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Social Comparison Processes in Autobiographies of Adult Cancer Survivors

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Abstract

Cancer survivors often compare their situations to other survivors' situations. However, types of social comparison processes used and resulting outcomes are not clearly delineated. This study explores usage and consequences of three social comparison styles (downward, upward and parallel) of adult cancer survivors in free narratives, using content analysis of 30 autobiographical books by survivors ranging in age from 30-70 ($M = 54$, $SD = 10.04$); 43 percent prostate cancer, 17 percent breast cancer and 40 percent other cancers. Overall, cancer survivors used more parallel comparisons than directional comparisons, followed by upward comparisons. Each type of comparison was associated with different kinds of positive and negative consequences.

Keywords

- cancer
- free narratives
- social comparison

PSYCHOLOGICAL and psychosocial aspects of dealing with cancer are of critical importance in the quality of life of the estimated 10 million cancer survivors living today in the United States (American Cancer Society, 2006). Thus, front-line providers of care, including oncological doctors, nurses and counselors, can play a significant role in enabling those survivors to develop and use successful yet person-specific ways of coping, leading to maximum life quality. One area of interest is how cancer survivors rely on comparing themselves to others with cancer to obtain both an understanding of their situation and an index of their own emotional reactions. If guidelines for ways those processes may be used beneficially can be developed, then both health providers and cancer survivors can be better informed about patterns and potential benefits of making social comparisons.

Background on social comparisons

Beginning in the late 1950s and early 1960s, social scientists began examining the usage of social comparison processes by persons experiencing various health-related threats (Gerard, 1963; Hakmiller, 1966; Schachter, 1959). With respect to cancer, the ability for survivors to manage and weather the uncertainty and novelty of the experience depends partly on effective coping strategies, such as having the opportunity to seek out others who have gone through a similar experience. This is done for the purposes of self-evaluation, self-appraisal and information gathering. The usage of social comparisons has consistently been found to be a critical factor for the purposes of understanding and explaining how a person reacts to and copes with a diagnosis with cancer (Molleman, Pruyn, & van Knippenberg, 1986; Taylor, Buunk, & Aspinwall, 1990; VanderZee, Buunk, Sanderman, Botke, & van den Bergh, 2000; Wood, Taylor, & Lichtman, 1985). However, much of this research is marked with inconsistent findings and artificially derived research designs.

Social comparison theory, originally formulated by Leon Festinger (1954), was used to explain the human drive to evaluate and appraise one's abilities and opinions objectively. Festinger hypothesized that in the absence of objective standards of comparisons in the physical world,

people will make social comparisons with the opinions and abilities of others. Moreover, in the absence of either physical or social comparisons, a person's subjective evaluation of their opinions and abilities will be unstable (1954, p. 119), which could potentially result in emotional distress.

The pioneering work of Schachter (1959) on social deprivation provided the link between social comparison theory and stress and health. Schachter (1959) found that when people are confronted with a fear-inducing threat, such as the anticipation of an electric shock, they prefer to affiliate with or be in the company of similar people anticipating the similar event. Given the many unknowns and uncertainties associated with a diagnosis of cancer, comparing one's situation to similar others is a natural mechanism for self-evaluation and coping. In the absence of social affiliation, people are likely to make unstable emotional reactions (Gerard, 1963), which could potentially lead to hasty decisions with respect to treatment and follow-up care for cancer.

The role of comparison processes in health

Upward and downward comparisons

Previous research reveals that engaging in upward or downward social comparisons can be beneficial or potentially harmful to the individual doing the comparing. For instance, comparing oneself to others who are apparently worse off (downward social comparisons) can result in an individual feeling better about his or her illness. In this situation, the purpose of downward comparison serves to enhance one's ego and/or to maintain positive affect (Heckhausen, 1999; Wood et al., 1985). On the other hand, it is also possible that in the same situation people could find themselves in despair over the possible future outlook. For instance, an individual who walks into a doctor's office waiting room and sees another patient who is not faring well may wonder if he or she will soon look and feel like them. Similarly, upward comparisons to those who have survived cancer in what is seen as a highly positive way are generally thought of as serving the purpose of self-improvement or engendering hope and optimism (Heckhausen,

1999; Stanton, Danoff-Burg, Camerson, Snider, & Kirk, 1999). There are numerous examples of celebrities who have had cancer and are now doing well (such as Lance Armstrong, Rudolph Giuliani, Bob Dole and Betty Ford). Interpreting upward comparison from a positive point of view, as in the situation above, can offer a person a sense of hopefulness and a 'can do' attitude. However, engaging in upward comparisons, for some, may cause an individual to realize that he or she is not as well off as others and ultimately feel worse (Taylor et al., 1990). An example of a negative consequence of engaging in upward comparison would be the feeling of not being able to live up to the standards or accomplishments of someone else.

