

Attitudes Toward Parents of Children with Cancer

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By

Faith Shafer

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Thesis Approval  
Department of Psychology  
Washburn University  
Topeka, Kansas

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I hereby recommend that the thesis prepared under my supervision by

FAITH SHAFER

Entitled

ATTITUDES TOWARD PARENTS OF CHILDREN WITH CANCER

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Tucker Jones, Ph. D  
Chair of the Thesis Committee

---

John Fritch, Ph. D  
Provost and Vice President for Academic Affairs

---

Cynthia L. Turk, Ph. D  
Head of the Department

Recommendation Concurred by

---

Dave Provorse, Ph. D

Committee for the Thesis

---

Julie Boydston, Ph. D

### **Abstract**

Although there is evidence involving how parents perceive their own parenting styles (e.g., Van Leeuwen & Vermulst, 2004), there is relatively little research on how others may evaluate various parenting behaviors. One of the goals of the current study was to assess if there are any differences in how various parenting behaviors (i.e., authoritarian vs. permissive) are perceived by others, and if these perceptions are influenced by the child's health status (i.e., child has cancer vs. healthy). Participants were randomly assigned to one of four possible conditions in which they were asked to read vignettes about either an authoritarian or permissive parent of a child who either has cancer or is healthy. Participants then rated their perceptions of the parent featured in the vignette using a 12-item person perception scale that assessed how warm (e.g., "This parent is kind.") or competent (e.g., "This parent is effective.") they perceived the parent to be. Results showed parents of children with cancer tend to be perceived favorably more favorably than parents of healthy children, which could alleviate some sources of potential stress for parents who are focused on the health and well-being of their children.

### **Attitudes Toward Parents of Children with Cancer**

Everyone has an opinion on parenting. We see it on the news, social media, and even in our social circles. With so many views on how people should parent their children, it is only fair to assume that parents experience considerable pressure when considering how they want to parent their children. Although there is considerable evidence involving how parents perceive their own parenting styles (e.g., Van Leeuwen & Vermulst, 2004; Robinson et al., 2001), there is relatively little research on how third-party observers may evaluate various parenting behaviors. Even more so, there is very little research on how third-party observers evaluate parenting styles when considerable stressors are affecting the family unit (e.g., a child's health concerns). Cancer has become prevalent within the United States. The Centers for Disease Control and Prevention (2023) reported that the United States had 1,603,844 new cancer cases in 2020 alone. In other words, for every 100,000 people, 403 were diagnosed with cancer and 144 died due to the illness. More specifically about 15,000 children and adolescents younger than 20 are diagnosed each year within the country.

### **Parenting Stressors**

Although stressors can come from various areas of our lives, research has shown many of the parenting stressors experienced tend to come from four distinct categories: cultural expectations and guilt, financial stressors, time pressures, and family stressors (Sidebotham, 2001). Cultural expectations and guilt may be a parent feeling like they do not parent correctly or fail to meet parenting expectations according to norms of a specific group. Financial stressors for a parent might include being unable to fulfill the need to buy their children clothes and toys or being unable to do family activities that exceed their budget (Sidebotham, 2001). Time stressors for parents are likely to include finding the time to finish domestic chores, fulfill work

obligations, and attend their children's extra-curricular activities (e.g., sports or school events). The fourth category of parent stressors includes family stressors. Such stressors range from parents' concerns regarding their children's behavior, safety, and health. Indeed, parents are especially likely to experience considerable stressors if their child experiences serious health concerns.

Previous research has examined children's health concerns, and how children's illnesses are likely to affect the parent-child dynamic. For example, Pinquart (2013) found that children with epilepsy tend to have weaker relationships with their parents compared to the relationships between parents and healthy children. This finding was also consistent for children with other illnesses such as cancer, cleft lip/palate, cerebral palsy, and visual impairments. However, Pinquart (2013) found that no illness significantly affected the parent's demandingness (i.e. putting own needs and desires ahead of those around them). Pinquart (2013) also reported that the parent-child relationship quality is especially influenced if the child's illness was present for over three years. The apparent decline in the relationships between parents and their chronically ill children may best be explained by the Family Stress Model.

The Family Stress Model suggests that external stressors (e.g., economic stressors and poverty) are not only likely to affect parents but can also cause relational problems between the parent and child (Masarik & Conger, 2017). The model starts with the family experiencing a specific hardship (e.g., losing a job, or in the case of the current study, a child being diagnosed with cancer), which leads to specific stressors (i.e., not being able to pay bills). Such stressors then lead to parental psychological distress which, in turn, leads to interparental stress and marital stress. This stress can then lead to disruption in parenting as the child starts to receive unsupportive or insensitive parenting, less time or lessened quality of time spent with their

parents, or punitive or over-controlling behaviors from the parent toward the child (Masarik & Conger, 2017). Finally, the child may also be monitored less frequently, and parents may display more harsh disciplinary actions as psychological and financial resources shrink. These parenting behaviors have been shown to lead to drinking problems as children enter adolescence, conduct disorders, and poor health outcomes (Masarik & Conger, 2017). Given that childhood cancer is often a long and expensive illness to endure and treat, it is plausible that many families of children with cancer may experience stressors and interpersonal conflicts resulting from these behaviors.

### **Evaluation of Parents**

Although there are many ways to evaluate various parenting styles, the current study will be looking at the parenting styles developed by Baumrind (1971) which include authoritarian, authoritative, and permissive parenting styles. Authoritarian parenting is often seen as low warmth toward their child with high control over their child. These parents may often be seen as trying to shape and control their children into specific standards that the parent holds (Kuppens & Ceulemans, 2019). Research has shown that children who are parented by authoritarian parents often have low social skills, low self-esteem, and higher levels of depression (Hoskins, 2014).

Permissive parents are often described as having high warmth and low control toward their children (Kuppens & Ceulemans, 2019). However, Baumrind (1971) described these parents as granting their children more autonomy than authoritarian parents. More specifically, these parents allow autonomy to the other extreme authoritarian parents which leads to different negative outcomes. Children who are parented by permissive parenting often have higher levels

of substance use, school conduct issues, and are less engaged and negatively oriented to school compared to children of other parenting styles (Hoskins, 2014).

Authoritative parents are often the hybrid between authoritarian and permissive parenting styles. These parents are high in warmth and control. Children who are parented with an authoritative parenting style often have more favorable outcomes than those children who are parented with an authoritarian or permissive parenting style. These differences include being more agreeable, achieving better grades in a school setting, lower alcohol use during college, and better adjustment to changing situations (Weiss & Schwarz, 1996). Due to the expansive research on these three parenting styles, the current study used these conceptualizations of parenting styles when designing the critical stimuli reported later in this document.

Most studies that evaluate parenting styles and behaviors tend to only consider the child's opinion/observation of their parent's parenting style (e.g., Buri, 1991), the parent evaluating their own parenting style (e.g., McEachern, 2011), or a mixture of the two (e.g., Van Leeuwen & Vermulst, 2004). However, The Parenting Styles and Dimensions Questionnaire, or PSDQ, allows parents to evaluate their partner's parenting styles (e.g., Robinson et al., 2001). Indeed, the PSDQ differs from other scales as it allows for an observer's viewpoint as they evaluate someone else's parenting style. Given that this measure is among the first to allow adults to evaluate *another* parent's behaviors, the study will use a modified version of the PSDQ.

Despite the differences in parents' behaviors toward their children with cancer (e.g., expectations, expression of emotions, worries; Hillman 1997) and no known findings of it having a significant effect on the parent-child relationship compared to chronic illnesses (Pinquart, 2013), there is relatively little research on how third-party observers may perceive and evaluate the parenting behaviors of parents who have a child with cancer. Research has shown how

important it is for humans to be seen as likable by and/or accepted within society (e.g., Boivin, 1994). Knowing this, parents of children with cancer may feel even more pressure to behave a certain way when interacting with their children, causing parenting to be a lonely time for their parents.

Despite the paucity of research on this topic, the person perception literature may offer a bridge to this gap in research. For instance, warmth judgments decide a person's approach-avoidance tendencies to a person being evaluated, while competence determines the extremity of the evaluation in a negative or positive direction (Fiske et al., 2006). If the observer perceives a negative behavior, it can destroy the observer's perception of morality-warmth and contribute more strongly to how the parent is perceived. For example, someone who is mean or unfriendly (someone whom many may consider a 'villain' in TV or movies) can still have behaviors that fall into the warmth category when engaged in something that they value. However, due to the negative behaviors being evaluated first, the person will usually still be seen as colder than someone who is only seen being warm or caring. Being seen as not warm or competent can have negative social effects like prejudices of seeing the subject as untrustworthy or dangerous (Fiske et al., 2006). However, favorable perceptions of warmth and competence can cause the observer to admire or express pride in the subject being observed.

