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Personality, health behaviors, and quality of life among colorectal cancer survivors: Results from the PROFILES registry

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ABSTRACT

\textbf{Purpose}: There is a paucity of research looking into the relationship between personality and health behaviors among cancer survivors. The aim of this study was to investigate whether Type D personality and its two constituent components, negative affectivity (NA) and social inhibition (SI), are associated with health behaviors, quality of life (QoL), and mental distress among colorectal cancer (CRC) survivors.

\textbf{Methods}: A population-based study was conducted among 2,620 CRC patients diagnosed between 2000 and 2009, who completed measures of personality (DS14), health behaviors, QoL (EORTC QLQ-C30), and mental distress (hospital anxiety and depression scale).

\textbf{Results}: Personality was not associated with body mass index or smoking. Those scoring high on NA (with or without SI) were more often nondrinkers and less physically active compared to those scoring high on neither or only SI. Personality (high scores NA) and health behaviors (inactivity) were independently associated with poor QoL and mental distress.

\textbf{Conclusions}: CRC survivors with high scores on NA are at risk of being inactive and have worse health outcomes.

KEYWORDS

colorectal cancer; distress; health behaviors; quality of life; Type D personality

Introduction

With the ongoing improvements in early detection and treatment along with the aging of population, the number of colorectal cancer (CRC) survivors is rapidly increasing in the Western world. In the Netherlands, there were about 77,000 CRC survivors in 2009 and expected to increase to 121,000 in 2020 (Dutch Cancer Society, 2011). CRC has increasingly been referred to as a chronic disease since the majority (53%) of the patients survive relatively long term (>10 years after...
diagnosis) (Dutch Cancer Registry, 2012). Many of those CRC survivors face continuing physical and psychosocial problems due to cancer and its treatment, which could negatively impact health-related quality of life (HRQoL) (Denlinger & Barsevick, 2009).

Health behaviors like engaging in regular physical activity, increased fruit and vegetable intake, moderate alcohol consumption, not smoking, and maintaining a healthy weight have been shown to play an important role in CRC prevention, mortality, survival, and recurrence (Je, Jeon, Giovannucci, & Meyerhardt, 2013; Johnson et al., 2013; Simons, et al., 2013; Vrieling & Kampman, 2010). In addition, studies have shown higher overall HRQoL and less fatigue, pain, insomnia, and mental distress among CRC survivors who are physically more active, have a high vegetable and fruit intake, and who do not smoke (Blanchard, Courneya, & Stein, 2008; Buffart et al., 2012; Grimmett, Bridgewater, Steptoe, & Wardle, 2011; Lynch, Cerin, Owen, Hawkes, & Aitken, 2008). Given these favorable HRQoL outcomes of health behaviors among CRC survivors, it is important to gain an insight into the predictors of health behaviors.

Several studies relate personality to health behaviors (Anton & Miller, 2005; De Moor, Beem, Stubbe, Boomsma, & De Geus, 2006; Malouff, Thorsteinsson, Rooke, & Schutte, 2007; McWilliams & Asmundson, 2001; Munafo, Zetteler, & Clark, 2007; Rhodes, Courneya, & Jones, 2004; Shankar, McMunn, Banks, & Steptoe, 2011; Valtonen et al., 2009). Most studies focused on the five-factor model of personality and reported neuroticism, extraversion, and conscientiousness as reliable correlates of health behavior. For example, persons with negative emotion personality traits such as anxiety (McWilliams & Asmundson, 2001), anger and hostility (Anton & Miller, 2005), loneliness (Shankar et al., 2011), and hopelessness (Valtonen et al., 2009) may be less likely to engage in physical activity compared to those with lower scores on these traits. In addition, high scores on activity (Rhodes et al., 2004) and sensation seeking (de Moor et al., 2006), as facets of extraversion, were positively correlated to physical activity. Both increased extraversion and increased neuroticism were associated with an increased likelihood of being a smoker rather than a nonsmoker (Munafo et al., 2007). A meta-analysis showed that alcohol consumption was associated with low conscientiousness, low agreeableness, and high neuroticism (Malouff et al., 2007).