Parallel comparison

Both downward and upward comparisons involve thinking about oneself in relation to others who are similar on one central characteristic (a specific disease, in this example); they also require that the person be different on at least one characteristic (doing better or doing worse). However, cancer survivors, especially newly diagnosed, may also regularly engage in comparisons that are as close to themselves on *all* characteristics as possible, including both the disease itself and its severity and timing, as well as age, gender, type of treatment and so on. Although not researched as frequently as the above two comparison processes, research has found that older adults in general (Heckhausen, 1999) and cancer patients specifically also engage in such parallel (or lateral) comparisons. This appears to be for purposes of seeking information so that they can 'place' themselves in relation to their situation by using similar others as a guide (Heckhausen, 1999; Molleman et al., 1986).

This type of comparison, rather than upward or downward, is essentially what Festinger (1954) and Schachter (1959) featured in their original analyses. They contended that people tend to seek others who have experienced the same situation or stressor for informational purposes. In addition to seeking similar others for informational purposes, it is likely that this type of comparison could be engaged in for emotional reasons. For example, cancer patients may feel alone at times in dealing with the emotional aspects of their experience, and thus

would rather affiliate with someone who is in the same situation as they are at the respective point in time rather than someone who is worse or better off. Although parallel comparisons are less frequently studied than upward and downward, it seems evident their use can be an important aspect in dealing with the uncertainties associated with a serious health threat.

For instance, a study of 300 women who were about to undergo breast biopsy found that uncertainty accounted for a significant amount of variance in measures of emotional distress (Northhouse, Jeffs, Cracchiolo, & Lampman, 1995). Similarly, Christman (1990) found that greater uncertainty in cancer patients undergoing radiotherapy was associated with more psychosocial adjustment problems. Reducing uncertainty through comparing oneself to similar others appears to have adaptive benefits with respect to emotional and potentially physical health.

It is likely that all three processes may be engaged in over the course of a particular health threat, sometimes distinct from one another and other times simultaneously. Nevertheless, it is apparent that each of these processes offers potentially a positive or negative outcome depending on how one interprets the dimension being compared. Suls, Martin and Levental (1997) contend that the type of comparison one engages in begins with a level of uncertainty that motivates the individual toward relevant comparisons with relevant others. They further state that the type of comparison sought and the effect of the comparison vary depending on the attribute being evaluated.

The impetus for the present study

In reviewing the literature we point out three factors that serve as the motivation for conducting this inquiry. The first concerns method. Much of the research that has examined social comparison theory has employed research designs that could be considered artificially derived (e.g. Amabile & Glazebrook, 1982; Molleman et al., 1986; Stanton et al., 1999). For instance, a study conducted by Stanton et al. (1999) had breast cancer patients listen to one of three different versions of an audiotape. Each version represented a fellow patient with either

a 'good', 'poor' or 'unspecified' level of psychological adjustment and physical health status. Subjects then completed measures that assessed the following: affect, self-evaluation, desire for affiliation with, information and emotional support from the person they listened to on the tape. These forced types of answers may not reflect the way people respond in real-world settings (an aspect Stanton and her colleagues acknowledged).

Little is actually known about how people respond in a natural setting. Even one study that is presented as examining 'naturally occurring' social comparison processes (Heckhausen, 1999) is still quite reactive. In this paradigm, persons are briefed on the types of social comparisons. Then, whenever they feel they are making one, they are asked to fill out a questionnaire about that occurrence.

