Chapter 2
Social comparison and patient information: What do cancer patients want?

Abstract
The present study focused on social comparison processes among cancer patients. The sample consisted of 60 (ex-) cancer patients who participated in a course ‘Coping with cancer’. This study examined several aspects of social comparison: the need for comparison, the preferred direction of comparison, and the influence of mode (information or contact seeking) and dimension (illness severity or coping) of social comparison, as well as the influence of indicators of low well-being. The results show that the need for comparison is particularly enhanced among those who evaluate their own health negatively. In addition, patients preferred to receive information about others who are better off, but also want contact with others who are better off. They are specifically interested in receiving information about others who are coping better. Practical implications are discussed.

‘It is very comforting to meet people who know from experience what it means to have cancer and to undergo treatments’ (Personal interview, Groningen, 1999). Statements like these are often made by cancer patients. Patients regularly refer to positive experiences with fellow patients. However, there are also patients who are less positive about confrontations with fellow patients. To what extent are cancer patients interested in the experiences of other patients and in meeting these patients? And if so, what kind of information and contact do they prefer? In the present study, these questions were addressed, using the social comparison theory as a theoretical basis.

A great deal of attention has been given to social comparison processes among people experiencing serious health problems in recent years (e.g., Affleck & Tennen, 1991; Buunk & Gibbons, 1997; Taylor, Buunk, Collins & Reed, 1992; Tennen, McKee & Affleck, 2000). This interest can be traced back to Festinger’s work on social comparison (Festinger, 1950; 1954). He theorized that people’s opinions, attitudes, and beliefs ‘must have some basis upon which they rest for validity’ (Festinger, 1950, p. 272). When no objective information is available, people will try to evaluate their abilities and opinions by comparing themselves with others (Festinger, 1954). He further argued that individuals will prefer information about others who are relatively similar, as these others will provide the most relevant

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information (Festinger, 1954). Most cancer patients are confronted with a shortage of objective information and have a high need for clarification. Van den Borne and Pruyn (1985) specified the experience of lack of information as one of the major psychological problems among cancer patients. Patients are left with many questions, often without clear answers available (for example, ‘How will the disease progress?’, and ‘How do I tell my family?’). Because of this lack of objective information, it is assumed that cancer patients have a high need for social comparison, that is, they feel a need to compare their illnesses, treatments, feelings, and their coping strategies with other patients. A study among cancer patients did indeed reveal such a relationship between uncertainty about one’s illness and treatment and the need for social comparison (Van den Borne and Pruyn, 1985). In addition to uncertainty, other negative cognitive and emotional states may also promote the need for comparison. For example, a study by Buunk (1995) indicated that anxiety, lack of control, and frustration are associated with a need for social comparison information (i.e., information about how similar others are doing, feeling, and coping). In addition, there is some evidence that people experiencing depressive symptoms are more interested in and more open to social comparison information (Ahrens & Alloy, 1997). In the present study, it was examined whether the need for social comparison is related to uncertainty, lack of control, anxiety, depressive symptoms, and a low subjective evaluation of one’s own health.

What kind of social comparison information do people faced with a health threat prefer? Do they want to compare themselves with others who are worse off (downward comparison) or with others who are better off (upward comparison)? Research findings on this issue seem to contradict each other. For example, several studies suggest that people who are confronted with a serious illness compare themselves with others who are doing worse (Affleck & Tennen, 1991; Bogart & Helgeson, 2000), which does not necessarily imply that they want to meet them. Quite in contrast, some studies have found that people actually avoid contact with others who are worse off (Molleman, Pruyn & Van Knippenberg, 1986). With respect to upward comparison, similarly divergent findings exist; a study among cancer patients, for example, indicated that they selected and spent more time reading interview fragments containing information about others who were better off than about others who were worse off (Van der Zee, et al., 1996). However, other studies indicate that patients actively avoid making upward social comparisons (Wood, 1989).

Taylor and Lobel (1989) have tried to integrate these seemingly contradictory findings into one model, describing social comparison processes among people faced with serious health threats. In this model, they distinguish between different modes of social comparison: on the one hand, seeking information and seeking contact with others, and on the other hand, making relative evaluations
(i.e., evaluations of the self in comparison to others). According to Taylor and Lobel (1989), these modes of comparison occur in different directions. People in stressful situations prefer to seek information about or seek contact with others who are doing better. By doing so, they may learn how to improve their own situation, and, at the same time, they may obtain hope and motivation. On the other hand, people prefer to evaluate their situation in comparison to others who are doing worse in order to feel better about their own situation. The mode of comparison is thus considered as the major determinant of the direction of social comparison: people seek information about and contact with others who are doing better, while evaluations are made in comparison to others who are doing worse (Taylor & Lobel, 1989).

