals and are known to abandon difficult-to-attain or unattainable goals; these issues can persist for as long as 18 months after diagnosis.⁶⁾ Higher goal disturbance in cancer survivors is associated

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with a decreased quality of life (QoL) at 7 and 18 months post-diagnosis.⁷⁾ Conversely, findings have also indicated that survivors who used more goal-adjustment strategies between 7 and 18 months post-diagnosis reported higher QoL at 18 months post-diagnosis.⁷⁾ Moreover, when cancer survivors can experience more progress in achieving goals or downgrade the importance of unattainable goals, they are less likely to experience reductions in global QoL over time.⁸⁾ These findings suggest that healthcare professionals should assist cancer survivors to set life goals. Specifically, for cancer survivors to live with and beyond cancer, it is vital for them and their healthcare professionals to collaboratively set life goals that reflect their QoL.

Goal setting is the formal process in which a rehabilitation professional or team, together with the patient and/or their family, negotiates goals.⁹⁾ Several studies on goal setting have been conducted for adults with acquired disabilities¹⁰⁾ and those undergoing geriatric rehabilitation.¹¹⁾ However, to the best of our knowledge, there are few studies on goal setting for cancer rehabilitation. Cancer survivors may require unique life goal strategies that differ from those of individuals with other illnesses because they may have the abovementioned life goal disabilities. Therefore, this study aimed to describe classifications related to goal domains, goal traits, and the goal-setting process as revealed by the previous life goal-setting practices of healthcare professionals collaborating with cancer survivors. It was expected that understanding such descriptive data would help us to recognize the challenges and essential elements in this field where evidence is lacking.

MATERIALS AND METHODS

Study Design

This study was a scoping review. The review was conducted following the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR).^{12,13)} The recommended population, concept, and context (PCC) mnemonic,¹⁴⁾ which was used to identify the focus and context of the research question for the scoping review, was as follows: the population comprised adults aged 18 years or over who were experiencing or had experienced cancer treatment; the concept encompassed life goal domains, goal traits, and the goal-setting process; and the context encompassed inpatient and outpatient facilities, community, and home.

Data Sources and Searching Strategies

The MEDLINE, Academic Search Premier, and CINAHL databases were used in this study. The search terms were [(cancer) OR (oncology) OR (malignant tumor)] AND [(goal-setting) OR (goal-planning) OR (goal-directed) OR (goal-oriented)] AND [(rehabilitation) OR (nurse) OR (occupational-therapy) OR (physiotherapy) OR (physical-therapy)] AND [(life) OR (living) OR (activity) OR (occupation)]. The last search date was September 5, 2022.

Inclusion and Exclusion Criteria

The inclusion criteria were as follows: (1) the papers were peer-reviewed; (2) the language was English; (3) participants were diagnosed with cancer; (4) participants were at least 18 years of age; (5) life goals were set collaboratively by cancer survivors and healthcare professionals; (6) life goal domains, goal traits, or the goal-setting process was described; (7) quantitative outcome data or narratives of cancer survivors showing the set goals' effectiveness were described; (8) the full text was available. The exclusion criteria were as follows: (1) participants were end-of-life cancer patients (individuals whose prognosis for life was expected to be less than 6 months), and the papers were (2) university bulletins, (3) case reports, or (4) protocol papers.

Paper Extraction

Identification, screening, eligibility, and inclusion steps were performed following the PRISMA flow diagram.¹⁵⁾ In the identification stage, the authors consulted a librarian and attempted to gain access to the full-text papers if they were unavailable for initial evaluation. At the screening stage, papers that did not meet the inclusion criteria or those that met the exclusion criteria based on titles and abstracts were excluded. Those that could not be evaluated by the title and abstract alone or those in which the title and abstract met the inclusion criteria were carefully reviewed by thorough reading of the full text at the eligibility stage. The remaining papers were included in the final analysis.

Data Analysis

After paper extraction, an abstract table for the included papers was constructed for analysis. This abstract table summarizes the main healthcare professionals involved in the study, the study design, and participant characteristics (main cancer type, age, stage, period since diagnosis or treatment, and sample sizes).

