A Reexamination of a Childhood Cancer Stereotype

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Objective: To examine whether young adults have stereotypical beliefs toward children who have been treated for cancer.

Methods: Undergraduate participants read a vignette describing a child labeled either healthy (HL), in remission from cancer and no longer undergoing treatment (RCL), or in remission and still undergoing treatment (RCTL) and rated the child on the Ratings of the Child Questionnaire (ROCQ). Univariate and multivariate analyses of variance were conducted.

Results: Participants rated the HL child more positively than the RCL or RCTL child; the RCL and RCTL child ratings did not differ. Females evaluated the child more positively than did males.

Conclusions: These results support previous findings of a childhood cancer stereotype. However, effect sizes were small, which may indicate a weak stereotype with these specific participants.

Key words: cancer; children; stereotype.

From 1973 to 1988, the incidence rate for childhood cancer increased by 4%; however, the mortality rate for children younger than 15 years of age when diagnosed fell by 38% (Bleyer, 1993). Indeed, the 5-year survival rate for these children was 70% from 1986 through 1991 (Parker, Tong, Bolden, & Wingo, 1996). The increased survival rate has brought psychosocial issues to the forefront as mental health professionals try to understand the impact of cancer survival on children and adolescents (Friedman & Mulhern, 1991). Some studies have found that children treated for cancer have few adjustment problems (Noll et al., 1997; Sawyer, Antoniou, Toogood, & Rice, 1997; Spirito et al., 1990), whereas others have found evidence of less positive self-concepts and possible difficulties in social relationships (Anholt, Fritz, & Keener, 1993; Greenberg & Meadows, 1991; Noll, Bukowski, Davies, Koontz, & Kulkarni, 1993; Noll, Bukowski, Rogosch, LeRoy, & Kulkarni, 1990).

Stereotypes about cancer may be particularly important for adjustment. As suggested by Koocher and Stern (1988), children with cancer may be subject to a process of stigmatization similar to that for adult cancer patients. The general characterizations or stereotypes that people hold about children with cancer may lead to stereotyped expectations about and behaviors toward a specific child with cancer; their expectations and behaviors, in turn, may affect the child's behavior and experience of having cancer. For example, the literature on gender stereotyping (Deaux & Major, 1987) suggests that expectations are important for the display of behavior in a social context. People may respond to individuals based on preconceptions of a person's character; also, people may behave in ways congruent with
another person’s expectations for them (Darley & Fazio, 1980). Given that children treated for cancer may be less attractive (due to physical side effects of treatment) and delayed in their social and academic skills, these characteristics may affect other’s judgments of them.

To discern whether a childhood cancer stereotype exists, Stern and her colleagues (Stern & Arenson, 1989; Stern, Ross, & Bielass, 1991a; Stern, Ross, & Bielass, 1991b) conducted several studies. Stern and Arenson (1989) found that assigning a label of healthy (HL) or in remission from cancer for several years (RCL) to a videotaped child stimulus affected the way undergraduates and medical students rated the child. Children labeled RCL were rated as less sociable, well-behaved, cognitively competent, physically potent, and likely to do well in the future. This stereotype persisted even after providing corrective information for one group of advanced medical students (Stern et al., 1991b). Stern, Van Slyck, and Bielass (1991) also found evidence for a stereotype using a vignette technique with undergraduates.

Two other studies, however, did not find evidence for a stereotype. Orf (1994) expanded on Stern and colleagues’ studies (Stern & Arenson, 1989; Stern & Karraker, 1989; Stern et al., 1991b) by adding a third health label (RCTL: remission from cancer for six months but still receiving treatment) to explore whether a stronger stereotype could be identified. Surprisingly, no evidence in support of a stereotype emerged for any of the health labels. To clarify this unexpected finding, Fischer (1996) conducted a follow-up study comparing the procedures of Stern et al. (1989) and Orf (1994) to see if minor differences between the studies accounted for discrepancies; Fischer also found no evidence for a stereotype.