In their model, Taylor and Lobel (1989) consider seeking information and seeking contact as the same mode of comparison. However, Buunk (1995) challenged this notion in a study among individuals receiving payment under the Disablement Insurance Act. Buunk's study showed that, although seeking information and seeking contact are both directed upward (i.e., to others doing better), seeking of information is directed significantly more upward than seeking of contact (affiliation). People with low well-being apparently want information about others who are better off than they are, but are more reluctant to actually meet these upward comparison others. It is assumed that having actual contact with someone who is doing better may be more threatening to one's self-image than obtaining information about those upward others (Brickman & Bulman, 1977). This suggests that seeking information and seeking contact are indeed two distinct processes.

In the present study, the comparison preferences of cancer patients were examined. In particular, it was examined whether cancer patients prefer to seek out upward or downward comparison, and which factors influence these preferences. First, it was assumed that the mode of comparison influences directional preferences. In line with Buunk (1995), two different modes of social comparison were examined, namely seeking comparison contact and seeking comparison information. It was expected that people would prefer upward comparison when seeking comparison information and contact, but that this preference for upward comparison would be greater when seeking information than when seeking actual contact.

Second, it was assumed that the dimension on which the comparison takes place influences the preferences for upward or downward comparison. Complying with Wood and Taylor's (1991) plea for more attention to the dimension of comparison, a distinction was made between two dimensions on which social comparison can take place. The first dimension, coping, refers to the way in which other cancer patients cope with their illness and related issues; the second dimension, illness severity, refers to the physical well-being of other cancer patients. A major
distinction between these dimensions is the level of perceived controllability. Cancer patients may feel they have more control over their coping strategies than over the course and severity of their illness. In addition, it is assumed that upward comparison is motivated by a need to improve oneself (Taylor & Lobel, 1989). If this is indeed the case, people will mostly be interested in comparing themselves with upward others on a dimension over which they feel they have control, in this case, the way they cope with their disease. This will be less so on the illness severity dimension, as there is little to learn from information on this dimension which can help one improve one’s own situation. From research among rheumatoid arthritis patients, there is indeed some evidence that patients prefer downward social comparison information on the illness severity dimension, while they prefer upward social comparison information on the coping dimension (De Vellis, et al., 1991). It was, therefore, expected that when patients are seeking information or contact, they would prefer more upward comparisons on the coping dimension than on the illness severity dimension.

Third, it was assumed that a number of psychosocial factors influence the directional preferences. For people whose future is still uncertain, feelings of control seem to be a major factor (Buunk, Collins, Taylor, Van Yperen & Dakof, 1990; Jensen & Karoly, 1992; Major, Testa & Blylisma, 1991). People with low perceived control may consider upward comparison as a reminder of the fact that they will never reach that level. However, when people do feel that they have control over their situation, they display an interest in upward comparison (Testa & Major, 1990). It was, therefore, expected that the more people feel they have control, the more they will be interested in upward information and contact (i.e., information about and contact with others doing better). In addition, because the present study was conducted among cancer patients, the roles of several other relevant indicators of low well-being were examined, namely uncertainty, anxiety, depression, and subjective evaluation of one’s own health.

**Specification of research issues**

Several research questions were formulated in the present study. The first was whether the need for social comparison was influenced by several indicators of low well-being. The second was whether cancer patients prefer upward or downward social comparison information and contact. Furthermore, it was examined whether these directional preferences were influenced by the dimension of comparison (illness severity or coping). The last question was whether directional preferences were influenced by a number of indicators of low well-being.
Method
Sample and procedure
All respondents were (ex-) cancer patients who participated in a course called ‘Coping with cancer’, which was organized by the Comprehensive Cancer Center North-Netherlands. The main aim of this course was to introduce various coping techniques to the patients and to give them the opportunity to exchange their experiences and ideas with fellow cancer patients. The patients participated in courses that were given in several cities in the northern part of the Netherlands.