Subsequently, classifications of the goal domains, goal traits, and the goal-setting process were mapped. First, the

goal domains were classified as life goals that were health related, psychological, social, achievement-related, and leisure goals, following Pinquart et al.⁶⁾ Health-related goals focused on maintaining and improving one's physical health (e.g., getting healthy and increasing physical fitness). Psychological goals focused on inner psychological states (e.g., increasing self-insight and learning to be satisfied with one's present state). Social goals focused on interpersonal relations, such as the enlargement and maintenance of one's current social relationships (e.g., spending time with friends and relatives). Achievement-related goals included gains in prosperity and material possessions, improvement in one's material conditions, career development, and gaining social prestige (e.g., finding a new job or buying a new car). Leisure goals focused on intrinsically meaningful and self-rewarding activities in which people engaged by choice rather than necessity (e.g., going on a holiday or reading a novel).

Second, goal traits were classified according to the specific, measurable, achievable, relevant, and timed (SMART) criteria proposed by Schut and Stam¹⁶⁾ and Bovend'Eerd et al.¹⁷⁾ The number of goal domains and goal traits (maximum of five for each) included in each analyzed paper was counted. This was because, in general, there is not only one goal set, but several, including an overall rehabilitation goal and corresponding specific rehabilitation goals.¹⁸⁾

Third, the goal-setting process was classified based on goal-setting phases and components following those proposed by Lenzen et al.¹⁹⁾ The goal-setting phases were divided into: (1) preparation (patients engaging in activities prior to setting goals), (2) formulation of goals (patients' goals are made explicit and written down), and (3) follow-up (patients actively working on achieving their goals and/or are supported in working on their goals). Preparation phases included components such as patient education, patient self-reflection, and identification of topics for setting goals. The formulation of goals did not have any component, whereas follow-up phases included components such as patients' self-monitoring of progress toward goal achievement, support for the patients, and the evaluation of progress or achievement.

Reliability of Analysis

The search, extraction, and analysis of the papers were conducted independently by the first (KI) and second authors (SN). If the results of the two researchers differed, they conducted a joint analysis until a consensus was reached.

RESULTS

Process of Adopting Papers

After searching the databases, 229 papers were identified (86 from MEDLINE, 72 from Academic Search Premier, and 71 from CINAHL). These papers were published between 1986 and 2022. We screened 161 papers after removing duplicates. In the screening step, 77 papers were excluded because they did not meet the inclusion criteria. In the eligibility step, a total of 60 papers were excluded because they were not peer-reviewed (n=3), were not written in English (n=4), did not include the participants' cancer diagnosis (n=4), did not include participants aged 18 years or older (n=1), did not address collaborative goals (n=17), did not describe goal domains, goal traits, or the goal-setting process (n=17), did not report quantitative outcome data or narratives from cancer survivors that showed the goals' effectiveness (n=13), and did not include full access to the text (n=1). Ultimately, 24 papers were included in the analysis (**Fig. 1**).^{20–43)}

Overview of Included Papers

The primary healthcare professionals involved in goal setting included physicians (4.2%), registered nurses (58.3%), physiotherapists (33.3%), occupational therapists (25.0%), speech–language–hearing therapists (4.2%), clinical psychologists (12.5%), registered dietitians and nutritionists (12.5%), and social workers (4.2%). The study designs were as follows: randomized controlled trials (including pilot randomized controlled trials; n=4, 16.7%), non-randomized controlled trials (n=1, 4.2%), single-arm pre–post (n=6, 25.0%), longitudinal observational (n=1, 4.2%), mixed methods (n=3, 12.5%), qualitative (n=8, 33.3%), and measurement development (n=1, 4.2%). The main cancer types of the participants were breast, hematopoietic, gastrointestinal, gynecological, and lung. Participants were aged 20–88 years. The cancer stage was not reported in 15 papers (62.5%). In the 9 papers that reported cancer stage, 5 included stage I (55.6%), 6 included stage II (66.7%), 6 included stage III (66.7%), and 3 included stage IV (33.3%). Some papers reported the period since diagnosis or treatment. Participants were reported as undergoing cancer treatment in 7 papers (29.2%). The time since diagnosis was reported in 8 papers (33.3%), ranging from 1 to 156 months. The time since treatment was reported in 7 papers (29.2%), and some participants had cancer for up to 60 months after treatment. The time since diagnosis and treatment was not reported in 6 papers (25.0%). The sample sizes of the included papers ranged from 6 to 151. These details are summarized in **Table 1**.