Observers of a family may criticize different parenting styles, whether in person or by seeing an article on the news with little to no information. Unfortunately, bringing a cancer diagnosis into the equation is only likely to add more stress to the family, including difficulties in social groups, treatment, and changing the family's daily routine (Hildenbrand et al., 2011). Children with cancer may be taken out of school for treatment and fall behind in learning, be subjects of bullying, or have difficulty maintaining relationships during treatment. Previous



research often focuses on stressors parents are likely to experience due to their child being diagnosed with cancer. However, relatively little research has explored potential external stressors (e.g., unfavorable evaluations by others) that parents may also be experiencing in this situation. As such, the goal of the current study was to address this gap in the literature and provide a potential explanation of how parents are evaluated as a function of their child's health status.

### **Extra Parenting Stressors when Parenting a Child with Cancer**

When a child receives a cancer diagnosis, the family dynamic can shift drastically, causing even more stressors within the family unit (Demirtepe-Saygili & Bozo., 2018; Hildenbrand et al., 2011). For example, this can include the changing of schedules or needs of the family. These changes are likely to result in stressors stemming from the child's treatment and its side effects (e.g., pain, hair loss, taking medication, extended hospital visits, sleep difficulties, and social group interruptions; Hildenbrand et al., 2011). These added stressors while parenting can manifest in several ways, creating different environments and parenting factors compared to families with healthy children. For example, such experiences can cause strained family relationships (e.g., mothers feeling as though they have to be the 'strong' one when a father cannot cope with the diagnosis), modification of roles (e.g., fathers learning to do more household chores, one parent becoming the primary decision maker), financial burdens (e.g., a father working more to allow a mother to stay at the hospital with child), and social isolation within families (e.g., some children feeling the need to be seen as normal by peers; McGarth, 2001). These added stressors throughout diagnosis and treatment could also be contributing to parents' ongoing concerns regarding their parenting ability and/or parenting style.

Previous research has shown that parents feel pressured to keep their lives as normal as possible (McGarth, 2001). More specifically, McGarth (2001) surveyed parents of children with cancer and found that the parents were trying to keep their life as close to the way it was before the diagnosis despite having to introduce medical treatments that create large changes to routine. Additional research on parents of children with cancer has reported an increase in parents' negative emotions following their child's diagnosis, including sadness, anger, guilt, and anxiety (Demirtepe-Saygili & Bozo, 2018). For the parents who experienced sadness, they reported that the negative emotions were usually the most intense shortly after their child's diagnosis. As for anxiety, some parents tend to use a variety of avoidance-based strategies, including avoiding their daily responsibilities so that they can be at the hospital with their child or avoiding the name 'cancer' and referring to it as 'illness' or 'it.' Avoiding the name 'cancer' may help parents feel as though their child is relatively healthy, or potentially downplay the seriousness of the illness.

Other research suggests some parents struggle to acknowledge their emotions at all. These parents would avoid using emotional words in their responses to the researchers' questions, or say they felt like feeling an emotion but chose to ignore said feeling (Demirtepe-Saygili & Bozo, 2018). Demirtepe-Saygili and Bozo (2018) also found that the parents who expressed anger often directed it at their spouse. More specifically, these parents often acknowledged that anger toward their spouse is the illness having its effect on them. Some parents stated they felt guilty for spending less time with their other children, leaving the hospital, and doing other activities, or regret for not noticing the child's cancer symptoms sooner.

Finally, Demirtepe-Saygili and Bozo (2018) found some parents also reported that their own well-being often was a direct result of their child's well-being, such that if their child was not doing well, then the parents' well-being would also deteriorate (Demirtepe-Saygili & Bozo, 2018). The emotional interdependence between the ill child and the parents may best explain the decline in parents' well-being. However, this decline in well-being can be combatted by individuals expressing their emotions (Demirtepe-Saygili & Bozo, 2018). For example, Demitepe-Saygili & Bozo (2018) found a guided writing disclosure intervention lowered PTSD symptoms in the child's caregivers. While clinicians cannot always help cure the major stressors in these parents' lives, they can help reduce the stress the parents are feeling. All of these negative feelings expressed by parents who are parenting children with cancer should be brought to the attention of clinicians and be taken seriously as the child undergoes treatment.

Although parents are likely to experience considerable stressors regarding their child's cancer diagnosis, other evidence suggests children may be perceived negatively for having cancer. For example, research has shown that undergraduate students are likely to perceive children with a cancer diagnosis less favorably than children who are healthy (Wiens & Gilbert, 2000). More specifically, the healthy child may be perceived as being more sociable than the child receiving cancer treatment or in remission. The healthy child was also seen as more physically potent (stronger, less passive, and quicker) than the child receiving treatment. Similarly, research has also shown that children currently undergoing treatment tend to be perceived less favorably by adults than children in remission (Hall et al., 2019). This may be due to adults seeing cancer differently if it is "active" versus being "under control" (i.e., in remission). According to Hall et al. (2019), the children undergoing cancer treatment were perceived by adults to have a challenging life and uncertain future, which will most likely

negatively impact their physical, cognitive, and social-emotional development. Given these subjective perceptions of children with cancer, parents may feel more pressure to create a relatively “normal” childhood for the child with cancer. Related research has shown that adults tend to be especially likely to let children “off the hook” for possessing an undesirable characteristic (e.g., overweight, aggressive), but are much more likely to blame the parents of a child with the same undesirable characteristics (Wadian et al., 2019).

Fortunately, parents reported some positive aspects when parenting a child with cancer. For example, some parents reported realizing the importance of family, better organization of priorities within the family unit, and self-efficacy (Demirtepe-Saygili & Bozo, 2018). This more positive view of the consequences of a cancer diagnosis created feelings of being proud, strong, interested, and motivated throughout the treatment. Further, one mother reported that she felt as though she had grown up and become more of a woman through her child’s treatment (Demirtepe-Saygili & Bozo, 2018). However, most of the parents who reported positive effects had children in better health than other parents who were surveyed.

With such a difference in experiences between parents of healthy children compared to parents of children with cancer, it is only to be expected that the parenting styles may differ and, importantly, may be seen differently through the eyes of an observer. Indeed, self-evaluations of parents of children with cancer have found parents of children with cancer have different parenting expectations, discipline, expression of emotion, parental concerns, and worries, and display more overprotectiveness when compared to self-evaluations of parents of healthy children (Hillman, 1997). Parents with a child with cancer were more likely to restrict their child’s independence. These parents are also more likely to describe themselves as less strict and more willing to spoil their children than those raising healthy children. However, these parents

are less likely to say they kissed and hugged their child and were less likely to talk things over with their child when their child misbehaved (Hillman, 1997).

Similarly, childhood cancer survivors (CCS) also described their parent's parenting as different from their peers (Ernst et al., 2019). CCS often described their father and mother as warmer and less rejecting or punishing than their peers' parents. For older surveyors, parents of CCS were seen as less overprotective, controlling, but also less warm than those of healthy children. The parents' ambition of older CCS, or inspiring the child to do their best, was also reported as lower than their healthy peers' parents (Ernst et al., 2019). However, when all surveyors were included, parents of CCS were found to be more affectionate, overprotective, and have less ambition than the general public. Despite these general evaluations of parents of children with cancer, there is a relative paucity of research regarding the perceived *parenting styles* of parents of children with cancer.

### **Overview of the Current Study**

The goal of the current study was to assess if there is a difference in how parents of children with cancer are perceived by adults compared to parents of healthy children. More specifically, the study compared the extent to which parents of children with cancer (compared to parents of healthy children) are perceived to be warm, competent, authoritarian, permissive, and authoritative. The current study also assessed how likely participants would be to anticipate wanting to be the parent's friend as well as how likable they perceived the parent to be. Adults assessed the parenting behaviors of hypothetical parents, and it was hypothesized that adults' perceptions of hypothetical parents will be significantly influenced by the health status of the hypothetical child. Additional hypotheses include whether parents of children with cancer with authoritarian behaviors would be seen as less warm, competent, likable, and participants would

be less likely to befriend the authoritarian parent of a child with cancer. Given such findings by Wadian and colleagues, adults may be especially likely to perceive the parent of the child with cancer as less favorable than the parent of the healthy child. Put simply, adults may view the parent of a child with cancer as stricter, less warm, and less competent than the parent of a healthy child.

Prior research has also shown that children with cancer are perceived less favorably than healthy children (Hall et al., 2019). Given such results, it is also important to assess how a child's health status is likely to influence how adults perceive the parent's behaviors/parenting style. If the current study can show that adults' perceptions of parents change based on the health status of the parents' children, we could start to develop tools for parents with cancer to inoculate them against the stress they may feel from others as they actively work to manage the stress of more pressing matters (i.e., having a child with cancer).