A total of 62 patients from ten different groups were approached for this study, and all of them agreed to participate. However, two patients could not continue their participation due to deteriorating health. Therefore, a total of 60 participants filled out the questionnaires. The sample consisted mostly of women (75%). The age of the participants varied from 30 to 82 years ($M = 51$). About 30% of the participants had primary education or lower professional training, 52% had high school education or middle professional training, and 17% had a higher education or higher professional training. Most of the participants were married (78%), 7% lived alone, 3% lived with a partner, 5% was divorced, and 7% was widowed.

The participants had been treated for a wide variety of forms of cancer. However, the most prevalent forms of cancer were breast cancer (42%), lung cancer (14%), and intestinal cancer (12%). Diagnosis was made, on average, 2.4 years before participation to the study, most patients were, therefore, no longer undergoing treatment. Half of the patients reported that their prognosis was good; for others, it was unsure (43%) or bad (7%).

Measures
Before participating in the course, the participants were asked to fill out a questionnaire, which consisted mainly of questions about several social comparison processes and several indicators of low well-being. After participating in the course, another questionnaire was filled out, with questions about the social comparison processes within the group.

Social comparison variables
Need for social comparison was measured using a self-constructed scale, consisting of four items. For examples, ‘How often do you want to find out more about how other cancer patients experience problems with their disease?’ and ‘How often do you want to find out how you are doing in comparison to other patients with the same disease?’ Answers were given on a 5-point scale from 1 = never to 5 = often. Cronbach’s alpha = .85.
Direction of preference of comparison information was measured on two dimensions; on the coping dimension (If you could choose, would you prefer
to know more about other cancer patients who are coping better (worse) with their disease than you are?), and on the illness severity dimension (If you could choose, would you prefer to know more about other cancer patients who are better (worse) off than you?). Both questions were answered on a 5-point scale from 1 = much worse to 5 = much better. Direction of preference of comparison contact was also measured on the coping dimension (Did you prefer to be in contact with other patients from the group who were coping better (worse) with their disease than you are?) and on the illness severity dimension (Did you prefer to be in contact with other patients from the group who were better (worse) off than you?). Both questions were answered on a 5-point scale from 1 = much worse to 5 = much better. These preferences were measured after participation in the course, so that patients could indicate with which group members (upward or downward) they preferred to have contact. This questionnaire was returned by 37 respondents.

**Indicators of low well-being**

*Uncertainty* was measured using a scale consisting of six items. For example, ‘I feel that I don’t know enough about my disease and it’s treatment’ and ‘I am uncertain about what to think of my illness and the effects of the treatment’. This scale is based on a scale developed by Van den Borne and Pruyn (1985) to measure the information needs among cancer patients and a scale developed by Buunk (1994) to measure internal feelings of uncertainty. The scale has previously been used in other studies examining uncertainty among cancer patients with satisfactory reliability (e.g., Van der Zee, Buunk, Sanderman, Botke & Van den Berg, 1999). Answers were given on a 5-point scale from 1 = not at all applicable to 5 = very much applicable. Cronbach’s alpha = .76.

The amount of *anxiety* experienced by the patients was measured using the State-Trait Anxiety Inventory (STAI; Ploeg, Defares & Spielberger, 1981), of which only the ‘state’-part was issued to the patients. An example is ‘I worry about things that might happen’. Answers were given on a 4-point scale from 1 = not at all to 4 = very much. Cronbach’s alpha = .97.

*Depressive symptoms* were measured using the Center for Epidemiology Studies Depression Scales (CES-D; Bouma, Ranchor, Sanderman & Van Sonderen, 1995). The CES-D is a 20-item instrument developed to measure current levels of depression. An example is ‘During the past week, I thought my life was a failure’. Answers were given on a 4-point scale from 0 = rarely or never to 3 = often or always. Cronbach’s alpha = .90.

*Control* was measured using a self-constructed scale, consisting of six items. For example, ‘I have control over the way my disease influences my daily activities’. Answers were given on a 5-point scale from 1 = not at all to 5 = very much. Cronbach’s alpha = .60.
**Subjective evaluation of health** was measured using a subscale from the RAND-36, consisting of five items (Van der Zee & Sanderman, 1993). For example ‘I expect my health to deteriorate’. Answers could be given on a 5-point scale from 1 = completely true to 5 = completely untrue. Some items were recoded so that a higher score on the scale indicated a lower evaluation of health. Cronbach’s alpha = .75.