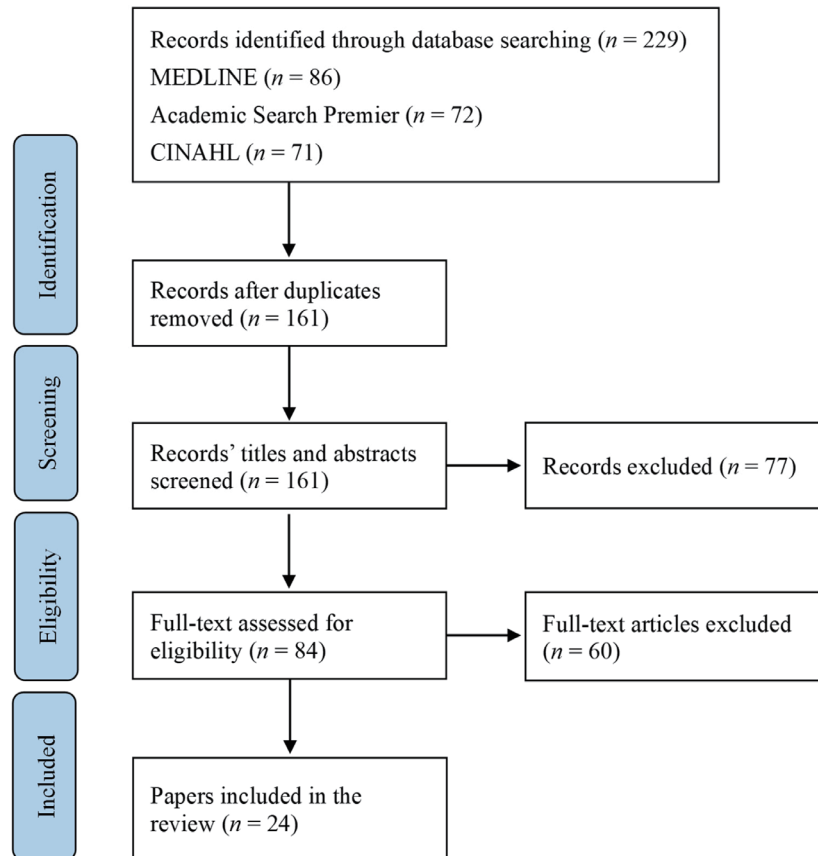


Fig. 1. PRISMA flow diagram for selection and assessment of relevant papers. Reasons for exclusion in the screening and eligibility stages are described in the text.

Goal Domains

Health-related goals were included in 24 papers (100.0%), psychological goals in 20 papers (83.3%), social goals in 17 papers (70.8%), achievement-related goals in 11 papers (45.8%), and leisure goals in 15 papers (62.5%). Three papers (12.5%) contained one goal domain, 2 papers (8.3%) contained two goal domains, 6 papers (25.0%) contained three goal domains, 3 papers (12.5%) contained four goal domains, and 10 papers (41.7%) contained five goal domains. The average number of goal domains was 3.6. These details are summarized in **Table 2**.

Goal Traits

Specific goals were included in 15 papers (62.5%), measurable goals in 12 papers (50.0%), achievable goals in 15 papers (62.5%), relevant goals in 22 papers (91.7%), and timed goals in 5 papers (20.8%). Five papers (20.8%) contained one goal trait, 6 papers (25.0%) contained two goal traits, 4 papers (16.7%) contained three goal traits, 5 papers (20.8%) con-

tained four goal traits, and 4 papers (16.7%) contained five goal traits. The average number of goal traits was 2.9. The details of these traits are summarized in **Table 3**.