### **Standpoint Statement**

When I was younger, I discovered I had a health condition that led to me spending a lot of time seeing doctors, some of whom refused to see me due to my age. These experiences could influence my findings by looking for what I expect the results to be which is the parent with the child with cancer will be seen as less warm and competent than the parent with the healthy child. These experiences are also what sparked my interest in this topic as I saw the stress my parents experienced as we had to travel out-of-state for medical care. In addition, I have attended camps for kids with childhood cancer and terminal/chronic illnesses in the past summers. These experiences have allowed me to understand better how to approach the complex topic of children suffering from illness. These camps have also influenced me to investigate the different experiences that a family with a child with cancer has. Finally, seeing at an older age how some

parents may react to their child after finding these illnesses could influence how I word things in my vignettes.

## Methods

### Participants

For the current study, 322 participants were recruited.<sup>1</sup> Participants were recruited through Amazon's MTurk<sup>2</sup> ( $n = 78$ ) and Washburn University's Introductory Psychology classes ( $n = 186$ ). However, 40 participants were excluded for finishing the questionnaire too quickly (i.e., finishing in less than 4 minutes), 6 participants were excluded due to missing data, 6 participants were excluded due to uniform responding, and 6 were excluded due to failing the content validation (answering incorrectly to a prompt to select a specific choice). This left 264 participants, 186 (70.5%) from Introductory Psychology and 78 (29.5%) from MTurk. The participants' age range was 18-71 ( $M = 24.38$ ;  $SD = 8.81$ ). See Table 1 for the complete demographic breakdown.

Participants were also asked to indicate if they themselves had children. Approximately 33% of participants reported having children of their own, ranging from 1 child to more than 10, with 45.8% having 1 child. Participants were randomly assigned to 1 of 4 vignettes, there were 67 participants in the permissive and healthy condition, 69 participants in the permissive and

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<sup>1</sup> The proposed number of participants was based on a power analysis that was conducted using GPower (Faul et al., 2007; 2009) with 4 groups (Statistical Test: "MANOVA: Special effects and interactions", the Effect size of  $f^2 = .0625$ ,  $\alpha = .05$ , power = .95, the number of predictors is 2, Response variables/dependent variables are 9). To obtain the size needed for this study, participants were recruited using both Washburn University's Psychology 100 classes and MTurk which allowed for a diverse range of opinions regarding how parenting styles are viewed and if the child's health status (i.e., diagnosed with cancer vs. healthy) is likely to influence people's perceptions of the parent's behaviors.

<sup>2</sup> Amazon's Mechanical Turk (or MTurk) is an online labor market that has allowed researchers and businesses to assign tasks virtually to a labor pool (Thompson et al., 2022). These tasks consist of surveys and experiments.

child with cancer condition, 63 participants in the authoritarian and healthy condition, and 65 participants in the authoritarian and child with cancer condition.

**Table 1**

*Demographics of Participants*

<b>Variables</b>	<b>Total</b>	<b>Percentage</b>
<b>Age in years</b>		
Mean $\pm$ SD	24.38 $\pm$ 8.81	
Min - Max	18-71	
<b>Gender</b>		
Female	143	54.2
Male	115	43.6
Gender-Queer/Nonconforming	3	1.1
Unidentified	2	.8
Transgender	1	.4
<b>Ethnicity</b>		
White/Caucasian	180	68.2
Black	20	7.6
Hispanic/Latino/a	28	10.6
Asian	17	6.5
Native American	4	1.5
Multiracial	15	5.7

**Materials**

**Vignettes.** The vignettes varied depending on whether the child has cancer or is healthy and if the parent behaves in an especially authoritarian or permissive way. The parent in the vignettes was not gendered to combat the possibility of seeing a father as more or less warm or competent than a mother for the same behaviors. The participants were then randomly assigned to one of four vignettes. More specifically, one vignette featured a child who has cancer and an authoritarian parent. The second vignette featured a child who does not have cancer and an authoritarian parent. A third vignette featured a child with cancer and a permissive parent. The fourth vignette featured a child who does not have cancer and a permissive parent. For a list of all the vignettes in the study, see Appendix A.



**General Person Perception Scale.** In order to assess the participants' opinions of the parents featured in the vignettes, the current study used general person perception scale similar to those used in previous studies (e.g., Jingjing, 2022). More specifically, this scale contained five items that have been designed to measure warmth, including how warm, kind, friendly, gregarious, and honest the parent in the vignette is perceived to be. The five-item Warmth scale was also strong reliability (Cronbach's Alpha = .87).

The scale also included five questions on how competent, entrepreneurial, efficient, creative, and talented the parent in the vignette is perceived to be. The five-item Competence scale seemed to have good reliability (Cronbach's Alpha = .88). The scale also included two questions designed to assess participants' personal rankings on how likable the parent is (*How likable do you find the parent?*) and if participants are willing to be the parent's friend (*How likely are you to be the parent's friend?*). However, to be easier understood by participants, the majority of which are college aged, the words entrepreneurial and gregarious were changed to a more common language. Entrepreneurial was changed to effective and gregarious was changed to sociable. Slightly adjusting items within a scale is often practiced in person perception literature to help create a better understanding from participants, culturally and educationally. However, the study does recognize that this scale has not been formally validated with the words substituted for more common language. Slightly modifying the scale was deemed appropriate since not understanding the words would possibly affect the findings more than changing the words to more commonly known synonyms. Participants then rated their perceptions regarding the parent's warmth, competence, likability, and desire to be the parent's friend using a 5-point Likert scale ranging from 1 (*not at all*) to 5 (*extremely*). Participants' scores were aggregated such that higher scores indicated greater perceived warmth, competence, likability, and desire to be the parent's friend. For the scale used in this study, see Appendix B.

**Parenting Styles and Dimensions Questionnaire.** To assess participants' general perceptions of the parenting behaviors described in the randomly assigned vignettes, a modified version of the Parenting Styles and Dimensions Questionnaire, or PSDQ (Robinson et al., 2001), was used in the current study. The PSDQ was designed to assess parents' opinions of their (and their partner's) parenting styles with a 62-item scale derived from the original 133-item scale. The questions were retained if when a principal axis factoring was ran, they held a loading near or over .30, and was consistent findings between parent genders and child age, and if correlations with factor scores were more than .25 (Robinson et al., 2001). The parents are asked to rank their perceptions of their parenting (and their partner's parenting) for the given statement on a 5-point Likert scale ranging from 1 (*never*) to 5 (*always*). Within the PSDQ, each parenting style was subdivided into several related sub-scales. For the current study, the items were slightly rewritten (i.e., the mother's version of the PSDQ stated "*I encourage our child to talk about the child's troubles*" or "*He encourages our child to talk about the child's troubles*" to "*The parent likely encourages the child to talk about their troubles*") so that a third-party observer could rate a given parent's parenting style along the dimension of authoritative, authoritarian, and permissive parenting. Robinson et al. (2001), found this shortened version of the questionnaire to be consistent with Baumrind's three parenting types. The study also reported the PSDQ can be used for intergenerational study. Thus, this scale has already been modified in similar ways to different perspectives. In previous research, scales have been modified to help better fit the aims of a given study and have still been found to be reliable sources. For example, Weins and Gilbert (2000) used a scale that was originally used to assess adult perceptions of premature babies and had been modified to be used for adult perceptions of children with cancer and healthy children. Participants then rated their perceptions regarding the parent's parenting behaviors and styles using a 5-point Likert scale ranging from 1 (*not at all*) to 5 (*extremely*). Participants' scores were

aggregated such that higher scores (i.e., average scores closer to 5) indicated greater perceived permissiveness, authoritarianism, and authoritativeness. For the full scale used in this study, see Appendix C.

**Authoritative Subscale.** The authoritative subscale was comprised of four factors: warmth and involvement, reasoning/induction, democratic participation, and good-natured/easygoing. The warmth and involvement factor contained 11 questions (e.g., *“This parent knows the names of the child’s friends.”*). The reasoning/induction factor had seven questions (e.g., *“This parent explains the consequences of the child’s behavior.”*). The democratic participation factor contained five questions (e.g., *“This parent takes into account the child’s preferences in making family plans.”*). The good-natured/easygoing factor had four questions (e.g., *“The parent is easygoing and relaxed with the child.”*). Previous research has shown the authoritative scale has Cronbach’s alpha = .91. The revised twenty-item Authoritative scale from the PSDQ for the current study has demonstrated good reliability (Cronbach’s alpha = .97).