Our approach, on the other hand, allows for truly non-reactive self-generated social comparisons, for the descriptions of comparisons were made without a research frame, but rather as part of a need to 'tell one's story,' as everyone who has cancer does, whether in the formal way of writing a book or the more informal, and more typical, way of talking to friends, family, co-workers and others. In this sense, our approach is rooted in study of autobiographies of persons dealing with illness, what Hawkins (1993) calls 'pathographies' and Brody (1987) called 'stories of sickness'. These are a well-respected way to understand the psychological impacts of disease. In a variety of ways, persons dealing with disease such as cancer communicate their thoughts and feelings in an autobiographical form or narrative (Brody, 1987; Gergen & Gergen, 1988; Hawkins, 1993; Mishler, 1995). These are seen as therapeutic attempts to make sense of one's situation, to provide a coherent story of one's life into which the illness experience 'fits'. Some even write and publish full books on their experience. While this may also be therapeutic for them, these authors have clear goals beyond their own therapy: they feel the need to convey to others—newly diagnosed, their families, but also doctors and other health professionals—what it feels like to be a patient and a survivor (Brody, 1987; Hawkins, 1993; Kleinman, 1988).

These autobiographies are clearly biased, including self-presentational, dramatizing and

selective aspects (Hawkins, 1993). They share these characteristics with all autobiographies (Eakin, 1985; Mishler, 1995; Pascal, 1960). Thus, care must be taken in interpreting such data. However, they are likely to be much less self-conscious about the specific sort of issues addressed herein. While an author may want to present himself or herself as redeemed, or triumphant, strong or vulnerable, he or she is unlikely to be self-conscious about social comparisons to one or another kind of 'similar other'. Thus, this approach becomes complementary to more standardized, reactive modalities of understanding social comparison processes in cancer survivors.

Second, the above methodological approaches provide us with a post-hoc snapshot of social comparison processes, rather than providing information as to when cancer patients are naturalistically more or less likely to engage in the different social comparison styles over the course of their illness. Again, despite their limitations as edited presentations, many of the books are based on journals or diaries that come closer to a contemporaneous expression of making comparisons.

A third reason for conducting this study is the apparent disagreement in the literature as to the type of comparison processes cancer patients generally engage in. For instance, Molleman et al. (1986) examined 418 cancer patients who were being treated at an out-patient clinic. Their findings suggest that patients significantly preferred to interact with those who were similar or somewhat better as opposed to those fellow-patients who were worse off. This contradicts Wood et al.'s (1985) findings that, generally speaking, cancer survivors tend to engage in more downward comparisons than upward or parallel throughout the course of the disease. It is important to acknowledge that Molleman and colleagues examined cancer patients' social comparison processes while many patients were still in treatment. Also, the measure used to assess preference was somewhat artificial. Rather than assessing whom a cancer patient compares him or herself to in real-life situations, they were asked to indicate preference of comparison by checking off one of five categories (much worse off, slightly worse off, similarly off, slightly better off and much better off). It is possible that cancer patients may have

different social comparison needs at different points in their illness, as well as using a more nuanced set of factors on which to compare themselves to other survivors than simply 'I'm better off' or 'I am worse off'.

That being said, our goal in this review is not to be critical of past research; rather, we are acknowledging the difficulty in obtaining data in a real-world setting. Thus, the current study is an attempt to examine the usage of the three different social comparison processes discussed earlier in book-length descriptions of individuals' naturally occurring processing of their cancer experiences. Moreover, a second aim of this study is to explore the positive and negative consequences of engaging in the three types of comparisons.

The two research questions that are explored in the current study include: (a) overall, what types of social comparison processes do cancer survivors engage in; and (b) does engaging in upward, downward and parallel comparisons result in both positive and negative outcomes?

Methods

Participants

The sample in this study was obtained from an in-depth content analysis of 30 autobiographical books, primarily those written by individuals who had cancer. In a few cases, spouses of cancer survivors were co-authors. Books ranged in length from 57 to 471 pages. Each book was treated as the unit of analysis for the qualitative analyses. However, the quantitative analysis is based on the total number of comparisons across all of the books rather than each book. The mean age of the subjects, that is, authors, was 54 years ($SD = 10.05$), with a range from 30 to 70 years of age. Seventy percent of the subjects were male. Of the 30 subjects 43.3 percent had prostate cancer, 16.7 percent had breast cancer, 6.7 percent had lung cancer and 33.3 percent reported other classifications such as colon, ovarian, brain, testicular and bladder cancer. Forty percent of the total sample was treated with surgery, 13.3 percent were treated with chemotherapy, 43.3 percent were treated with a combination of two or three of the following: surgery, chemotherapy and radiation. One subject with prostate cancer was treated with seed implantation. Although time since

diagnosis was not readily apparent for all of the subjects, of the 19 who did report the year they were diagnosed, the average was 5.68 years, with a standard deviation of 3.73.