Goal-setting Process

All papers included either of the components that comprise the preparation or formulation phases. However, 3 papers (12.5%) did not include any of the three components in the follow-up phase. Regarding the preparation phase, patient education was included in 16 papers (66.7%), patient self-reflection was included in 18 papers (75.0%), and identification of topics for setting goals was included in 24 papers (100%). The formulation phase was included in all papers (n=24, 100%). For the follow-up phase, self-monitoring was included in 14 papers (58.3%), support for the patient was included in 17 papers (70.8%), and evaluation of progress or achievement was included in 17 papers (70.8%). The details of these phases and components are included in **Table 4**.

Table 1. Abstract table of study characteristics

Reference	Primary healthcare professionals	Study design	Characteristics of participants				Sample size
			Main cancer type	Age (years) ^a	Stage	Period since diagnosis or treatment (months)	
20	PT, OT, RN	Qualitative	Breast, gastrointestinal, hematopoietic, gynecological, lung	30–69	Unclear	1 after diagnosis	56
21	RN	RCT	Gastrointestinal	41–76	II–IV	UT	124
22	RN	Single-arm pre–post	Breast, gastrointestinal, hematopoietic, renal	21–80	Unclear	Unclear	54
23	RN	Qualitative	Hematopoietic	22–74	Unclear	1–2.5 after diagnosis	22
24	RN	Mixed methods	Lung	40–82	IV	UT	60
25	PT	Single-arm pre–post	Breast	Mean 58.1	IV	112.8 after diagnosis	55
26	RDN	Qualitative	Breast	Mean 62	Unclear	120 after diagnosis	17
27	CP	Pilot RCT	Breast, melanoma, hematopoietic, sarcoma	Mean 32.6	Unclear	24.8 after diagnosis	56
28	RN, CP, SW, administration	Qualitative	Male reproductive system	Median 63	Early stage and advanced cancer	12–36 after diagnosis	18
29	RN	Qualitative	Lung	40–75	I–III	Unclear	22
30	PT, OT, RDN	Qualitative	Breast, hematopoietic, lung, gynecological, melanoma	Mean 52.7	Unclear	3–24 after treatment	26
31	OT	Pilot RCT	Hematopoietic	Mean 73.9	Unclear	Unclear	28
32	PT, OT, ST, RN, RDN, physicians	Measure development	Head and neck	Mean 57.6	Unclear	8 after diagnosis	23
33	RN, PT	Mixed methods	Hematopoietic, breast	44–88	Unclear	Unclear	11
34	RN	Non-RCT	Gastrointestinal	Mean 64.2 (intervention group), 58.4 (control)	Unclear	UT to 1 after treatment	56
35	OT	Mixed methods	Hematopoietic, breast, lung, gastrointestinal, melanoma	Mean 72	Unclear	UT to 6 after treatment	30
36	PT	Single-arm pre–post	Breast, gynecological, hematopoietic, urologic, melanoma	31–78	Unclear	5–156 after diagnosis	24
37	RN	Longitudinal observational	Gynecological	20–75	Unclear	1–3 after treatment	151
38	RN	Single-arm pre–post	Breast	Mean 52 (study 1), 46 (study 2)	I–III	UT to 6 after treatment	16
39	RN	Single-arm pre–post	Gynecological, hematopoietic, breast, male reproductive system, gastrointestinal	25–35	Unclear	UT to 60 after treatment	16
40	PT	Qualitative	Gynecological	38–78	I–III	Unclear	16
41	RN	Qualitative	Male reproductive system	29–45	Unclear	1–3 after treatment	6
42	OT	Pilot RCT	Breast	Mean 54.3	I–III	UT	15
43	PT, CP	Single-arm pre–post	Breast, sarcoma, gastrointestinal, renal	38–60	I–III	Unclear	13

^a Participant age is given as range, mean, or median.