In recent years, Type D (distressed) personality has become an important research topic in the field of medical psychology (O’Dell, Masters, Spielmans, & Maisto, 2011). Type D personality has been described as the tendency to experience a high joint occurrence of negative affectivity (NA) and social inhibition (SI) (Denollet, 2005). People who score high on NA have the tendency to experience negative emotions, while people who score high on SI have the tendency not to express these emotions, because of fear of rejection or disapproval by others (Denollet, 2005). NA is positively correlated with neuroticism ($r = 0.68$) and SI is negatively correlated with extraversion ($r = -0.59$) (Denollet, 2005). Type D personality, the combination of the two personality traits NA and SI, possibly leads
to poor health behaviors. Healthy individuals and people with a cardiac condition with a Type D personality are found to be less likely to be physically active, are more often smokers, and have poor dietary habits (Borkoles, Polman, & Levy, 2010; Gilmour & Williams, 2012; Mommersteeg, Kupper, & Denollet, 2010; Williams et al., 2008).

Up to now, no studies have focused on the role of the personality traits NA and SI and their combined effect (Type D personality) on the health behaviors of cancer survivors. However, research shows that having a Type D personality among cancer survivors is associated with having more comorbid conditions (Mols, Oerlemans, Denollet, Roukema, & van de Poll-Franse, 2012) and lower HRQoL, more disease-specific complaints, and higher levels of mental distress (Mols, Thong, van de Poll-Franse, Roukema, & Denollet, 2012). It could be hypothesized that the association between Type D personality and HRQoL is partly explained by poorer health behaviors of those survivors. Therefore, the aims of the present study were to explore whether Type D personality and its two constituent components—NA and SI—are associated with health behaviors among CRC survivors and specifically, whether or not Type D personality and health behaviors are independently associated with HRQoL and mental distress or have (partly) overlapping variances.

Methods

Setting and participants

This study is a population-based survey among CRC survivors registered within the Eindhoven Cancer Registry (ECR) of the Comprehensive Cancer Centre South. The ECR compiles data of all individuals newly diagnosed with cancer in the southern part of the Netherlands, an area with ten hospitals serving 2.3 million inhabitants (Janssen-Heijnen, Louwman, Van de Poll-Franse, & Coebergh, 2005). All individuals diagnosed with CRC between 2000 and 2009 as registered in the ECR were eligible for participation ($N = 6,446$). We excluded patients who participated in another CRC study ($N = 2,388$), died before our study ($N = 327$), had cognitive impairment, or were too ill at the time of the study (medical records and advice from the attending specialist $N = 63$), or the tumor was not staged ($N = 83$). This study was approved by the certified Medical Ethics Committee of the Maxima Medical Centre in Veldhoven.

Data collection

This study was conducted in December 2010 within patient-reported outcomes following initial treatment and long term evaluation of survivorship (PROFILES) (van de Poll-Franse et al., 2011). PROFILES is a registry for the study of the physical and psychosocial impacts of cancer and its treatment on a dynamic, growing population-based cohort of both short and long-term cancer survivors. PROFILES
contains a large web-based component and is linked directly to clinical data from the ECR. Details of the PROFILES data collection method have been previously described (van de Poll-Franse et al., 2011).

**Study measures**

**Sociodemographic and clinical characteristics**
Survivors’ sociodemographic and clinical characteristics at the time of cancer diagnosis (e.g., sex, date of birth, and cancer diagnosis, tumor stage, primary treatment) were available from the ECR. Self-reported comorbidity at the time of survey was assessed with the Self-administered Comorbidity Questionnaire (Sangha, Stucki, Liang, Fossel, & Katz, 2003). Self-designed questions on marital status, educational level, and current occupation were added to the questionnaire.

**Type D personality**
Type D personality was measured with the self-administered 14-item Type D personality scale (DS14) (Denollet, 2005). Items are scored on a five-point response scale ranging from 0 (false) to 4 (true). Seven of these items refer to “NA” or the tendency to experience negative emotions in general (feelings of dysphoria, anxiety, and irritability). The remaining seven items refer to the patient’s level of “SI” or the tendency to inhibit the expression of emotions in social relationships (discomfort in social interactions, lack of social poise, and the tendency to avoid confrontation in social interaction leading to nonexpression). At the intermediate level, NA/SI is assessed as continuous dimensions, and Type D refers to the combination of these traits at a superordinate level. Patients were categorized as having a Type D personality using a standardized previously established cutoff score of ≥10 on both the NA and SI subscales (Denollet, 2005); using the item response theory shows that the DS14 has the highest information around this point (Emons, Meijer, & Denollet, 2007). The DS14 is a valid and reliable scale with Cronbach’s alpha of 0.87/0.88 in our study sample and a test–retest reliability over a 3-month period of $r = 0.72/0.82$ for the two subscales, respectively (Denollet, 2005).