Both Fischer and Orf utilized the videotape methodology with undergraduates, whereas Stern used this videotape primarily with medical students. With the videotape, all participants respond to a concrete child stimulus who neither looks particularly sick nor different from a typical child (the child model in the videotape was in fact healthy). Participants, particularly undergraduates, may have responded to what they “saw” as a “healthy” child. Indeed, Stangor and Lange (1994) wrote:

When making judgments of group labels, the perceivers’ focus is on the label, and few competing representations will be strongly acti-

The purpose of this study was to clarify disparate findings using a sample of undergraduates. This sample was chosen to maintain comparability with previous studies by Orf (1994), Fischer (1996), and Stern and Arenson (1989). This study used a vignette instead of the videotape. A vignette methodology presents the child stimulus in the abstract. In order for participants to make decisions, they must draw on their schemas of children as well as their schemas for cancer and illness. As in the gender stereotyping literature (Deaux & Major, 1987), these schemas may result in expectations of how the child will behave. This methodology may therefore reveal whether people hold a stereotype, even though the retrieval of such a stereotype in making real-life judgments may be situation- or stimulus-dependent.

We hypothesized that the RCTL-labeled child would be rated more negatively than the RCL-labeled child, who in turn would be rated more negatively than the HL-labeled child. Although not a main focus of this study, based on consistent gender effects found in previous studies (Fischer, 1996; Orf, 1994; Stern et al., 1991b), our expectation was that females would rate the child stimulus more positively than would males.

Method

Participants

Participants for the three phases of this study included 207 undergraduates enrolled in either an introductory psychology or child psychology course at a large Midwestern university. Students received class credit for participation. The Introduction to Psychology course meets a university-wide graduation requirement and is generally representative of the student body. Participants in the three phases of the study included: 36 (19 female, 17 male) in the vignette pretesting, 31 (16 female, 15 male) in the picture pretesting, and 139 (63 female, 76 male) in the main study. Responses from 22 participants were excluded because they provided incomplete
Thus, a considerable number of participants (over 90%) had contact with at least one person with cancer, while around 3% had contact with as many as five people. Mean closeness and contact to people with cancer was high (close to five on a 7-point scale), indicating that many participants had someone close to them cope with cancer. Although our sample consisted of undergraduates, the majority had some personal experience with the effects of cancer.

*Ratings of the Child Questionnaire (ROCQ).* This questionnaire was originally developed by Stern and Karraker (1989) to measure adult perceptions of premature infants and was refined by Stern and Arenson (1989) to measure perceptions of children with cancer as compared to healthy children. The rating scale contains 19 items rated on 7-point Likert scales and can be grouped into eight subscales (Stern & Arenson, 1989). The subscales and their Cronbach alpha coefficients for this study are as follows: Sociability (friendly/shy, happy/sad, and fun to play with/not fun to play with; .73); Cognitive Competence (smart/dumb and attentive/inattentive; .71); Behavior (loud/quiet, well behaved/not well behaved, coordinated/not coordinated; .06); Physical Potency (strong/weak, assertive/passive, fast/slow; .69); Liking (how much the student liked the child, would like to be close to the child, and would like to take care of the child; .85); and Future Adjustment (child is likely/unlikely to adjust well to kindergarten, child is likely/unlikely to adjust well academically, and occupational achievement level the child might attain in the future; .60). Two items (big/little; attractive/not attractive) were analyzed separately because they did not relate strongly to any of the other subscales (Stern & Arenson, 1989). The subscales and their Cronbach alpha coefficients for this study are as follows: Sociability (friendly/shy, happy/sad, and fun to play with/not fun to play with; .73); Cognitive Competence (smart/dumb and attentive/inattentive; .71); Behavior (loud/quiet, well behaved/not well behaved, coordinated/not coordinated; .06); Physical Potency (strong/weak, assertive/passive, fast/slow; .69); Liking (how much the student liked the child, would like to be close to the child, and would like to take care of the child; .85); and Future Adjustment (child is likely/unlikely to adjust well to kindergarten, child is likely/unlikely to adjust well academically, and occupational achievement level the child might attain in the future; .60). Two items (big/little; attractive/not attractive) were analyzed separately because they did not relate strongly to any of the other subscales (Stern & Arenson, 1989). The Cronbach alpha for the total scale in the current study was .88. In addition to the above 19 items, 3 items were included as a method check on the validity of the vignettes, and 1 item was included as a manipulation check.