PT, physiotherapist; OT, occupational therapist; RN, registered nurse; RDN, registered dietitian and nutritionist; CP, clinical psychologist; SW, social worker; ST, speech–language–hearing therapist; RCT, randomized controlled trial; UT, undergoing treatment.

Table 2. Inclusion of goal domains in assessed publications

Reference	Health-related goals	Psychological goals	Social goals	Achievement-related goals	Leisure goals	Total
20	✓	✓	✓	✓	✓	5
21	✓	✓	✓			3
22	✓	✓			✓	3
23	✓	✓	✓	✓	✓	5
24	✓	✓	✓	✓	✓	5
25	✓					1
26	✓		✓			2
27	✓	✓		✓		3
28	✓	✓	✓			3
29	✓	✓	✓			3
30	✓	✓	✓	✓	✓	5
31	✓	✓	✓		✓	4
32	✓	✓	✓	✓	✓	5
33	✓	✓	✓	✓	✓	5
34	✓					1
35	✓	✓	✓		✓	4
36	✓					1
37	✓	✓	✓		✓	4
38	✓	✓	✓	✓	✓	5
39	✓	✓	✓	✓	✓	5
40	✓	✓				2
41	✓	✓	✓	✓	✓	5
42	✓	✓	✓	✓	✓	5
43	✓	✓			✓	3
Total	24 (100%)	20 (83.3%)	17 (70.8%)	11 (45.8%)	15 (62.5%)	3.6 (mean)

DISCUSSION

Goal Domains

The most frequently included goal domains were health-related goals, followed by psychological and social goals. It has been reported that cancer survivors' emotional, social, and spiritual needs, such as reducing stress or worrying, concerns about the cancer coming back, and dealing with the impact that cancer has on their relationship with their partner, were more likely to be unmet than needs in other domains.⁴⁴ Meanwhile, stroke survivors have reported more unmet needs in physical function, such as pain and bladder/bowel continence, than in psychosocial function.⁴⁵ Direct comparison of the goal domains of cancer survivors with those of non-cancer survivors is difficult because of the low number of studies reporting the goal domains of non-cancer survivors. However, cancer survivors' goal domains may be

characterized by inclusion of psychological and social goals.

Notably, 10 papers (41.7%) contained five goal domains, and 19 (79.2%) of the 24 analyzed papers included three or more goal domains, indicating that most papers included multiple goal domains. The rehabilitation goals and needs identified by cancer survivors indicated that they tend to place equal (and high) value on their multiple rehabilitation goals across each of the three occupational performance areas (self-care, leisure, and productivity), regardless of age or gender.^{46,47} Hematological malignancy survivors who had diverse types of distress, including fatigue, anxiety, fear of relapse, drastic economic changes caused by loss of employment, feelings of being let down, identity crises, and loss of work-related friendships, reported that setting new or different goals in life helped them adapt to the changes following cancer treatment.⁴⁸ Therefore, it is considered essential that numerous life goals covering numerous domains be set to address such

Table 3. Inclusion of goal traits in assessed publications

Reference	Specific	Measurable	Achievable	Relevant	Timed	Total
20	✓		✓	✓		3
21	✓		✓	✓		3
22	✓	✓	✓	✓		4
23				✓		1
24				✓		1
25			✓	✓		2
26	✓	✓	✓	✓	✓	5
27	✓			✓		2
28	✓	✓	✓	✓	✓	5
29		✓	✓			2
30	✓			✓	✓	3
31			✓	✓		2
32	✓	✓	✓	✓		4
33				✓		1
34	✓	✓		✓		3
35	✓	✓	✓	✓	✓	5
36	✓			✓		2
37	✓	✓	✓	✓	✓	5
38	✓	✓	✓	✓		4
39	✓	✓	✓	✓		4
40		✓				1
41			✓	✓		2
42	✓	✓	✓	✓		4
43				✓		1
Total	15 (62.5%)	12 (50.0%)	15 (62.5%)	22 (91.7%)	5 (20.8%)	2.9 (mean)

extensive negative influences.