**Health behaviors**
Physical activity was assessed with questions derived from the validated European Prospective Investigation into Cancer Physical Activity Questionnaire (Pols et al., 1997). Participants were asked how much time they spend on the following activities (average number of hours per week, in the last summer and winter separately): walking, bicycling, gardening, housekeeping, and sports. Six separate sports could be specified. The mean number of hours of physical activity per week in summer and winter was computed. To include an estimate of intensity, metabolic equivalent of task (MET) values (MET value: 1 MET = 4.184 kJ/kg body weight/h) were assigned to each activity, according to the compendium of physical activities (Ainsworth et al., 2000). Total physical activity (PA) was
calculated by summing hours per week of all activities. The duration of moderate
to vigorous physical activity (MVPA) was assessed as time (h/wk) spent on walk-
ing, bicycling, gardening, and sports (≥3 MET), excluding housekeeping and
light intensity sports (MET) (Buffart et al., 2012). MVPA was dichotomized
according to whether meeting the Dutch PA guideline of 150 min/wk or not
(Nederlandse Norm Gezond Bewegen, 2013).

Current smoking status was assessed by the question “Do you smoke?”
Response options included “No,” “No, but I used to,” and “Yes.” Alcohol
consumption in the last 12 months was categorized as nondrinker, moderate
drinker (>1 and <14 glasses for women per week; >1 and <21 glasses for men),
and heavy drinker (Grimmett et al., 2011). Body mass index (BMI) was calculated
with self-reported height and weight and classified as (1) underweight, (2) normal
(18.5–24.9), (3) overweight (25–29.9), and (4) obese (≥30).

Health-related quality of life
The EORTC QLQ-C30 (Version 3.0) was used to assess HRQoL (Niezgoda &
Pater, 1993). It contains five functional scales on physical, role, cognitive,
emotional, and social functioning, a global health status/QoL scale, three symptom
scales, and six single items. Each item is scored from (1) not at all to (4) very
much, except for the global QoL scale, which ranges from (1) very poor to (7)
excellent. Cronbach’s alpha ranged from 0.52 to 0.89. Scores were linearly trans-
formed to a 0–100 scale; a higher score on the functional scales and global QoL
means better functioning and QoL. Clinical relevance was determined
following evidence-based guidelines for EORTC QLQ-C30 scores (Cocks et al.,
2011).

Mental distress
Mental distress was assessed with the Hospital Anxiety and Depression Scale
(HADS), with seven items each for assessing both anxiety and depression (Zig-
mond & Snaith, 1983). A meta-analysis showed that the Cronbach’s alpha of the
anxiety scale varied from 0.68 to 0.93 (mean 0.83) and the depression scale from
0.67 to 0.90 (mean 0.82) (Bjelland, Dahl, Haug, & Neckelmann, 2002). Clinically
meaningful differences were determined with Norman’s “rule of thumb,” whereby
a difference of ~0.5 SD indicates a threshold of discriminant change in scores of a
chronic illness (Norman, Sloan, & Wyrwich, 2003).

Statistical analyses
ECR data on sociodemographic and clinical characteristics enabled us to com-
pare the group of respondents, nonrespondents, and patients with unverifiable
addresses, using analyses of variance for continuous and chi-square analyses
for categorical variables. Similar statistics were applied to analyze differences
in sociodemographic and clinical characteristics, health behaviors and HRQoL,
and mental distress between patients with (1) Type D personality (NA+/SI+), (2) SI only (NA−/SI+), (3) NA only (NA+/SI−), and (4) the reference group (NA−/SI−).

Hierarchical linear regression models were constructed to assess a unique variance in HRQoL and mental distress (dependent variables) explained by personality and health behaviors separately and total variance (entering personality and health behavior together in the model). Overlapping variances are determined by the difference in the sum of unique variance explained by personality and health behaviors and total variance. The variables were entered to the model as follows: confounders (age, time since diagnosis, sex, number of comorbid conditions, marital status, educational level, disease stage, and treatment) (step 1); confounders + personality (step 2); confounders + health behaviors (step 3); confounders + personality + health behaviors (step 4). Partial mediation will be indicated if the relationship between personality and HRQoL is significant in step 2, and smaller, but still significant in step 4 when health behaviors are added. Full mediation will be indicated when the relationship between personality and HRQoL is significant in step 2, and not significant in step 4 when health behaviors are added (Baron & Kenny, 1986). The Sobel test will be conducted to provide statistical evidence for mediation, using the unstandardized regression coefficients and standard errors for the relationships between the independent variable and mediator, and between the mediator and the dependent variable (Baron & Kenny, 1986). Missing data at random were treated as another category when dummy variables were created to ensure complete case analyses.