Autobiographical books were selected that were written based on journal notes and diary records of the person's cancer experience. These were a set of books listed on Amazon.com in 1999 and 2000. In order to be included in this study, the books had to represent a first-person account of an unfolding, free-narrative story of having cancer. The selection represents all the autobiographical prostate cancer books ($n = 16$) that Amazon.com listed during that year, and a sampling of other classifications of cancer, such as breast ($n = 5$), lung ($n = 2$) and colon ($n = 2$). Publication dates ranged from 1984–2000.

Procedure

The purpose in using autobiographical books was that it allowed us to get as close as possible to observing a person's experience as it unfolds without actually having to follow individuals longitudinally. Although some of the books may have been written months or years following their diagnosis, including only those books that were written based on journal or diary notes helps minimize recall bias. Of course, as already noted, other biases are built into the writing and publication process, and those could not be fully controlled. Still, this exploratory methodology is an attempt at providing researchers with an alternative to the forced response designs of the past (e.g. Amabile & Glazebrook, 1982; Molleman et al., 1986; Stanton et al., 1999).

Measures

The three directions of social comparisons were defined in a way similar to definitions used in previous research (e.g. Molleman et al., 1986; Wood et al., 1985). Upward comparison is defined as the tendency to compare one's situation to someone who appears to be doing better than oneself on the particular dimension being compared. These types of comparison are engaged in for the purposes of identification or evaluation. Downward comparison is defined as the tendency to compare oneself to others who are worse off than oneself on a particular dimension. This type of comparison allows individuals to see their situation as less severe or bleak compared to others. Parallel comparison

is defined as comparing oneself to someone who appears to be similar to the self-evaluator on a particular dimension. Engaging in parallel comparisons appears to serve the purpose of information seeking and reduction of uncertainty.

Each book was read and coded with a focus on the author's narrative account of situations in which he or she engaged in social comparisons. Each situation in which the authors engaged in any of the three types of comparisons were marked in the book using a highlighter, then transcribed verbatim into a Microsoft Word document. A total of 468 references to social comparison were noted. In addition, the page number of each comparison was noted so that we could refer back to it to determine the context in which the comparisons were made. These statements were then coded as upward, downward or parallel based on our operational definitions discussed earlier. The frequency with which each author engaged in the three different types of comparisons was summed and inputted into SPSS for quantitative descriptive analysis, while the transcribed statements were used for descriptive purposes.

In order to examine the positive and negative consequences of engaging in the three different comparison styles, the investigators sought examples of each by examining the transcribed word documents. This purpose was to confirm or disconfirm whether positive and negative consequences of engaging in social comparisons existed in a free narrative situation, as opposed to previous forced-response designs (Stanton et al., 1999; Taylor et al., 1990).

Due to the fact that there were three readers, first each reader read and coded the same book independently, and the extent of agreement was used to obtain inter-rater reliability of our constructs. The three readers combined displayed a reliability score of 85 percent (each

reader marked the same comparison in the book), and two of the three readers revealed a reliability of .95. After initial reliability checks the books were divided, read and coded by three different graduate research assistants. The two readers with the higher inter-rater reliability rating did the majority of the reading and coding.

Results

Overall findings with respect to the types of comparisons that cancer survivors engaged in throughout the course of the disease are presented in Table 1. Means and standard deviations presented in Table 1 represent the total number of comparisons engaged in across all books. Overall, we coded 147 situations that represented upward comparisons, 89 incidences that were reflective of downward comparisons and 232 parallel comparisons. As the table reflects, cancer survivors in this study used more parallel comparisons than upward and downward comparisons. Further, they engaged in more upward than downward comparisons.

To bring specificity to the comparisons and to examine further whether engaging in upward, downward and parallel comparisons results in both positive and negative outcomes, the next step was to identify selected illustrations of the types of comparisons and the way they were described within the broader context of positive or negative emotions.