Goal Traits

Relevant goals among the SMART criteria were the most frequently included. Cancer survivors realize that their lives are finite at least once because of their diagnosis, and many have concerns about the cancer coming back.⁴⁴⁾ Many of the goals were relevant to cancer survivors because of the need to set life goals that reflect QoL. In contrast, timed goals were the least included. Timed goals specify the time period in which the goal should be achieved.¹⁷⁾ Cancer is a progressive disease with an unclear prognosis, which may explain why relatively few timed goals are set.

The number of goal traits included in the analyzed papers was almost evenly distributed between one to five. Some reports^{9,37)} indicated that it is challenging for cancer survivors and rehabilitation staff to meet all the SMART criteria, and some may not meet any of the criteria. Therefore, cancer

survivors and healthcare professionals do not need to expect that the life goals they set will meet all the SMART criteria. Although healthcare professionals may consider utilizing more of the goal traits that meet the SMART criteria when setting goals, the goal traits should ultimately be based on the clinical situation of the cancer survivors.

Goal-setting Process

In a previous systematic review on the phases and components of goal setting for persons with diabetes, rheumatic disease, stroke, and other diseases, patient education components were 82%, and evaluation of progress or achievement components were 41%.⁴⁹⁾ Therefore, this scoping review had a relatively low percentage of patient education and a high percentage of evaluation of progress or achievement. The following discussion is divided into patient education and evaluation of progress or achievement.

In considering the relevance of patient education, it is

Table 4. Details of the phases and components of the goal-setting process in assessed publications

Reference	Phase:	Preparation			Formulation	Follow-up		
	Component:	Patient education	Patient self-reflection	Identification of topics for setting goals		Patient self-monitoring	Support for the patient	Evaluation of progress or achievement
20		✓		✓	✓		✓	✓
21		✓	✓	✓	✓			✓
22			✓	✓	✓			
23				✓	✓			✓
24			✓	✓	✓			
25				✓	✓			✓
26		✓	✓	✓	✓	✓	✓	✓
27		✓	✓	✓	✓	✓	✓	✓
28		✓	✓	✓	✓	✓	✓	✓
29		✓	✓	✓	✓	✓	✓	✓
30		✓	✓	✓	✓	✓	✓	✓
31				✓	✓	✓	✓	
32			✓	✓	✓			
33			✓	✓	✓		✓	
34		✓		✓	✓	✓		✓
35		✓	✓	✓	✓	✓	✓	✓
36		✓	✓	✓	✓	✓	✓	✓
37			✓	✓	✓		✓	✓
38		✓	✓	✓	✓	✓	✓	✓
39		✓	✓	✓	✓	✓	✓	✓
40		✓	✓	✓	✓	✓	✓	✓
41		✓	✓	✓	✓		✓	
42		✓	✓	✓	✓	✓	✓	✓
43		✓		✓	✓	✓	✓	
Total		16 (66.7%)	18 (75.0%)	24 (100%)	24 (100%)	14 (58.3%)	17 (70.8%)	17 (70.8%)

presumed that some cancer survivors are unable to accept an unknown or poor life expectancy. This is because there are multiple barriers regarding goal setting between cancer survivors and healthcare professionals, such as unknown life expectancy, unknown patient wishes, deteriorating disease status, difficulty for patients to understand the limitations of life-sustaining treatment, lack of ability to determine the goals of care, and differences of opinion between patients and healthcare professionals.^{50,51} In such cases, healthcare professionals might be hesitant to attempt patient education toward goal setting, which was a possible reason for the low rate of patient education in this study. In goal setting with stroke survivors, patient education prior to starting the goal-setting process is expected to increase the chances of setting realistic goals that are consistent with the patient's