All statistical analyses were performed using SPSS version 19.0 (Statistical Package for Social Sciences, Chicago, IL, USA) and p values <0.05 were considered statistically significant.

Results

Respondents and nonrespondents

Seventy-three percent of the 3,585 cancer survivors returned a questionnaire (N = 2,620). For 240 patients, the number of missing items was too high and those patients were therefore excluded from analyses. Compared to respondents, nonrespondents (N = 624) were statistically significantly older, more often female, more often diagnosed Stage II disease, and they were more often treated with surgery only. Those with unverifiable addresses (N = 341) had a longer time since diagnosis compared to respondents.

Type D, sociodemographic, and clinical characteristics

In total, 21% (N = 490) of the respondents could be classified as having a Type D personality, 11% (N = 256) scored above the cutoff for NA only
Patients with high scores on NA only or with a Type D personality more often reported two or more comorbid conditions, more often had a lower educational level, and were married less often compared to the reference group (NA−/SI−). Patients with SI only were more often male compared to the other three groups.
Type D personality and health behaviors

No significant differences were found between the four personality groups on BMI and smoking behavior (Table 2). Patients scoring high on NA only or patients with a Type D personality were more often nondrinkers (38 and 36%, respectively) compared to the reference group or patients scoring high on SI only (28 and 25%, respectively; \( p < 0.01 \)). Patients with a Type D personality spent fewer hours per week on walking, cycling, and gardening activities, resulting in a lower total number of hours spent on physical activity per week compared to the other three
groups ($p < 0.05$). The total number of hours per week spent on MVPA was also lower for patients with a Type D personality compared to the other three groups. In addition, cancer patients with high scores on NA only or a Type D personality (20 and 21%, respectively) were less likely to meet the national guidelines for healthy physical activity, compared to patients with SI only or the reference group (12 and 13%, respectively; $p < 0.01$).

**Type D personality and health-related quality of life/mental distress**

Significant main effects for personality were evident for all HRQoL and mental distress subscales (all $p$s $< 0.01$; Table 2). Post hoc pairwise comparisons revealed that patients scoring high on NA only or having a Type D personality had statistically significant and clinically relevant (small–medium) lower scores on all functioning scales of the EORTC QLQ-C30 compared to the reference group (Table 2).

In multivariate linear regression analyses, Type D personality, high scores on NA only, and MVPA were significantly associated with HRQoL and mental distress when corrected for covariates (Table 3). A significant negative association between smoking behavior and HRQoL was found (except for social functioning). The effects of Type D personality slightly diminished when health behaviors were added to the model (model 4). The overlapping variances between personality and health behaviors ranged from 2.5% for physical functioning to 0.7% for cognitive functioning. Statistical evidence for partial mediation of physical activity into the relationship between personality and HRQoL and mental distress was indicated by the Sobel test (all $p$s $< 0.01$), only for patients with a Type D personality. No statistical evidence for mediation of the other health behaviors was found.

**Discussion**

This population-based study showed that CRC patients with Type D personality or high scores on NA were less likely to meet the physical activity guidelines and to drink alcohol compared to those scoring high on neither or only SI. No differences between the four personality groups were found with respect to BMI and smoking behavior. High scores on NA (with or without SI), physical activity, and smoking behavior were independently associated with HRQoL and mental distress; however, the effect of Type D personality slightly diminished when health behaviors were added to the model.

With respect to physical activity, our results are partly in agreement with previous research, which found Type D personality (Borkoles et al., 2010; Gilmour & Williams, 2012; Mommersteeg et al., 2010; Williams et al., 2008) and both neuroticism and introversion (Courneya & Helsten, 1998) to be related to less active behavior. Our results indicate that NA was more prominent in explaining physical activity behavior than SI. The exercise barriers (lack of motivation/desire, lack of energy, and embarrassment in a fitness evaluation) associated with neuroticism (Courneya & Helsten, 1998) may therefore be stronger determinants of physical activity behavior than the social barriers experienced by introvert persons.
Table 3. Standardized betas of hierarchical multiple linear regression analyses evaluating the association of personality and health behaviors with health-related quality of life, anxiety, and depression scales.

