CHAPTER 8

Summary
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Cancer and cancer-related treatments can seriously affect people’s physical health as well as their psychological functioning. Numerous studies have tested the effectiveness of psychological care in assisting people to adapt with cancer. By using an experimental randomized controlled trial design, most previous intervention studies mainly examined how people, as a group, changed in their adaptation to cancer. Therefore, little is known regarding how individuals may differ from each other in their responses to receiving psychological care. In order to fill in this gap, the current thesis applied a naturalistic intervention study in a large group of cancer patients receiving psychological care and aimed to identify subgroups of people with different patterns of adaptation to cancer while receiving psychological care.

Part 1. Outcomes of adaptation to cancer: negative and positive outcomes

In the first part of the thesis (Chapters 2, 3 & 4), we focused on both negative (i.e., symptoms of depression, anxiety, and fatigue) and positive outcomes (i.e., benefit finding) of adaptation to cancer. Regarding negative outcomes, we explored how symptoms of depression, anxiety, and fatigue are co-morbid in Chapter 2, and examined different subtypes of depressive symptoms in Chapter 3. Regarding positive outcomes, we focused on benefit finding and identified distinct growth trajectories of benefit finding in cancer patients over the period of psychological care in Chapter 4.

We started with the co-morbidity patterns of depressive, anxiety, and fatigue symptoms. In Chapter 2, we found three subgroups of patients with distinct co-morbidity patterns during the nine-month period of psychological care. One group of patients had elevated symptoms of depression, anxiety, and fatigue, thus was labelled as ‘mood disturbances and fatigue’. One other group reported elevated symptoms of depression and anxiety, and was labelled as ‘mood disturbances’. A last group of patients had low levels of symptoms of depression, anxiety, and fatigue. This class was labelled as ‘few symptoms’. Moreover, we examined whether and how individuals transitioned between the three distinct co-morbidity patterns during psychological care. For those patients with ‘few symptoms’ pattern at baseline, most of them were found to remain in the same pattern over time. For those patients with ‘mood disturbances and fatigue’ and those with ‘mood disturbances’, half of them remained in the same pattern, with the other half reporting improvements in their symptoms over time by transitioning into less severe pattern.

In Chapter 3, we focused on symptoms of depression and aimed to gain deeper insight into distinct subtypes of depressive symptoms in cancer patients. Before the start of
psychological care, we found three subtypes of depressive symptoms, differing in both types and severity of symptoms. The largest group of patients (Class 1: 47%) had a mild depression and mainly reported concentration problems, sleeping problems, and fatigue. The second largest group of cancer patients (Class 2: 41%) had a slightly higher level of depressive symptoms on average, and reported similar concentration and sleep problems and an additional depressed mood. The smallest group of patients (Class 3: 12%), with more severe depression, reported mainly a depressed mood and additional fatigue and concentration problems. We also found that the three subtypes of depressive symptoms before the start of psychological care did predict the longitudinal courses of depressive symptoms while receiving psychological care: people in Class 1 reported moderate improvements, people in Class 2 reported large improvements, and people in Class 3 reported the largest improvements in symptoms of depression over time.

After examining those negative outcomes reported by cancer patients, we turned to positive outcomes of adaptation to cancer (i.e., benefit finding) in Chapter 4. We found five subgroups of cancer patients with distinct trajectories of benefit finding while receiving psychological care. These five trajectories can be seen as five subgroups with three differential patterns: three subgroups showing small increases in benefit finding but started with very low, low, and moderate levels respectively (i.e., ‘very low level-small increase, 16%’, ‘low level-small increase, 39%’, and ‘moderate level-small increase, 29%’), one subgroup showing a stable level with high starting levels of benefit finding (i.e., ‘high level-stable, 8%’), and one subgroup showing large increases in benefit finding (i.e., ‘low level-large increase, 8%’). These findings indicated that only a small portion of cancer patients were able to report large-sized increases in benefit finding over time. Furthermore, this chapter also examined to what extent these trajectories were associated with changes in psychological symptoms (i.e., depressive and anxiety symptoms) over time. It was found that people with different benefit finding trajectories reported distinct courses of depressive symptoms, but not anxiety symptoms. Compared with people in the other trajectories, people with a ‘low level-large increase’ trajectory reported the largest improvements in psychological symptoms over the nine-month period of psychological care.

Part 2. Predictors of adaptation to cancer: personal resources promoting adaptation

The second part of the current thesis (Chapters 5 & 6) focused on two personal resources that might promote adaptation to cancer (i.e., personal control and goal adjustment). Specifically,
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we explored to what extent individuals may differ from each other on their changes in these personal resources while receiving psychological care. The associations of differential changes in personal resources with changes in symptoms of depression, anxiety, and/or fatigue were examined as well.

The main aim of Chapter 5 was to identify subgroups of cancer patients with distinct trajectories of personal control over the period of receiving psychological care. We found three subgroups of cancer patients with distinct trajectories of personal control. The largest group of cancer patients (50%) started out with relatively moderate levels of personal control, and first reported an improvement in control over the first three months of psychological care and then a reduction in personal control during the following six months. Thus, this group was labelled as ‘temporary improvement group’. Another large group of cancer patients (41%) started out with a high level of personal control, and reported a continued improvement in personal control over time. This group was therefore labelled as ‘enduring improvement group’. The last group contained only a small number of cancer patients (9%), and started with a low level of personal control. This group reported a decline in personal control over time and was labelled as ‘deterioration group’. Moreover, people with distinct personal control trajectories reported different levels of psychological symptoms, but did not differ in their courses of psychological symptoms. Patients with both enduring and temporary control improvements trajectories experienced significant improvements in depressive and anxiety symptoms over time. However, the small group of patients with a control deterioration trajectory maintained stably high levels of depressive and anxiety symptoms while receiving psychological care.

In Chapter 6, we focused on goal adjustment capacities (i.e., goal disengagement and goal reengagement capacities) reported by cancer patients. The main objective of this chapter was to examine whether patients receiving psychosocial care reported differential changes in goal adjustment capacities and how these changes were related to changes in symptoms of depression, anxiety, and fatigue. Specifically, changes in goal adjustment capacities were examined at a group level as well as at an individual level. At the group level, we found that cancer patients reported only small-sized increases in goal disengagement capacities but no significant change in goal reengagement capacities. At the individual level, cancer patients did report differential changes in goal disengagement and goal reengagement over time: around 30% of patients experienced an improvement in goal disengagement and/or goal reengagement capacities over time, around 50% of cancer patients remained stable in these
capacities, and around 20% of patients showed a decrease in goal disengagement and/or reengagement capacities. Moreover, increases in goal reengagement capacities were found to be significantly related with improvements in both depressive and anxiety symptoms, but not to fatigue. Findings of this chapter clearly confirmed that improvements in goal reengagement capacities were beneficial for cancer patients’ psychological functioning.

To conclude, the current thesis examined how individuals may differ from each other with regard to psychological adaptation to cancer over a period of receiving psychological care. Findings of this research clearly confirmed that people may report different patterns of adaptation to cancer in response to psychological care.