**Results**

**Demographics**

First, it was examined whether demographic variables showed any relationship with the other variables. These analyses included gender, age, marital status, education, religion, work status, form of cancer, prognosis, and the presence of metastases. Correlations were calculated between these variables, the indicators for low well-being and the social comparison variables. None of these correlations were significant (p’s > .05). Because of this, the demographic variables were omitted from further analyses.

**Need for social comparison**

The results show that the need for social comparison was reasonably high (M = 3.47). Which indicators of low well-being were related to this need to know more about comparison others (in this case other cancer patients)? Table 1 shows that the need to compare oneself with other cancer patients was strongly related to several indicators of low well-being. The more uncertainty, anxiety, and depressive symptoms the patients experienced, the more they wanted to know about comparison others. In addition, a strong relation between subjective health evaluation and the need for social comparison information was found: people who evaluated their health negatively reported a higher need for social comparison information. No significant relationship was found between feelings of control and the need for social comparison information.

Because the different indicators of low well-being correlated with each other, a stepwise regression analysis was performed to examine which indicator of well-being fostered the most need for social comparison. Table 2 shows that the patients’ subjective evaluation of their own health was the best predictor of the need for social comparison information. After that, depressive symptoms were the best predictor. When these two variables were entered into the analysis, none of the other low well-being indicators added a significant amount of variance.

**Seeking contact and seeking information**

It was expected that people in stressful situations would show a preference for upward social comparison information and contact. The results show that there
was indeed a preference for seeking information and seeking contact with equal or upward others (see Table 3). Were these directional preferences for comparison influenced by the mode of comparison and the comparison dimension? Seeking contact and seeking information were both measured on the coping and illness severity dimension. The two comparison modes did not correlate significantly with each other, neither on the coping dimension, nor on the illness severity dimension ($r = -.14$, ns and $r = .24$, ns, respectively) and could, therefore, be considered as two separate processes.

To examine the effects of mode and dimension of comparison on the preference for comparison direction, a MANOVA Within Subjects analysis was performed. This analysis revealed a significant main effect of mode of comparison, $F(1,30) = 7.09, p < .05$, as well as a significant main effect of comparison dimension, $F(1,30)$

<table>
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<tr>
<th>Table 1</th>
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<tr>
<td>Correlations between the indicators of low well-being and the need for social comparison</td>
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<table>
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<tr>
<th>Well-being indicators</th>
<th>Need for social comparison</th>
<th>Control</th>
<th>Depression of health</th>
<th>Anxiety</th>
</tr>
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<tbody>
<tr>
<td>Uncertainty</td>
<td>.34**</td>
<td>-.42***</td>
<td>.41***</td>
<td>-.43***</td>
</tr>
<tr>
<td>Control</td>
<td>-.12</td>
<td>-.48***</td>
<td>.32**</td>
<td>-.31</td>
</tr>
<tr>
<td>Depression</td>
<td>.39**</td>
<td>-.37**</td>
<td>.58***</td>
<td></td>
</tr>
<tr>
<td>Evaluation of health</td>
<td>-.45**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>.14*</td>
<td></td>
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*** $p < .001$, ** $p < .01$, * $p < .05$

<table>
<thead>
<tr>
<th>Table 2</th>
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<td>Summary of regression analysis of the indicators of low well-being, predicting the need for social comparison</td>
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<tr>
<th>Well-being indicators</th>
<th>$\beta$</th>
<th>$\mathbf{T}$</th>
<th>$p&lt;$</th>
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<tbody>
<tr>
<td>Evaluation of health</td>
<td>-.34</td>
<td>-.275</td>
<td>.01</td>
</tr>
<tr>
<td>Depression</td>
<td>.31</td>
<td>2.53</td>
<td>.05</td>
</tr>
<tr>
<td>Uncertainty</td>
<td>.12</td>
<td>.84</td>
<td>ns</td>
</tr>
<tr>
<td>Control</td>
<td>.13</td>
<td>.97</td>
<td>ns</td>
</tr>
<tr>
<td>Anxiety</td>
<td>.06</td>
<td>.40</td>
<td>ns</td>
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Thus, both mode of comparison and dimension of comparison influenced directional preferences in social comparison. As can be seen in Figure 1, the preference for social comparison information was more upward than for seeking contact. In other words, patients preferred to compare themselves with more upward others when it involved information than when it involved actual contact. Furthermore, patients preferred more upward comparison on the coping dimension than on the illness severity dimension. They were more interested in comparing themselves with others who were coping better than those who were better off physically. In fact, they actually preferred seeking contact with others who were slightly worse off physically. In addition to these two main effects, a significant interaction effect was found, $F(1, 30) = 4.26, p < .05$. This finding indicates a more upward preference for information than for contact, especially when it concerned comparison on the coping dimension. Patients were especially interested in fellow patients who were coping better than they were.