<table>
<thead>
<tr>
<th>Model 1: confounders</th>
<th>Global health status</th>
<th>Physical functioning</th>
<th>Role functioning</th>
<th>Cognitive functioning</th>
<th>Emotional functioning</th>
<th>Social functioning</th>
<th>HADS-depression</th>
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<td>BMI</td>
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<tr>
<td>Normal</td>
<td>Ref</td>
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<td>Ref</td>
<td>Ref</td>
</tr>
<tr>
<td>Overweight</td>
<td>−0.02</td>
<td>0.05**</td>
<td>−0.01</td>
<td>−0.04</td>
<td>−0.04*</td>
<td>0.02</td>
<td>0.02</td>
<td>0.03</td>
</tr>
<tr>
<td>$R^2$</td>
<td>0.22</td>
<td>0.30</td>
<td>0.17</td>
<td>0.12</td>
<td>0.32</td>
<td>0.16</td>
<td>0.34</td>
<td>0.36</td>
</tr>
</tbody>
</table>

SI, social inhibition; NA, negative affectivity; BMI, body mass index; Ref, reference category; HADS, hospital anxiety and depression scale.

*Confounders include age, time since diagnosis, sex, number of comorbid conditions, marital/partner status, educational level, disease stage, treatment.

$p < 0.05$; $\cdot \cdot p < 0.01$
With respect to alcohol and smoking behavior, the results of previous studies
are inconsistent. In accordance with our findings, a study among a large com-
munity sample in the Netherlands found no differences between Type Ds and non-
Type Ds in their smoking behavior, and Type Ds were found to be less likely to
consume alcohol (Mommersteeg et al., 2010), while other studies among healthy
participants and cardiac patients did find an association between Type D personal-
ity and more smoking behavior (Einvik et al., 2011; Gilmour & Williams, 2012;
Svansdottir et al., 2012). In addition, other studies found both increased extrav-
ersion and neuroticism to be associated with an increased likelihood of being a
smoker rather than a nonsmoker (Munafo et al., 2007), while high neuroticism,
low conscientiousness, and low agreeableness were associated with more alcohol
consumption (Malouff et al., 2007). It could be that more substance use (e.g., alco-
hol consumption, smoking) is a strong correlation with other personality charac-
teristics including novelty seeking, harm avoidance, or an antisocial personality
rather than Type D personality.

Consistent with previous research, both personality and health behaviors were
independently associated with health outcomes (Anton & Miller, 2005; Blanchard
et al., 2008; Buffart et al., 2012; De Moor et al., 2006; Grimmett et al., 2011; Malouff
et al., 2007; McWilliams & Asmundson, 2001; Munafo et al., 2007; Rhodes et al.,
2004; Shankar et al., 2011; Valtonen et al., 2009). A small part of the variances of
personality and health behaviors overlapped, suggesting that maladaptive health
behavior could only partly act as a (behavioral) mechanism to explain the link
between personality and health outcomes. This behavioral mechanism could act
through negative illness perceptions of Type D cancer patients’ experience (Mols,
Denollet, Kaptein, Reemst, & Thong, 2012). Individuals scoring high on neuroti-
cism, which is highly correlated with NA, might be more prone to somatic aware-
ness, monitoring of fear of disease recurrence, and more negative illness
perceptions. They will therefore possibly associate physical activity with worsening
of their disease and stay inactive. A recent study among coronary artery disease
patients showed that patients with a Type D personality had a decreased motiva-
tion for activity (Bunevicius et al., 2014) and will probably remain inactive. In
addition, Type D cancer survivors perceive to have received less information from
their health-care provider compared to nonType Ds (Husson, Denollet, Oerle-
mans, & Mols, 2013), and the importance of maintaining a healthy lifestyle might
therefore not be clear to those survivors. However, only a small part of the
explained variances of NA and health behaviors overlapped, indicating that other
mechanisms may play a more important role in explaining the relation between
NA and health outcomes. The joint presence of NA and SI showed the strongest
association with mental distress in the present study; it could therefore be hypothe-
sized that mental distress acts as a mediating mechanism in the relation between
personality and HRQoL. Those patients with the NA component might assess their
HRQoL more negatively compared to those who lack the NA component. Besides
this, Type D personality has previously been associated with depression, anxiety,
loneliness, inadequate social support, and stressful life events (Bjelland et al., 2002; Michal, Wiltink, Grande, Beutel, & Brahler, 2011; Mols & Denollet, 2010; Statistiek). People high on NA are quite likely to discuss their own thoughts, feelings, and behaviors with other people, while patients with a Type D personality may feel a similar need to express themselves, but they are held back by social evaluation concerns (SI component) which may add to their overall distress levels.