Alphas were also computed by deleting individual items from the subscales to explore whether the internal consistencies for some subscales could be improved. Alphas improved for both the Future Adjustment and the Behavior subscales when items were removed. Specifically, the alpha for Future Adjustment improved slightly when the occupation item was deleted (.78), and the alpha for Behavior increased markedly to an acceptable level when the item loud/quiet was deleted (.71). Given the poor reliability for the original Behavior subscale (.06), data, responded incorrectly to the manipulation check, or were non-native English speakers. This left 35 participants in the vignette pretesting, 29 in the picture pretesting, and 120 in the main study. Excluded participants were replaced randomly by new participants to ensure proportionate cells in the design. The final 120 participants in the main study included 54 females and 66 males. The mean age of these female participants was 19.8, with 98.1% between the ages of 18 and 25. The mean age of male participants was 19.8, with 98.5% between the ages of 18 and 26. In the main study, 70% of participants were Caucasian, 20.8% were African American, and 9.2% were Asian-American, Hispanic, American Indian, or other. Two participants had been treated for cancer themselves (one male, one female), and both were currently not in treatment. One of these participants was in the HL condition and the other in the RCTL condition. These participants were retained in the analyses for two reasons: (1) one participant was in the HL condition and was unaware of the childhood cancer conditions, and (2) inspection of the data for the other participant revealed no outlying responses. Two participants indicated that they had siblings who had been treated for cancer. One was in the HL condition and one in the RCTL condition. Their data were also retained for the above reasons.

**Measures**

**Demographic Questionnaire.** This questionnaire (Orf, 1994) requested information on gender, age, ethnicity, level of parental education, native language, and experience with cancer. In order to assess experience with cancer, we asked participants the following yes/no questions: “Have you ever been exposed to any information about childhood cancer before this study?” “Have you ever been diagnosed with cancer?” “Have you ever had contact with a child who had been diagnosed as having some form of cancer?” “Have you ever had contact with an adult who had been diagnosed as having some form of cancer?” Participants responding yes to either of the latter questions indicated their relationship to the person with cancer and rated how close they were to the person and the degree of contact with the person on 7-point Likert scales.

Prior to this study 57% of participants had been exposed to information on childhood cancer. Over 80% had previous contact with an adult with cancer, and 43% had contact with a child with cancer. Thus, a considerable number of participants (over 90%) had contact with at least one person with cancer, while around 3% had contact with as many as five people. Mean closeness and contact to people with cancer was high (close to five on a 7-point scale), indicating that many participants had someone close to them cope with cancer. Although our sample consisted of undergraduates, the majority had some personal experience with the effects of cancer.
this scale is highly suspect; therefore, the multivariate analyses were first conducted dropping the Behavior subscale. The analyses were then repeated including the problematic Behavior subscale to allow for comparison with previous studies.

**Procedures**

In each step of the study, participants were blocked by gender and assigned to one of the conditions according to the order of their arrival. All materials were administered by a female experimenter, and all materials (i.e., vignettes, child photographs, and health status labels) were counterbalanced across participants. After reading an informed consent form approved by the Carbondale Committee for Research Involving Human Subjects, participants were asked to read the directions and then complete the questionnaires. Participants could decide not to participate in the study at any time and still receive course credit. Each step of the study did not require more than 20–30 minutes of the participant’s time in order to maximize participant attention. Procedures specific to each step of the study are described below.

**Procedure for Pretesting Vignettes.** Each pretest participant was handed a packet containing four vignettes: two depicting a medical setting and two depicting an education setting (order was counterbalanced across participants). Participants were instructed to read these closely and then fill out the ROCQ and a vignette rating scale following each separate vignette.

**Procedure for Collection and Pretesting of Child Photographs.** Photographs of nine Caucasian children around the age of five (five girls, four boys) were used in this study. Two color photographs of each child were taken: one with the child wearing a cap, and one without the child wearing a cap. Each pretest participant was handed a packet containing the photographs (without caps) with each picture followed by a scale to be used for rating the photographs. Participants were asked to look at each photograph and rate the child before moving on to the next photograph. Photograph order was counterbalanced across participants.