Next, it was examined whether the indicators for low well-being influenced these directional preferences. It was found that uncertainty and control influenced directional preferences. The more uncertainty the patients experienced, the more they preferred upward social comparison information on the coping dimension ($r = .29, p < .05$). In other words, with increasing levels of uncertainty, the desire for information about fellow patients who were coping better also increased. Feelings of control seemed to influence the preference for social comparison contact only marginally. The more the patients felt that they had control over their situation, the more they preferred to have contact with others who were coping better than they were ($r = .27, p < .10$). Apparently, when the patients felt

**Table 3**

Percentages of patients who want information about or contact with fellow patients, measured on two dimensions: coping and illness severity

| Level of fellow patients | Information | | | Contact | | |
|--------------------------|-------------|-------------------|-------------|-------------------|
|                          | Coping | Illness severity | Coping | Illness severity |
| Much worse               | - | 3 | 3 | 7 |
| Slightly worse           | 3 | 14 | 7 | 16 |
| Equal                    | 38 | 69 | 71 | 65 |
| Slightly better          | 33 | 3 | 13 | 10 |
| Much better              | 26 | 10 | 7 | 3 |

$= 13.89, p < .001$. Thus, both mode of comparison and dimension of comparison
that they had control over their own situation, they wanted to know how they could exert that control.

**Discussion**

In present study, social comparison processes among cancer patients were explored. It was found that the respondents had a relatively high need for social comparison. This need for social comparison was strongly influenced by a number of indicators of low well-being. The predictions were, therefore, largely confirmed: four out of the five indicators of low well-being related significantly to the need for social comparison information. The more patients evaluated their own health negatively, and the higher the level of depressive symptoms, anxiety, and uncertainty, the greater the need for social comparison. However, no relationship was found between feelings of control and the need for social comparison. In contrast to the findings of Buunk (1995), subjective health evaluation, and not uncertainty, was the best predictor. One possible reason for this may be the fact that all participants had been confronted with a life threatening disease, and that health and illness had, therefore, become highly salient for them. Apparently, the way cancer patients evaluate their health is very important and may influence the way they feel about almost every other aspect of their lives, including their need for social comparison.

Furthermore, the factors which influenced the preferences for upward or downward comparison were examined. As expected, the mode of comparison influenced directional preferences. The respondents preferred upward social comparison information and social comparison contact, but this preference was more upward for comparison information. These results are in line with the

**Figure 1**

**Preferred direction of seeking contact and seeking information**

![Bar chart showing preferred direction of seeking contact and seeking information.](chart)

- **Others better off**
  - 4.0
  - 3.8
  - 3.6
  - 3.4
  - 3.2
  - 3.0
  - 2.8
  - 2.6

- **Equal others**
  - Contact
  - Information

- **Coping**
  - Illness severity
assumption that actually meeting the comparison others, however informative, can be very threatening, especially to the self-image (Brickman & Bulman, 1977). One is not only confronted with the fact that another person is doing better, but the other person is also a witness to the fact that one is doing worse. The dimension of comparison also influenced directional preferences. It was found that patients preferred more upward social comparison information on the coping dimension than on the illness severity dimension. Patients who are coping better are, indeed, the best source of information in order to learn how to improve one’s own situation. However, this applied particularly to seeking information; patients were more reluctant to actually meet fellow patients who were doing better. It is possible that seeking information and seeking contact are not only different mechanisms, but also have different underlying motivations. With the present design, however, this was impossible to examine. Future research should provide more clarity on this issue. Finally, several indicators of low well-being influenced directional preferences. It was found that the more uncertainty patients felt, the more they preferred to receive information about others who were coping better. These results confirm the notion that upward comparison is mainly used for self-improvement purposes (problem focused coping). It was also found that feelings of control influenced the preferences for comparison others. The more patients felt they had control over their situation, the more they wanted to have contact with others who were coping better than they were. As expected, it seemed that when patients felt that they had control over their own situation, they wanted to learn from others how to best use that control to their advantage. In these circumstances, meeting patients who are coping better can be very informative, although it can also be very threatening. It is, therefore, important to note that especially patients with relatively high levels of control are interested in meeting these superior others. If they feel they have control, this situation apparently poses less of a threat.