**Authoritarian Subscale.** The authoritarian subscale included four factors: verbal hostility, corporal punishment, non-reasoning/punitive strategies, and directiveness. The verbal hostility factor contained four questions (e.g., *“This parent explodes in anger towards the child.”*). The corporal punishment factor had six questions (e.g., *“The parent uses physical punishment as a way of disciplining the child.”*). The non-reasoning/punitive factor contained six questions (e.g., *“The parent punishes by taking privileges away from the child with little if any explanations.”*). The directiveness factor had four questions (e.g., *“The parent tells the child what to do.”*). Previous research has shown the authoritarian scale has a Cronbach’s alpha = .86. The revised twenty-seven-item Authoritarian scale from the PSDQ for the current study has demonstrated good reliability (Cronbach’s alpha = .96).

**Permissive Subscale.** The permissive subscale had three factors: lack of follow-through, ignoring misbehaviors, and self-confidence. The lack of follow-through factor contained six questions (e.g., “*The parent states punishments to the child and does not actually do them.*”). The ignoring misbehavior factor had four questions (e.g., “*The parent allows the child to interrupt others.*”). The self-confidence factor contained five questions (e.g., “*The parent appears confident about their parenting abilities.*”). Previous research has shown the permissive scale has Cronbach’s  $\alpha = .75$ . The revised fifteen-item Permissive scale from the PSDQ for the current study had demonstrated good reliability (Cronbach’s  $\alpha = .89$ ).

### **Design and Procedure**

The current study is an experimental 2 (parent’s behavior: permissive vs. authoritarian) x 2 (child’s health: healthy vs. diagnosed with cancer) factorial between-groups design. The dependent variables for this study included perceived warmth and competence, general perceptions of the parent, and perceptions of parenting style.

Participants were compensated in one of two ways. First, those who complete the survey through Washburn University’s Introductory Psychology classes received course credit. The participants recruited through MTurk received \$3.63 for their time after completing the survey. The monetary amount was decided by estimating the time to take the survey to be 30 minutes and using the federal minimum wage for this time (Searle & McWha-Hermann, 2020). For the informed consent for the Washburn University Introductory Psychology students, see Appendix D. For the informed consent for the MTurk participants, see Appendix E.

After obtaining IRB approval for this study, participants were recruited from Washburn University’s Introductory Psychology classes and MTurk. After obtaining informed consent from the participants, they were asked various demographic questions (e.g., age, gender identity, if they are a parent; Appendix F). The participants were then randomly assigned to one of four

conditions that varied regarding the parent's behaviors and the child's health. After reading the randomly assigned vignette, the participants were asked to rank the parent on the Person Perception Scale and the Parenting Styles and Dimensions Questionnaire (Revised). Finally, the participants were debriefed and thanked for their time. For the debrief for Washburn University Introductory Psychology students, see Appendix G. For the debrief for MTurk participants, see Appendix H.

### Results

To test the hypothesis that parents of children with cancer will be perceived differently (i.e., more unfavorably) than parents of healthy children, a 2 (Parent's Behavior: Authoritarian vs. Permissive) x 2 (Child's Health Status: Has Cancer vs. Healthy) factorial MANOVA was conducted. The independent variables included the parent's behavior (authoritarian or permissive) and the child's health status (healthy or has cancer). The dependent variables included the extent to which participants perceived the hypothetical parents to be competent, warm, likeable, and participants' anticipated likelihood of wanting to be the hypothetical parent's friend. Participants' ratings of perceived parenting style (i.e., authoritative, authoritarian, or permissive) were also included as dependent variables.

The MANOVA results showed a significant Box's M score ( $p < .001$ ), so the data fails to meet the assumption of homogeneity of variance. Thus, Wilk's Lambda was used to assess heterogeneous variance between the variables. Using Wilk's Lambda in such circumstances is consistent with field standards and allows for more robust results (e.g., Ateş et al., 2019).

Using Wilk's Lambda as the criterion, the results from the MANOVA yielded a significant multivariate main effect for Parent Behavior,  $F(7, 254) = 40.37, p < .001, \eta^2 = .53$ , a significant multivariate main effect for Child's Health,  $F(7, 254) = 3.71, p < .001, \eta^2 = .09$ , and a significant multivariate Parent Behavior X Child's Health interaction,  $F(7, 254) = 2.64, p =$

.012,  $\eta^2 = .07$ . Univariate ANOVAs were then conducted on each dependent measure to determine the locus of the statistically significant multivariate main effects and interactions of the child's health and the parent's behaviors. See Tables 2 and 3 for the means (and standard deviations) for the main effects reported above.

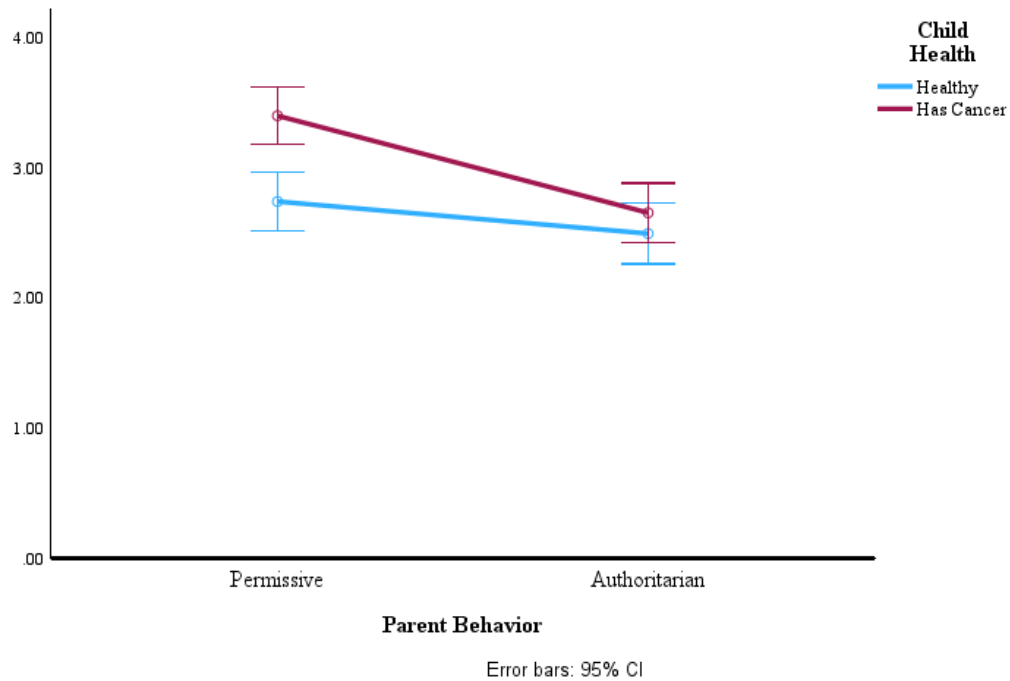
### ***Competence***

Results from the univariate ANOVAs using Competence as the dependent variable revealed that there was a significant main effect for the child's health status,  $F(1, 260) = 12.70$ ,  $p < .001$ ,  $\eta^2 = .05$ . More specifically, parents of healthy children ( $M = 2.62$ ,  $SD = .97$ ) were perceived to be less competent than parents of children with cancer ( $M = 3.04$ ,  $SD = .97$ ). Results also revealed a significant univariate main effect for Parent's Behavior,  $F(1, 260) = 18.64$ ,  $p < .001$ ,  $\eta^2 = .07$ , such that parents who displayed permissive behaviors ( $M = 3.07$ ,  $SD = .95$ ) were perceived to be more competent than parents who displayed authoritarian behaviors ( $M = 2.57$ ,  $SD = .97$ ). Finally, there was a significant univariate Parent Behavior X Child's Health interaction,  $F(1, 260) = 4.73$ ,  $p = .03$ ,  $\eta^2 = .02$ . Simple effects tests revealed that there was no significant difference in perceived competence for Permissive Parents of Healthy Children ( $M = 2.74$ ,  $SD = .97$ ) and Authoritarian Parents of Healthy Children ( $M = 2.49$ ,  $SD = .95$ ). However, as represented in Figure 1, Permissive Parents of Children with Cancer ( $M = 3.40$ ,  $SD = .80$ ) were perceived as significantly more competent than Authoritarian Parents of Children with Cancer ( $M = 2.65$ ,  $SD = .99$ ).

**Figure 1**

*Simple Effects Tests Probing the Significant Parent Behavior X Child's Health Interaction*

*Regarding Perceived Competence*



*Note:* This figure demonstrates the levels of competence participants perceived each hypothetical parent.