**Procedure for Main Study.** Each participant was handed a packet of instructions and vignettes that differed according to health condition. Each packet contained two vignettes from the same health condition: one depicting a medical situation and one depicting an education situation. Each participant was exposed to only one health condition, and the order of vignette presentation was counterbalanced. Each vignette was accompanied by a picture of a child in order to make the study more ecologically valid. One picture was of a healthy child without a cap and the other was of a healthy child wearing a cap. The child pictured with a cap was assumed to be a more ambiguous stimulus because one could infer that this child was sick since many children treated for cancer may lose their hair due to chemotherapy treatment. The two photographs were of different children who were matched on characteristics during the pretesting phase. Each participant was asked to read the first vignette closely and complete the ROCQ. Participants read and rated the second vignette in the same manner. Following this, each participant was administered the demographic questionnaire. When all materials were completed, a feedback form was given to participants, they were informed of the purpose of the study, and asked to refrain from discussing the experiment with other students.

**Materials**

**Vignettes.** There were two alternate forms of the vignette for each of the three health status conditions in this study. The child in each vignette was named Chris and was not labeled as a boy or a girl. One form of the vignette depicted a child about to receive a flu shot at either a well-child unit (HL) or a pediatric cancer outpatient unit (RCL, RCTL) of a hospital.1 The second form of the vignette depicted a child waiting in a kindergarten classroom while the child’s mother talks to the child’s kindergarten teacher for the upcoming year. The wording of the two vignettes was similar in most respects with the exception of the situation depicted and health status of the child. Two vignettes including differing amounts of detail were pretested. There were two forms (medical or education setting) of each of these vignettes for a total of four vignettes. Pre-

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1Although children in active treatment for cancer do not receive live vaccines, this situation resulted from the RCTL condition added by Orf (1994). Stern and Arenson’s (1989) original RCL condition and the RCL condition in this study describe a child in remission for several years who is no longer receiving active treatment. To our knowledge, no subject asked about this inconsistency in the RCTL condition in the work conducted at our site with 700-plus participants to date, even when participants were specifically asked to comment on the vignettes during pretesting. Whether this may have influenced previous or present findings is unknown. This oversight should be corrected in future research using these scenarios, and its potential implications should be considered when interpreting the present and previous findings.
Results

Two sets of analyses were conducted to address the main hypotheses. First, a 3 (health status: HL vs. RCTL vs. RCL) × 2 (participant gender: male vs. female) × 2 (ROCQ: first vignette vs. second vignette) repeated measures ANOVA was conducted using the total score from the ROCQ as the dependent measure followed by planned comparisons between each pair of health status conditions. Second, a 3 (health status) × 2 (participant gender) × 2 (ROCQ) repeated measures multivariate analysis of variance (MANOVA) was conducted using the seven ROCQ subscales with acceptable levels of reliability (excluding Behavior subscale) as the dependent measures followed by planned comparisons between each pair of health status conditions for subscales with significant univariate results. This analysis was repeated using Stern’s original eight subscales for the purpose of comparison with previous studies. For all analyses, the total sample size was 120 with 40 participants in each health condition. Males and females were represented with equal frequencies across conditions. For each significant analysis, an effect size is provided (partial $\eta^2$). An alpha level of .05 was used for all statistical tests.

Analysis Using Total Score

Both the main effects of health status, $F(2, 114) = 3.83, p < .05$, and participant gender, $F(1, 114) = 8.49, p < .01$, were significant using the total scale score as the dependent measure. The HL child was rated significantly more positively than both the RCL and RCTL child ($p < .05$ for both comparisons). However, the RCL and RCTL child did not differ ($p > .05$). These results support the hypotheses that the RCL and RCTL child would be rated less positively than the HL child but did not support the hypothesis that the RCL child would be rated more positively than the RCTL child. As hypothesized for participant gender, females rated the child stimulus more positively than did males ($p < .01$). Effect sizes for both health status ($\eta^2 = .07$) and participant gender ($\eta^2 = .06$) were small in magnitude. Overall means and standard deviations for gender and health status conditions are presented in Table I.