wishes and expectations.⁵² In particular, it is estimated that the presence or absence of patient education in the goal-setting process influences the ability to set achievable and relevant goals. In this study, however, achievable goals were set in five of the eight papers (62.5%)^{22,25,31,32,37} that did not address patient education and in 10 of the 16 papers (62.5%)^{20,21,26,28,29,35,38,39,41,42} that did address patient education, meaning that relative dominance of these approaches were the same. Relevant goals were also set in all eight papers (100%)^{22–25,31–33,37} that did not address patient education and in 14 of the 16 papers (87.5%)^{20,21,26–28,30,34–36,38,39,41–43} that addressed patient education, giving similar relative dominance for these approaches. Therefore, the presence or absence of patient education did not appear to influence the abilities of cancer survivors and healthcare profession-

als to set achievable and relevant goals. This may suggest that the mechanisms representing the relationship between the goal-setting process and goal traits differ between stroke survivors and cancer survivors.

In considering the importance of evaluating progress, it is notable that the previous systematic review⁴⁹⁾ focused on the level of active engagement in rehabilitation goal-setting interventions, whereas the current scoping review focuses on life goals. Because the life goals that lead to a person's identity are modified by various factors like age, gender, personality, affect, environment, and health,⁵³⁾ it is logical that a person's life goals should be continuously evaluated. Furthermore, some cancer survivors used more goal-adjusted strategies as time went on.^{54,55)} However, some self-developed strategies that cancer survivors use to manage specific occupations might also be counterproductive.⁵⁶⁾ Therefore, to set life goals, it would be critical to evaluate progress or achievement and to continuously adjust life goals with the cancer survivor.

Limitations and Future Research Directions

This scoping review has several limitations. First, in efforts to locate information sources, some papers in the searched databases may have remained undetected. Second, papers with unpublished results at the date of the search were not used in this scoping review because protocol papers were excluded. Third, papers written in languages other than English were not included.

Fourth, this scoping review focused on cancer survivors who varied in terms of age, cancer type, treatment type, stage, and functional disabilities. Goal domains, goal traits, and the goal-setting process may differ depending on the patient background. However, we analyzed these various backgrounds without distinguishing between them because no previous studies have comprehensively reviewed life goals set in collaboration between cancer survivors and healthcare professionals. Further research is needed to clarify the influence of different cancer types on goal traits and the goal-setting process, because it has been reported that different cancer types, such as those with different degrees of expected recovery, have different goal domains and levels of goal attainment.^{37,57)}

Fifth, this scoping review did not provide findings on the influence of infrequent patient education on goals traits in goal setting with cancer survivors. Therefore, further research is needed to investigate how the presence or absence of patient education for cancer survivors influences goal-setting practices.

Sixth, although this scoping review provided descriptive data on elements of life goals, it was not possible to determine for which outcomes and to what extent these life goals were effective. Systematic reviews, meta-analyses, or meta-syntheses may also be conducted to clarify which outcomes are positively affected by collaboratively set life goals and the degree of their effectiveness. In addition, further research is required to assess the effectiveness of life goal-setting interventions for cancer survivors that include the following: setting psychological and social goals, covering numerous goal domains, setting relevant goals, and evaluating progress or achievement.

Scoping reviews can contribute to the identification of gaps in knowledge and/or future research needs.⁵⁸⁾ By accumulating recommendations for further research and expanding on this study, the findings regarding the domains, traits, and setting process of goals collaboratively set between cancer survivors and healthcare professionals can help survivors to enhance their QoL and live with cancer on their own terms. This study is positioned as a first step in that direction.

CONCLUSION

We conducted a comprehensive review of classifications related to the life goal domains, goal traits, and the goal-setting process used in collaborations between healthcare professionals and cancer survivors. They set health-related, psychological, and social goals within numerous goal domains. Regarding goal traits, relevant goals were set based on the cancer survivor's clinical situation, whereas the setting of timed goals was less common. For the goal-setting process, there was a lower percentage of patient education during preparation and a higher percentage of evaluation of progress or achievement during follow-up when compared with previous studies. By accumulating further research and expanding on this study, the findings will contribute to understanding the challenges and essential classifications related to goal setting with cancer survivors.

CONFLICTS OF INTEREST

The authors declare no conflict of interest.

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