***Warmth***

Results from the univariate ANOVAs using Warmth as the dependent variable revealed that there was a significant main effect for the child's health status,  $F(1, 260) = 5.14, p = .02, \eta^2 = .02$ . More specifically, parents of healthy children ( $M = 3.08, SD = .98$ ) were perceived to be less warm than parents of children with cancer ( $M = 3.33, SD = 1.10$ ). Results also revealed a significant univariate main effect for Parent's Behavior,  $F(1, 260) = 124.78, p < .001, \eta^2 = .32$ , such that parents who displayed permissive behaviors ( $M = 3.78, SD = .71$ ) were perceived to be warmer than parents who displayed authoritarian behaviors ( $M = 2.60, SD = 1.00$ ). Finally, there

was no significant univariate Parent Behavior X Child's Health interaction,  $F(1, 260) = 1.80$ ;  $p < .18$ ,  $\eta^2 = .01$ .

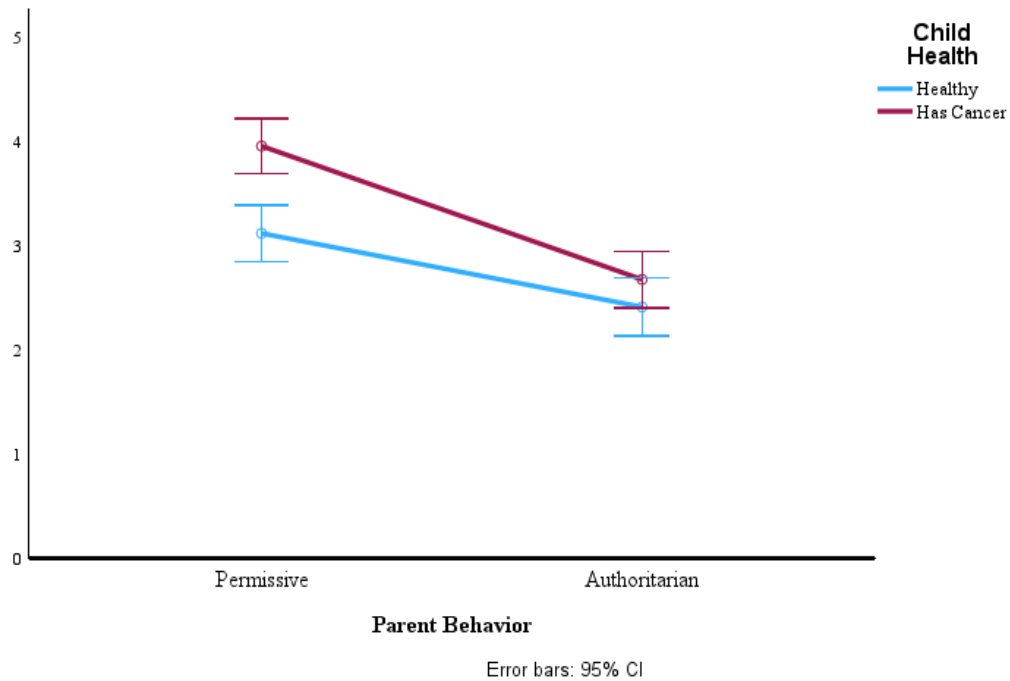
### ***Likability***

Results from the univariate ANOVAs using Likeability as the dependent variable revealed that there was a significant main effect for the child's health status,  $F(1, 260) = 16.07$ ,  $p < .001$ ,  $\eta^2 = .06$ . More specifically, parents of healthy children ( $M = 2.78$ ,  $SD = 1.18$ ) were perceived to be less likable than parents of children with cancer ( $M = 3.34$ ,  $SD = 1.27$ ). Results also revealed a significant univariate main effect for Parent's Behavior,  $F(1, 260) = 52.28$ ,  $p < .001$ ,  $\eta^2 = .17$ , such that parents who displayed permissive behaviors ( $M = 3.54$ ,  $SD = 1.10$ ) were perceived to be more likable than parents who displayed authoritarian behaviors ( $M = 2.55$ ,  $SD = 1.21$ ). Finally, there was a significant univariate Parent Behavior X Child's Health interaction,  $F(1, 260) = 4.35$ ,  $p = .04$ ,  $\eta^2 = .02$ . As presented in Figure 2, simple effects tests revealed that Permissive Parents of Healthy Children ( $M = 3.12$ ,  $SD = 1.12$ ) were perceived as significantly more likable than Authoritarian Parents of Healthy Children ( $M = 2.41$ ,  $SD = 1.15$ ) and Permissive Parents of Children with Cancer ( $M = 3.96$ ,  $SD = .92$ ) were perceived as significantly more likable than Authoritarian Parents of Children with Cancer ( $M = 2.68$ ,  $SD = 1.26$ ).



**Figure 2**

*Simple Effects Tests Probing the Significant Parent Behavior X Child's Health Interaction Regarding Perceived Likability*



*Note:* This figure demonstrates the levels of likability participants perceived each hypothetical parent.

### ***Desired Friendship***

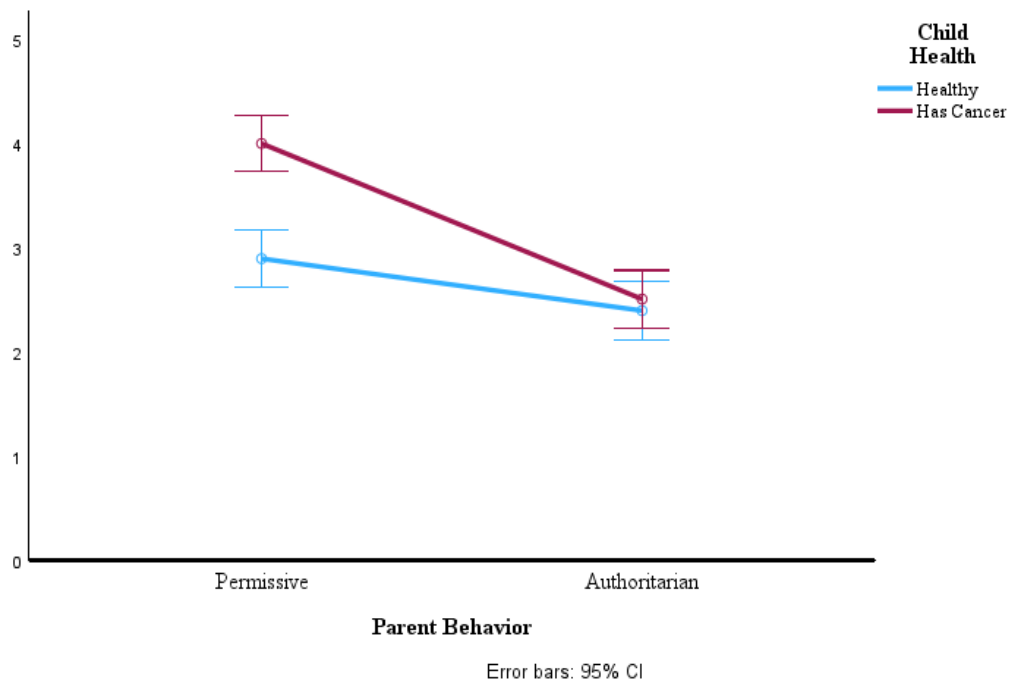
Results from the univariate ANOVAs using Desire to Friend as the dependent variable revealed that there was a significant main effect for the child's health status,  $F(1, 260) = 18.75$ ,  $p < .001$ ,  $\eta^2 = .07$ . More specifically, parents of healthy children ( $M = 2.65$ ,  $SD = 1.28$ ) experienced less desired friendship from observers than parents of children with cancer ( $M = 3.28$ ,  $SD = 1.25$ ). Results also revealed a significant univariate main effect for Parent's Behavior,  $F(1, 260) = 50.32$ ,  $p < .001$ ,  $\eta^2 = .16$ , such that parents who displayed permissive behaviors ( $M = 3.46$ ,  $SD = 1.19$ ) experienced more desired friendship from observers than parents who

displayed authoritarian behaviors ( $M = 2.45$ ,  $SD = 1.22$ ). Finally, there was a significant univariate Parent Behavior X Child's Health interaction,  $F(1, 260) = 12.53$ ;  $p < .001$ ,  $\eta^2 = .05$ .

As presented in Figure 3, simple effects tests revealed that Permissive Parents of Healthy Children ( $M = 2.90$ ,  $SD = 1.25$ ) experienced more desired friendship from observers than Authoritarian Parents of Healthy Children ( $M = 2.40$ ,  $SD = 1.28$ ) and Permissive Parents of Children with Cancer ( $M = 4.00$ ,  $SD = .82$ ) experienced more desired friendship from observers than Authoritarian Parents of Children with Cancer ( $M = 2.51$ ,  $SD = 1.17$ ).

### Figure 3

*Simple Effects Tests Probing the Significant Parent Behavior X Child's Health Interaction Regarding Perceived Desired Friendship*



*Note:* This figure demonstrates the levels of desired friendship participants perceived each hypothetical parent.