Our study suggests that there are important individual differences in the way people manage their health. NA and SI do not cover all personality dimensions relevant to health, but their combination (Type D personality) may help to identify those individuals who are at increased risk of suboptimal health behaviors and emotional distress. While health-care professionals may be aware of the consequences of NA, they may be less aware of the repercussions of its combination with SI. When health-care professionals may sense that something in the doctor–patient communication is not quite right, there is a brief screening tool available, the DS14, to measure NA and SI (Denollet, 2005). Although Type D personality has been shown to be a quite stable construct (Martens, Kupper, Pedersen, Aquarius, & Denollet, 2007), there are opportunities for interventions to reduce the negative symptoms and behaviors associated with Type D personality. For example, research has indicated that Type D personality is associated with maladaptive coping (Polman, Borkoles, & Nicholls, 2010). As such, coping interventions may help cancer survivors with Type D personality to better deal with problems. These interventions could in particular target the appraisal process through cognitive restructuring, development of emotion-focused coping skills to downregulate their emotional state while reducing maladaptive avoidance coping strategies. As health behaviors represent a potential mechanism to explain the negative effect of Type D personality on health outcomes, this represents a potential avenue for intervention as Type D individuals may benefit from intensive exposure to behavior change techniques (Williams, Abbott, & Kerr, 2015). In general, as a recent study showed that CRC survivors were significantly more likely to report lack of physical activity, fair/poor health, and other chronic health conditions compared with persons without a cancer diagnosis (Rohan, Townsend, Fairley, & Stewart, 2015), targeted interventions, such as self-management, to address these health issues should be considered for the whole CRC survivor group with poor health behaviors.

This study has some limitations that should be considered when interpreting the results. Although information was present regarding demographic and clinical characteristics of the respondents and nonrespondents, it remains unknown why nonrespondents declined to participate. Second, the cross-sectional design of this study limits the determination of causal associations between the study variables. The relationship between HRQoL and health behaviors can be bidirectional, since a healthy lifestyle can lead to a better physical and mental functioning; however, decreased HRQoL can also be a barrier to perform healthy behavior. Our finding that the effect of Type D personality diminished by adding health behaviors to the model is an indication that Type D personality and health behaviors partly share
the same mechanism or share the same confounder(s). Another limitation is the use of self-report questionnaires to assess health behaviors, which is susceptible to recall and social desirability bias. This may have led to an underestimation or over-estimation of healthy behaviors. In addition, our study sample is relatively healthy with respect to physical activity; potentially indicating survivorship bias as unhealthy lifestyles are related to mortality among CRC survivors. This means that the survivors who participated in this study may be more physically active because the inactive survivors died sooner after their diagnosis. It would be interesting for future research to confirm our results in other countries where people have a less active lifestyle and among younger or other cancer survivor populations. Furthermore, the DS14 is not validated among cancer patients; however, the Cronbach’s alphas were high in this study. Finally, we did not have information about dietary habits, drug consumption, and social environment, which are also important determinants of health for CRC survivors.

In conclusion, CRC survivors with high scores on NA (with or without SI) are at risk to be less physically active, have worse HRQoL, and higher levels of mental distress as compared to those scoring high on neither or only SI. Only a small part of the association between personality and HRQoL could be explained by maladaptive health behavior, therefore other mechanisms to explain this relation need to be explored. Individuals scoring high on NA might benefit from a more patient-tailored care approach, where health-care practitioners are sensitive to patients’ tendency to experience negative emotions and evaluate their illness and behavior negatively. Strategies for tailored long-term management and support for patients on the basis of a more individualized approach, as a function of stable differences in coping with chronic medical conditions, should be developed and evaluated.

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Olga Husson, Johan Denollet, Nicole Ezendam, and Floortje Mols conformed to the Helsinki Declaration concerning human rights and informed consent and followed correct procedures concerning treatment of humans and animals in research.

References