Taken together, the results of this study provide insight in the social comparison needs preferences among cancer patients. However, the results should be viewed with some caution. For one thing, the conclusions are based on correlational analysis. Strictly speaking, no causal relationships can be deducted from these analyses. This does not mean that these data do not provide relevant information about the social comparison processes of cancer patients. On the contrary, the results should be used as a basis for further study of these processes. Future studies should be designed so that causal relationships between several stress indicators and the need for social comparison can be examined. Another possible problem could be generalizability. The sample consisted of a very specific group of cancer patients, who were participating in a course which they knew would entail contact with other cancer patients. Furthermore, most patients were no longer undergoing treatment. As such, these patients constituted a highly specific group
of cancer patients. Therefore, the conclusions can not be generalized to the whole population of cancer patients. That does not mean, however, that the present study can not provide important insights into how cancer patients may use social comparison processes in coping with their illness. Furthermore, directional preferences for comparison contact were measured after participation in the course. This may have influenced the answers given by the participants and may have made these answers less comparable to the answers regarding preferences for comparison information, which were measured before the course. However, these answers do provide us with insight into the preferences of cancer patients based on their experiences of contact with very concrete examples of comparison others (i.e., group members).

**Practical implications**

What may be the practical implications of these results? A very obvious application lies in patient information and education. Patients very much need (and want) information about their diseases (Bilodeau & Degner, 1996; Galloway, *et al.*, 1997; Harrison, Galloway, Graydon, Palmer-Wickham, & Rich-Van der Bij, 1999), especially in the case of such a life-threatening disease as cancer. In addition to the information that is currently provided to patients, it would certainly be worthwhile to include social comparison information in patient information. It is apparent that patients have a need for this type of information. Patients want to know more about fellow patients; how they experience their diseases, how they are doing, and, most importantly, how they are coping with their illnesses and treatments. The present study also provides indications of how to design this type of information. For one thing, it seems most helpful to include upward social comparison information about how other patients are coping. Patients can use this information to improve their own situations. Not only do patients prefer this kind of information, but research shows that comparison with others who are coping well in spite of severe problems is helpful, and generates positive affect (Gibbons & Gerrard, 1991; Ybema & Buunk, 1995). It is very important to note that the aim of including comparison information is not to tell the patients how they *should* cope with their diseases, but to provide concrete examples of how they *could* cope. No one way of coping is the best way for all patients. On the basis of social comparison information and contact, people can get a better idea of how other patients are coping and how they might use this to cope better with their own diseases. However, little is known about the reactions to social comparison information on different dimensions. Experimental research should provide patients with social comparison information on different dimensions to examine their different effects.

Given the fact that patients indicate a relatively high need for social comparison information and contact, it is also recommended that doctors provide patients
with information about support groups for patients. Such groups provide a unique opportunity for patients to compare themselves with fellow patients. Although the benefits of such support groups have been widely acknowledged (Fobair, 1997; Gray, Fitch, Davis & Phillips, 1997; Posluzny, Hyman & Baum, 1998), studies have also found that many patients are unaware of the existence of support groups for patients (Eakin & Strycker, 2001). Physicians should, therefore, point out the possibility of participating in a support group to their patients.

To summarize, the present study may constitute a step forward in the understanding of social comparison processes among cancer patients. In general, it confirms the refinements Buunk (1995) made to Taylor and Lobel’s model (1989). However, given the complexity of the social comparison theory, it is not surprising that still a lot is to be learned about social comparison processes among cancer patients. Are there individual differences in preference for comparison dimension? Are information seeking and contact seeking based on different motivations? In addition to answering these theoretical questions, it is important to focus on more practical questions. Is patient information that includes social comparison information indeed more suited to the needs of patients? Intervention studies should be carried out to examine whether patient information incorporating social comparison information is, indeed, beneficial to the patients’ well-being.