### *Authoritative*

Results from the univariate ANOVAs using participants' ratings of how Authoritative they perceived the hypothetical parent to be revealed that there was no significant main effect for the child's health status,  $F(1, 260) = 3.06, p = .081, \eta^2 = .01$ . More specifically, parents of healthy children ( $M = 3.22, SD = .75$ ) were perceived similarly to parents of children with cancer ( $M = 3.37, SD = .79$ ). However, results revealed a significant univariate main effect for Parent's Behavior,  $F(1, 260) = 61.88, p < .001, \eta^2 = .19$ , such that parents who displayed permissive behaviors ( $M = 3.62, SD = .57$ ) were perceived to be more authoritative than parents who displayed authoritarian behaviors ( $M = 2.95, SD = .81$ ). Finally, there was no significant univariate Parent Behavior X Child's Health interaction,  $F(1, 260) = .06; p = .81, \eta^2 < .01$ .

### *Authoritarian*

Results from the univariate ANOVAs using participants' ratings of how Authoritarian they perceived the hypothetical parent to be revealed that there was no significant main effect for the child's health status,  $F(1, 260) = .01, p = .93, \eta^2 < .01$ . More specifically, parents of healthy children ( $M = 3.02, SD = .93$ ) were perceived similarly to parents of children with cancer ( $M = 3.04, SD = .99$ ). However, results revealed a significant univariate main effect for Parent's Behavior,  $F(1, 260) = 127.87, p < .001, \eta^2 = .33$ , such that parents who displayed permissive behaviors ( $M = 2.50, SD = .94$ ) were perceived to be less authoritarian than parents who displayed authoritarian behaviors ( $M = 3.60, SD = .58$ ). Finally, there was no significant univariate Parent Behavior X Child's Health interaction,  $F(1, 260) = .46; p = .50, \eta^2 < .01$ .<sup>3</sup>

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<sup>3</sup> When comparing differences between participants who reported having children and participants who reported not having children, there was a significant difference between how they rated on scores of authoritarian ( $p = .004$ ). Participants who had children ( $M = 3.39, SD = .84$ ) perceived the especially strict parent to be more authoritarian than participants who did not have children of their own ( $M = 2.85, SD = .96$ ).

### *Permissive*

Results from the univariate ANOVAs using participants' ratings of how Permissive they perceived the hypothetical parent to be revealed that there was no significant main effect for the child's health status,  $F(1, 260) = 1.21, p = .27, \eta^2 = .01$ . More specifically, parents of healthy children ( $M = 3.11, SD = .81$ ) were perceived similarly to parents of children with cancer ( $M = 3.02, SD = .72$ ). However, results revealed a significant univariate main effect for Parent's Behavior,  $F(1, 260) = 84.53, p < .001, \eta^2 = .25$ , such that parents who displayed permissive behaviors ( $M = 3.43, SD = .71$ ) were perceived to be more permissive than parents who displayed authoritarian behaviors ( $M = 2.68, SD = .63$ ). Finally, there was no significant univariate Parent Behavior X Child's Health interaction,  $F(1, 260) = .95, p = .33, \eta^2 < .001$ .<sup>4</sup>

### **Discussion**

The purpose of this study was to evaluate how observers' perceptions toward parents of children with cancer differ from perceptions toward parents of healthy children. For this study there were multiple hypotheses. The first was that especially strict parenting behaviors would be perceived as more authoritarian for the parents of children with cancer than the parents of healthy children. It was also hypothesized that parents of children with cancer would be perceived as less warm, competent, and likable, than parents of healthy children. Finally, individuals would be less likely to anticipate wanting to be the parent of a child with cancer's friend when compared to the parents of healthy children.

There are multiple findings of the present research. First, the observers' perceptions of the parenting style did not change based on the child's health status. However, observers'

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<sup>4</sup>When comparing differences between participants who reported having children and participants who reported not having children, there was a significant difference between how they rated on scores of permissive ( $p = .002$ ). Participants who had children ( $M = 3.29, SD = .62$ ) perceived the permissive parent to be more permissive than participants who did not have children of their own ( $M = 2.95, SD = .81$ ).

perceptions did change based on the parent's behaviors, thus showing that the manipulation of parenting behaviors was assessed properly. For example, observers rated the parenting style of the especially strict parent as authoritarian, whereas they rated the parenting style of the especially “laid back” parent as permissive. Second, observers were more likely to find the parents of children with cancer to be more likable, warm, and competent than the parents of healthy children. Observers were also more likely to anticipate wanting to be the friend of the parent of a child with cancer than the parent of a healthy child. These findings were counter to the hypotheses that parents of children with cancer would be seen as less warm, likable, and competent than those of healthy children. The results from the current study also suggest that there may be a difference in perceptions of children with illnesses than from other undesirable characteristics like being overweight or having ADHD symptomology that have been previously assessed in research (Wadian et al., 2019). In other words, illness may not be seen as directly correlated to negative perceptions of children and their parents as past research has suggested. Third, observers were more likely to find parents with permissive behaviors to be more competent, warm, likable than those with authoritarian behaviors. Observers were also more likely to anticipate wanting to befriend parents with permissive behaviors than the parents who displayed authoritarian behaviors. Finally, we obtained evidence that while a child’s health status may influence the way an observer views the parent’s warmth and competence, it does not affect how observers are likely to perceive a parent’s overall parenting style.

Inconsistent with previous research by Wadian et al. (2019), the parent of the child with cancer in the current study was perceived more favorably than the parent of healthy child on the dependent variables of competence and likable. Observers were also more likely to choose to be the parent of the child with cancer’s friend more than the parent of the healthy child. Although counter to the original hypotheses, this difference may best be explained by the tendency for the

participants to recognize the extra stressors and feelings that parents experience when their child has cancer such as guilt, sadness, and anxiety (Demirtepe-Saygili & Bozo, 2018). This difference may also be due to compassion or sympathy from the participants to the hypothetical parent. For instance, Chudzicka-Czupala and Basek (2019) found that participants continued to read memorials about children who had been lost due to compassion for the ones affected by the loss. These findings suggest that thinking about children and tragedy may be uncomfortable and spark compassion for children in such situations. Considering these findings for the current study, participants may be showing more compassion for parents of children with cancer. With the prominence of cancer, it is fair to assume that many participants may have known someone affected by cancer or may have themselves been diagnosed with cancer at some point in time. Indeed, this likelihood may have influenced participants' responses such that they were more likely to exhibit more compassion for the parents of children with cancer and to see it as more of an unfortunate circumstance than an undesirable characteristic.

### **Limitations**

Despite the current findings that suggest that parents of children with cancer tend to be perceived especially favorably, it is important to recognize several potential limitations. The first limitation is that the current study's age range is limited as most participants are from a college sample. College-age participants were less likely to have children of their own and may think of parenting behaviors in a slightly different way than older participants. A second limitation could be that thinking about cancer can be uncomfortable even for those living with it (e.g., Demirtepe-Saygili & Bozo, 2018). Such uncomfortable feelings could have influenced how participants viewed the parent (and the child) and may have influenced how participants reacted toward the vignette. Finally, another limitation with the study is that the scale for person perception scale has not been formally validated from past literature with the substitutions and the PSDQ had

been shortened before modification for this study. Due to the second modification of the PSDQ, the results cannot be as confidently interpreted as it could have been if the scale was originally developed for observers' perceptions. In other words, we must carefully interpret any results that were obtained using this modified measure.

Despite these limitations, the current study has important theoretical and practical implications. Using the Family Stress Model, clinicians can understand, and help their clients understand that observers' opinions may not be as negative as clients may be likely to assume and, therefore, less likely to become an additional stressor that parents in difficult circumstances need to be concerned with. Further, additional research on this topic has the potential to help parents of children with cancer to feel less pressure when parenting their child in front of other individuals.

Another potential implication is that the current study has the potential to lay the foundation for future research that more closely assesses “undesirable characteristics” (see Wadian et al., 2019). Indeed, the current study may provide a subtle, yet important distinction in the characteristics that are considered to be undesirable (e.g., being overweight, having ADHD; Wadian et al., 2019), compared to the characteristics that are considered to be unfortunate (e.g., being diagnosed with a serious illness). However, more research is needed to further assess this practical (and theoretically important) distinction.

Future research should also look at other ways observers are likely to perceive parenting styles as a function of different environmental circumstances (e.g., different health diagnoses, specific child behaviors) in order to assess the extent to which such environmental circumstances are likely to impact how parents are perceived. Although research on this topic has been conducted in the past (e.g., Wadian et al., 2019), if we have a greater understanding of which

environmental circumstances are especially likely to face criticism, clinicians can be better prepared when discussing such concerns with parents.