Downward comparison

A man with prostate cancer, who was 2 to 3 weeks post-diagnosis and still trying to make a treatment decision, reflects the potential negative consequence of engaging in downward comparisons: 'As I sign in at the front desk, I notice that Mawn's room (his doctor's office) is not as crowded as usual—just two ghostly

Table 1. Overall means, standard deviation and frequency of reporting engaging in the three different social comparison processes

	<i>Mean</i>	<i>SD</i>	<i>Overall percentage</i>
Upward comparison (<i>N</i> = 147)	4.90	6.02	31
Downward comparison (<i>N</i> = 89)	2.97	3.08	19
Parallel comparison (<i>N</i> = 232)	7.73	8.25	50

couples staring dispiritedly into some inner space. Will we, I wonder, soon look like them?' (Gottlieb & Mawn, 1999, p. 67). A second example from a woman who is having a recurrence of breast cancer one year post-radiation represents the potential positive consequence of engaging in downward comparisons:

I think of the really young who have leukemia or Hodgkin's, who haven't had a chance to live as much as I have . . . You can always think of others worse off than you, and that makes me more aware of the positive sides of my life . . . (Wilber & Wilber, 1993, p. 122).

Upward comparison

There was a propensity for cancer survivors who engaged in upward comparisons prior to treatment to experience both a degree of uncertainty and distress and positive affect. The following illustration from a man with prostate cancer facing the possibility of incontinence after surgery is reflective of a pre-treatment decision and a negative consequence of engaging in upward comparison: 'Men wear a diaper . . . You see it always. Some people you take the catheter out, like Norman Schwarzkopf . . . he was dry from day one. But we are not all exactly like Schwarzkopf, I thought' (Fine & Fine, 1999, p. 48). The next quotation represents a positive consequence from a man with prostate cancer early in the course of the disease, also in the midst of making a treatment decision: 'He did know a famed comedian-actor-director who, he informed me, had been operated on for prostate cancer a short while back and was now perfectly okay' (Gottlieb & Mawn, 1999, p. 47).

Parallel comparison

The analyses with respect to parallel comparisons reveal that these cancer survivors/authors engaged in parallel comparisons at all stages of their cancer experience, ranging from pre-treatment to end of life. However, it was difficult to distinguish positive and negative consequences as we did for both upward and downward comparisons. In some ways, this is reminiscent of the ambiguity about treatment and sometimes 'us against them' (survivors against doctors and/or non-survivors who 'can't understand') that resulted in Hawkins (1993) categorizing some pathographies as angry or as

'advertisements' for alternatives to traditional therapies. The following quotation is illustrative of a breast cancer survivor shortly before surgery: 'I am not alone in this . . . I have talked with a lot of other cancer patients who feel exactly as I do: With doctors, the disease, not the patient, is too often the focal point' (Edge, 1995, p. 76).

A breast cancer survivor, post-chemotherapy, indicates:

Other breast cancer survivors had made remarks, leading me to believe that they had experienced similar reactions. 'Everything now gets blamed on my having cancer,' one survivor remarked at a recent support group meeting, referring to her current care by the same internist she had seen before cancer. Her statement was greeted by a chorus of recognition from the other survivors. (Doyle, 1996, p. 200)

Finally, a man with advanced prostate cancer shortly before death remarks, 'Reading Alsop (the columnist, Stewart Alsop), there are times when I hear a common voice. He reports attitudes and feelings, concepts, and ideas that I also have met along the way' (Sheehan, 1996, p. 151).

In each of these cases, the authors are noting the similarity of self to the other and using those parallel comparisons as means to gather information and to regulate one's own reactions (Heckhausen, 1999). The similarities to others reduce uncertainty and ratify one's own feelings, experiences and reactions.

Discussion

As a preface to our discussion, we must acknowledge some of the limitations of this study. First, this study is based on data gathered from reading and coding autobiographical books about people's experience with cancer. Because of this, we were not able to control for potential confounding variables, such as personality dispositions, stage of disease and other characteristics of the illness, or exactly when the comparisons were described. It is possible that a person who is high on dispositional hope and optimism (Snyder, 2000) may see things in a positive light, regardless of the type of comparison processes engaged in. It is also possible that the stage of the disease, which was not always evident by reading the books, could influence

both the type of comparisons engaged in, and the potential consequences of different types of comparisons. For instance, someone with advanced prostate cancer may likely not see much benefit in comparing himself with another prostate cancer survivor who is apparently doing fine because of the potential reality of not being able to live up to those standards or expectations. Again, these limitations apply to all narrative style or autobiographical data, and so the truth value of statements must be tempered by the critiques of those sorts of data (Eakin, 1985; Hawkins, 1993; Pascal, 1960).