Future research should also look at if there is a limit to the extent to which permissive behaviors are considered acceptable. As mentioned earlier, permissive parenting can lead to the child engaging in more risky behaviors than a child of an authoritarian or authoritative parent (Hoskins, 2014). Future researchers may benefit from studying if there are negative observer consequences to permissive parenting as well.

Finally, although the revised PSDQ had good internal reliability within the current study, the field may benefit from an observer parenting scale made specifically for third-party observers. As mentioned, everyone tends to have an opinion on parenting. However, research has very limited reliable scales that give us the ability to assess how those opinions change based on knowledge of other factors. Knowing how to assess this or how different factors play a part in perceptions can allow clinicians to be knowledgeable when advising parents. In sum, the current study is a great initial step toward integrating two lines of research. That is, observers' perceptions of parents as well as their perceptions of children with various health concerns. Research in this area should be continued as it allows clinicians to create a better understanding of how observers are viewing parents they work with and the circumstances changing these views.

## **Conclusions**

This study aimed to assess the differences between observers' views of parents of children with cancer and parents of healthy children. Due to past research of "undesirable characteristics", it was expected to find that parents of children with cancer would be perceived more unfavorably than parents of healthy children. However, the results from the current research revealed that observers tended to actually perceive parents of children with cancer *more*



*favorably* than parents of healthy children. Although counter to the proposed hypotheses, the results from the current study suggest a more optimistic outcome compared to previous research such that observers may actually have more compassion for parents going through especially difficult times. Indeed, given the numerous stressors that parents of children with cancer are likely to face, it may be a relief for these parents to know that others are perceiving them with a degree of compassion.

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**Table 2**

*Participants' Mean (and SD) Ratings of Parents of Children with Cancer and Parents of Healthy Children*

	Child with Cancer	Healthy Child	<i>F</i> (1, 260)	<i>p</i>	$\eta^2$
Competence	3.04 (.97)	2.62 (.97)	12.70	<.001	.05
Warmth	3.33 (1.10)	3.08 (.98)	5.14	.02	.02
Likeability	3.34 (1.27)	2.78 (1.18)	16.07	<.001	.06
Desired Friendship	3.28 (1.25)	2.65 (1.28)	18.75	<.001	.07
Authoritarian	3.04 (.99)	3.02 (.93)	.01	.93	<.01
Authoritative	3.37 (.79)	3.22 (.75)	3.06	.081	.01
Permissive	3.02 (.72)	3.11 (.81)	1.21	.27	.01

**Table 3***Participants' Mean (and SD) Ratings of the Different Parent Behaviors*

	Permissive	Authoritarian	<i>F</i> (1, 260)	<i>p</i>	$\eta^2$
Competence	3.07 (.95)	2.57 (.97)	18.64	<.001	.07
Warmth	3.78 (.71)	2.60 (1.00)	124.78	<.001	.32
Likeability	3.54 (1.10)	2.55 (1.21)	52.28	<.001	.17
Desired Friendship	3.46 (1.19)	2.45 (1.22)	50.32	<.001	.16
Authoritarian	2.50 (.94)	3.60 (.58)	127.87	<.001	.33
Authoritative	3.62 (.57)	2.95 (.81)	61.88	<.001	.19
Permissive	3.43 (.71)	2.68 (.63)	84.53	<.001	.25

## Appendix A Vignettes

### Vignette 1:

Timmy is a healthy 8-year-old. He enjoys playing video games and playing baseball with his friends outside. His parent notices that he has not done anything that has been asked of Timmy today, including cleaning his room, putting away his laundry, and completing homework for school the following day. Timmy's parent sees Timmy playing video games in the living room. Timmy's parent turns off the video games and yells at Timmy, "Go to your room. You're grounded!"

### Vignette 2:

Timmy is an 8-year-old who was recently diagnosed with cancer and is currently undergoing treatment. He enjoys playing video games and playing baseball with his friends outside. His parent notices that he has not done anything that has been asked of Timmy today, including cleaning his room, putting away his laundry, and completing homework for school the following day. Timmy's parent sees Timmy playing video games in the living room. Timmy's parent turns off the video games and yells at Timmy, "Go to your room. You're grounded!"

### Vignette 3:

Timmy is a healthy 8-year-old. He enjoys playing video games and playing baseball with his friends outside. His parent notices that he has not done anything that has been asked of Timmy today, including cleaning his room, putting away his laundry, and completing homework for school the following day. Timmy's parent sees Timmy playing video games in the living room. Without saying anything to Timmy, his parent goes and puts Timmy's laundry away and cleans his room for him.

### Vignette 4:

Timmy is an 8-year-old who was recently diagnosed with cancer and is currently undergoing treatment. He enjoys playing video games and playing baseball with his friends outside. His parent notices that he has not done anything that has been asked of Timmy today, including cleaning his room, putting away his laundry, and completing homework for school the following day. Timmy's parent sees Timmy playing video games in the living room. Without saying anything to Timmy, his parent goes and puts Timmy's laundry away and cleans his room for him.

**Appendix B**  
**Person Perception Scale**

Regarding the parent you just read about, please rate how strongly you agree with the following statements ranging from 1 (*strongly disagree*) to 5 (*strongly agree*).

Warmth Scales

This parent is warm.

This parent is kind.

This parent is friendly.

This parent is sociable.

This parent is honest.

Competence Scales

This parent is competent.

This parent is effective.

This parent is efficient.

This parent is creative.

This parent is talented.

How likely are you to want to be the parent's friend?

How likable do you find the parent?

**Appendix C**  
**Parenting Styles and Dimensions Questionnaire (Revised)**

For the following questions, please rate how strongly you agree with the statements ranging from 1 (*strongly disagree*) to 5 (*strongly agree*).

**Authoritative Items**

***Warmth and Involvement***

1. The parent likely knows the name of the child's friends.
2. The parent is likely aware of problems or concerns about the child in school.
3. The parent likely gives praise when the child is good.
4. The parent likely gives comfort and understanding when the child is upset.
5. The parent likely expresses affection by hugging, kissing, and holding the child.
6. The parent likely shows sympathy when the child is hurt or frustrated.
7. The parent likely tells the child they appreciate what the child tries and accomplishes.
8. The parent is likely responsive to the child's feelings and needs.
9. The parent likely encourages the child to talk about their troubles.
10. The parent likely has warm and intimate times together with their child.
11. The parent likely apologizes to the child when making a mistake in parenting.

***Reasoning/Induction***

1. The parent likely explains the consequences of the child's behavior.
2. The parent likely gives the child reasons why rules should be obeyed.
3. The parent likely emphasizes the reasons for the rules.
4. The parent likely helps the child to understand the impact of behavior by encouraging the child to talk about the consequences of his/her own actions.
5. The parent likely explains how they feel about the child's good and bad behavior.
6. The parent likely talks it over and reasons with the child when the child misbehaves.
7. The parent likely tells the child their expectations regarding behavior before the child engages in an activity.

***Democratic Participation***

1. The parent likely takes into account the child's preferences in making family plans.
2. The parent likely allows the child to give input in family rules.
3. The parent likely takes the child's desires into account before asking the child to do something.
4. The parent likely encourages the child to freely express himself/herself even when disagreeing with the parent.
5. The parent likely channels the child's misbehavior into a more acceptable activity.

***Good-Natured/Easygoing***

1. The parent is likely easygoing and relaxed with the child.
2. The parent likely shows patience with the child.
3. The parent likely jokes and plays with the child.

4. The parent likely shows respect for the child's opinions by encouraging the child to express them.

### **Authoritarian Items**

#### ***Verbal Hostility***

1. The parent likely explodes in anger toward the child.
2. The parent likely yells or shouts when the child misbehaves.
3. The parent likely argues with the child.
4. The parent likely disagrees with the child.

#### ***Corporal Punishment***

1. The parent likely uses physical punishment as a way of disciplining the child.
2. The parent likely spanks when the child is disobedient.
3. The parent likely slaps the child when being disobedient.
4. The parent likely grabs the child when being disobedient.
5. The parent likely guides the child by punishment more than by reason.
6. The parent likely shoves the child when the child is disobedient.

#### ***Non-Reasoning/Punitive Strategies***

1. The parent likely punishes by taking privileges away from the child with little if any explanations.
2. The parent likely punishes by putting the child off somewhere alone with little if any explanations.
3. The parent likely uses threats as punishment with little or no justification.
4. When two children are fighting, the parent likely disciplines the children first and asks questions later.
5. The parent likely appears to be more concerned with their own feelings than with the child's feelings.
6. When the child asks why he/she has to conform, the parent likely states: because I said so, or I am your parent and I want you to.

#### ***Directiveness***

1. The parent likely tells the child what to do.
2. The parent likely demands that the child does/do things.
3. The parent likely scolds and criticizes to make the child improve.
4. The parent likely scolds or criticizes when the child's behavior doesn't meet their expectations.