Second, the sample size was relatively small due to the attention to detail that is required in reading each book. Thus, we were not able to generate sophisticated statistical analyses, such as gender comparisons, with an appropriate level of power. Also, books were selected in a careful fashion but, in fact, limited to those accessible on Amazon.com at a specific time, and selections were made within those biased toward those that could be ascertained to be primarily based on journal or diary approaches versus ones explicitly designed to promulgate one or another treatment.

Despite these limitations, this study has found both evidence that supports and some that contradicts previous research. For instance, the conclusion that this set of cancer survivors, overall, tend to use more parallel comparisons versus downward and upward comparisons contradicts previous research that has found under conditions of threat, people engage in more downward comparisons (Affleck, Tennen, Pfeiffer, Fifield, & Rowe, 1987; Wood et al., 1985). In fact, using the methodology that this study has employed, cancer patients report lower likelihood to engage in downward comparison compared to the other two processes. One particular explanation for this is that previous research that examined social comparison theory employed research designs that could be considered artificially derived, and many designs reflect simply a one-time post-hoc snapshot of the person. Further, the forced response survey format may not reflect the way people respond in real-world settings.

On the other hand, persons upon further reflection, as from writing a book, may rethink or downplay the extent of downward comparisons they may have engaged in. Although in a

sense this is a bias from the real-time processing, it is exactly this rethinking and reflective 'self talk' that cancer survivors and those who deal with them on an ongoing basis have presented to them. That is, as part of their ongoing coping everyone reworks and rethinks his or her situation and the ways he or she has dealt with it, and it is this ongoing narrative that defines the current situation and current relationships.

The specific consequences of engaging in parallel comparisons need to be further examined. While upward and downward comparisons can have both positive and negative consequences, the consequences of parallel comparisons are much harder to uncover. It is likely that engaging in parallel comparisons is done primarily for information seeking as opposed to making one feel better or worse.

Although the temporal nature of engaging in social comparisons was not a goal of this study, while examining the qualitative aspects of the study we found some interesting speculative findings. Consistent with previous work conducted by Molleman et al. (1986) and Taylor and Lobel (1989), this study found that where a person is in relation to the course of the disease may influence the type of comparison one engages in and its consequence. For instance, one may experience more negative consequences of engaging in downward comparison during the pre-treatment decision-making phase because of the uncertainty of one's present situation, as was the case with the prostate cancer survivor discussed earlier. However, in the post-treatment phase or in the event of a recurrence, many cancer survivors may find positive benefits from engaging in downward comparison for the purposes of self-enhancement. This was evident in the case of the woman with breast cancer discussed earlier. For instance, some may think 'I am not as bad off as others after all that I have been through'. These study results, in so far as analyses were possible, support Wood et al.'s (1985) findings that cancer survivors tend to engage in downward comparisons early on in the course of the disease.

This study offers a different kind of insight from previous research into the types of comparisons cancer survivors engage in over the course of their disease and at least begins to address how at different points in the course of

the disease, cancer survivors may have different social comparison needs. It may be that during the initial stage of the illness, positive upward comparisons may tend to be most important, due to the hopefulness of finding someone who has beaten this disease. Once the initial shock has subsided somewhat, it is likely that gathering information is of utmost importance to the survivor. Following the course of treatment, downward comparisons may come into play in order to make one feel as if he or she is doing as well, if not better than others who are in similar situations. Unfortunately, many of the books did not provide a precise enough timeline that they could be analyzed in this way. However, using a similar methodology with persons newly diagnosed with the disease and following them for some time may be very fruitful. Related to this, Tennen and Affleck (2002) have found a diary approach very illuminating in studying the experiences of fibromyalgia patients.

Both the broader findings and the potential temporal aspect are important for professionals who work with cancer survivors and family members of cancer survivors because it may be possible to provide survivors with opportunities for comparisons that are beneficial at specific points in time during the course of their disease. Interestingly, parallel comparisons are likely being used to answer a different need, and health care providers need to be cognizant of this less-noted form of comparison and provide opportunities for it in support groups and one-on-one support settings as well as to investigate further when this need is most relevant and beneficial in the course of the disease.

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