### **Permissive Items**

#### ***Lack of Follow-through***

1. The parent likely states punishments to the child and does not actually do them.
2. The parent likely threatens the child with punishment more often than giving it.
3. The parent likely spoils the child.
4. The parent likely gives into the child when he/she causes a commotion about something.
5. The parent likely carries out discipline after the child misbehaves. \*

6. The parent likely bribes the child with rewards to bring about compliance.

***Ignoring Misbehavior***

1. The parent likely allows the child to interrupt others.
2. The parent likely allows the child to annoy someone else.
3. The parent likely ignores the child's misbehaviors.
4. The parent likely withholds scolding and/or criticism even when the child acts contrary to their wishes.

***Self-Confidence***

1. The parent likely appears confident about their parenting abilities. \*
2. The parent likely appears unsure on how to solve the child's misbehavior.
3. The parent likely finds it difficult to discipline the child.
4. The parent likely sets strict well-established rules for the child. \*
5. The parent is likely afraid that disciplining the child for misbehavior will cause the child to not like his/her parents. <sup>5</sup>

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<sup>5</sup> \* Items are reverse scored.

## **Appendix D**

### **Informed Consent**

The Department of Psychology at Washburn University supports the practice of protection for human subjects participating in research. The following information is provided so that you can decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you may choose not to answer specific questions or exit the survey at any time if you no longer want to participate.

**Project Title:** Attitudes Toward Parents of Children with Cancer

**Principal Investigator:** Faith Shafer

**Contact Information for any Problems/Questions:**

Faith Shafer ([faith.burling@washburn.edu](mailto:faith.burling@washburn.edu))

(785)-670-1964

Henderson 211

**IRB Chair Contact Information:** Marian Jamison, Ph.D., Chair, Washburn University Institutional Review Board. [irb@washburn.edu](mailto:irb@washburn.edu)

**Purpose:** This project aims to examine individuals' beliefs and attitudes related to parents' behaviors toward their children with health concerns.

**Participation:** You will be asked to report your attitudes and beliefs toward a parent's behaviors after reading a brief description of parents and their interactions with their children. The study is expected to take about 30 minutes.



**Benefits Anticipated:** By participating in this study, you may learn about the psychological research process and gain insight into your attitudes and beliefs. Students currently enrolled in PY100 will earn course credit towards the Psychological Research Activities requirement.

**Risks Anticipated:** No risks are anticipated beyond what you are likely to experience in your day-to-day life. However, if any questions arouse strong emotions, you may choose not to answer the question(s) or stop participating at any time without explanation or penalty.

**Extent of confidentiality:** Your responses will be anonymous. At no time will your personal data be accessible. Your name and identity will not be associated in any way with the research findings—once your responses are entered into a secure statistical program, data will be examined in aggregate, such that no individual's responses will be traceable from the products of this work, such as journal articles and presentations.

**Alternative Research Options:** Alternative options to earn points towards the PY100 Psychological Research Activities requirement are available, including participation in other studies or completing a written assignment.

**Terms of Participation:** I understand this project is research and that my participation is completely voluntary. I also understand that if I decide to participate in this study, I may withdraw my consent at any time, and stop participating at any time without explanation or penalty.

**I verify that by clicking the button below, I am indicating that I have read and understand this consent form, and willingly agree to participate in this study under the terms described. By providing responses to this survey, I acknowledge that I have received this consent information. Please keep or print a copy of this form for your records.**

Sincerely,

Faith Shafer

## **Appendix E**

### **Informed Consent for Potential MTurk Participants**

The Department of Psychology at Washburn University supports the practice of protection for human subjects participating in research. The following information is provided so that you can decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you may choose not to answer specific questions or exit the survey at any time if you no longer want to participate.

**Project Title:** Attitudes Toward Parents of Children with Cancer

**Principal Investigator:** Faith Shafer

**Contact Information for any Problems/Questions:**

Faith Shafer ([faith.burling@washburn.edu](mailto:faith.burling@washburn.edu))

(785)-670-1964

Henderson 211

**IRB Chair Contact Information:** Marian Jamison, Ph.D., Chair, Washburn University Institutional Review Board. [irb@washburn.edu](mailto:irb@washburn.edu)

**Purpose:** This project aims to examine individuals' beliefs and attitudes related to parents' behaviors toward their children with health concerns.

**Participation:** You will be asked to report your attitudes and beliefs toward a parent's behaviors after reading a brief description of parents and their interactions with their children. The study is expected to take about 30 minutes.

**Benefits Anticipated:** By participating in this study, you may learn about the psychological research process and gain insight into your attitudes and beliefs. MTurk workers will also be financially compensated for their time. Upon completion, you will earn \$3.63.

**Risks Anticipated:** No risks are anticipated beyond what you are likely to experience in your day-to-day life. However, if any questions arouse strong emotions, you may choose not to answer the question(s) or stop participating at any time without explanation.

**Extent of confidentiality:** Your responses will be anonymous. At no time will your personal data be accessible. Your name and identity will not be associated in any way with the research findings—once your responses are entered into a secure statistical program, data will be examined in aggregate, such that no individual's responses will be traceable from the products of this work, such as journal articles and presentations.

**Terms of Participation:** I understand this project is research and that my participation is completely voluntary. I also understand that if I decide to participate in this study, I may withdraw my consent at any time, and stop participating at any time without explanation. However, I understand that I will only be financially compensated upon successful completion of this study.

**I verify that by clicking the button below, I am indicating that I have read and understand this consent form, and willingly agree to participate in this study under the terms described. By providing responses to this survey, I acknowledge that I have received this consent information. Please keep or print a copy of this form for your records.**

## Appendix F Demographic Information

I identify as

- Male
  - Female
  - Transgender
  - Gender Queer/Gender non-conforming
  - I'd rather not say
  - Other (Please specify)
- 

Please enter your age. \_\_\_\_\_

*Note to IRB Committee members:* This will be the only item that participants will be required to answer. If participants indicate that they are younger than 18, their participation in the online study will be automatically terminated.

What is your race/ethnicity?

- White/Caucasian
  - Black
  - Hispanic/Latino/a
  - Asian
  - Native American
  - Pacific Islander
  - Middle Eastern
  - Multiracial
  - Other (Please specify)
- 

Do you have any children?

- No
- Yes

[If Yes]

How many children do you have?

[Drop down box, from 1 to "more than 10"]

## Appendix G

### Debriefing for Washburn Participants

Thank you for your participation in this study. It would not be possible to conduct psychological research without your help. This study examined your attitudes and beliefs about parenting behaviors when a child is healthy or has a cancer diagnosis. Your responses will be anonymously entered into a secure statistical program, and your individual responses will not be traceable from any products of this work, such as journal publications and research presentations.

If you have any further questions regarding this experiment, please feel free to contact the Principal Investigator: Faith Shafer ([faith.burling@washburn.edu](mailto:faith.burling@washburn.edu)).

We understand illnesses can be a sensitive subject and it may cause negative emotions. If you experienced any distress while completing this study, you can reach out to several resources on campus. More specifically, Washburn University offers mental health counseling and assessment services to all students. For more information on available services, contact:

University Counseling Center

Kuehne Hall, Suite 200

[Counseling@washburn.edu](mailto:Counseling@washburn.edu)

(785) 670-3100 <https://www.washburn.edu/student-life/services/counseling/>

Washburn Psychological Services Clinic

Henderson Learning Center, Room 111

(785) 670-1750

**Please do not disclose the research procedures and/or purpose of this study to anyone who might participate in the future, as this could affect the results of the study.** We genuinely appreciate your cooperation and support of our research by keeping your knowledge about this study confidential. Thank you for participating in this study.

## Appendix H

### Debriefing for MTurk

Thank you for your participation in this study. It would not be possible to conduct psychological research without your help. This study examined your attitudes and beliefs about parenting behaviors when a child is healthy or has a cancer diagnosis. Your responses will be anonymously entered into a secure statistical program, and your individual responses will not be traceable from any products of this work, such as journal publications and research presentations.

If you have any further questions regarding this experiment, please feel free to contact the Principal Investigator: Faith Shafer ([faith.burling@washburn.edu](mailto:faith.burling@washburn.edu)).

We understand discussing cancer can be a sensitive subject and it may cause negative emotions. If your participation in this study has brought you any distress, here are some resources for help and support:

**American Cancer Society**  
**24/7 Helpline: 1-800-227-2345**  
**Website: [www.cancer.org](http://www.cancer.org)**

**Please do not disclose the research procedures and/or purpose of this study to anyone who might participate in the future, as this could affect the results of the study.** We genuinely appreciate your cooperation and support of our research by keeping your knowledge about this study confidential. Thank you for participating in this study.