Analysis Using Seven Subscales With Acceptable Reliabilities

The overall multivariate $F$ using Wilk’s lambda was significant for both health status, $F(14, 216) = 1.88, p < .05$, Wilk’s lambda = 0.79, and participant gender, $F(7, 108) = 5.01, p < .01$, Wilk’s lambda = 0.76. The effect sizes for health status ($\eta^2 = .11$) and participant gender ($\eta^2 = .25$) were small to medium in magnitude. Follow-up univariate analyses for

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HL = healthy label, RCL = in remission for several years label, RCTL = in remission for six months and currently in treatment label.
Total scores on the ROCQ range from 19–131.
Means in the same column that do not share the same subscripts differ at $p < .05$. 

$\eta^2$ indicates the proportion of variance explained by a given effect. The analysis of variance (ANOVA) is a statistical test used to determine whether there are significant differences between group means. In this context, ANOVA is used to compare the mean ratings given to children with different health statuses and to determine if there are any significant differences in how participants rated the children based on their gender. The results of the ANOVA are then followed up with planned comparisons between each pair of health status conditions.
health status revealed that the health status conditions differed significantly for the following two subscales: Sociability, \( F(2, 114) = 5.24, p < .01, \eta^2 = .08 \), and Physical Potency, \( F(2, 114) = 6.79, p < .01, \eta^2 = .11 \). Overall means and standard deviations for these subscales are presented in Table II.

Follow-up planned comparisons revealed that participants rated the HL child more positively on the Sociability subscale than either the RCL or RCTL child \((p < .05)\). The RCL and RCTL child did not differ significantly. Also, the HL child was rated as more physically potent than the RCTL child \((p < .001)\); the RCL child did not differ from either the HL child or the RCTL child. No other significant findings emerged. These findings are in the predicted direction for the hypothesis that the HL child would be rated more positively than the RCL or RCTL child but do not support the hypothesis that the RCL child would differ from the RCTL child.

Follow-up univariate analyses for participant gender indicated that males and females differed significantly on the following subscales: Liking, \( F(1, 114) = 17.17, p < .001 \), Sociability, \( F(1, 114) = 5.64, p < .05 \), Future Adjustment, \( F(1, 114) = 5.06, p < .05 \), and Attractiveness, \( F(1, 114) = 16.83, p < .001 \). The \( \eta^2 \) values ranged from .04 to .13. As predicted, females rated the child more positively on several dimensions than did males.

### Analysis Using Stern’s Eight Subscales

The overall multivariate \( F \) using Wilk’s lambda was significant for health status, \( F(16, 214) = 1.76, p < .05, \) Wilk’s lambda = 0.78, and participant gender, \( F(8, 107) = 4.34, p < .01, \) Wilk’s lambda = 0.75. Effect sizes for health status \( (\eta^2 = .12) \) and participant gender \( (\eta^2 = .25) \) were small to medium in magnitude. Follow-up univariate analyses for health status revealed that the health status conditions differed significantly for the following subscales: Behavior, \( F(2, 114) = 4.72, p < .05 \), Sociability, \( F(2, 114) = 5.24, p < .01 \), and Physical Potency, \( F(2, 114) = 6.79, p < .01 \). The \( \eta^2 \) values ranged from .08 to .11. Follow-up planned comparisons revealed the same results as mentioned above for the Sociability and Physical Potency subscales. For the Behavior subscale, participants rated the HL child more positively than either the RCL or the RCTL child \((p < .05)\); the RCL and RCTL child did not differ. Follow-up univariate results for participant gender produced the same results as outlined above under the seven subscale analysis. Exploratory analyses were also conducted using a modified Behavior subscale (omitting the problematic loud/quiet item). We found no significant univariate effects for the Behavior subscale. The significant univariate results found for the unmodified Behavior subscale in this study may be due to measurement error. Thus, the usefulness of the original scale is highly questionable.

### Exploratory Analyses of Photographs

Exploratory one-way ANOVAs were conducted to investigate whether the child wearing a cap was rated differently than the child without a cap. When comparing ratings on individual items, only 2 of the 19 items on the ROCQ differed significantly. A MANOVA was also conducted to test for a cap \( \times \) health status interaction and was nonsignificant; thus, the presence of a cap did not seem to be a factor in the health status main effect.

### Discussion

This study found evidence for a childhood cancer stereotype for both children labeled as currently receiving treatment for cancer (RCTL) and children labeled as in remission from cancer for several years (RCL). The healthy child (HL) was seen in a more advantageous light than either of the other two children. Specifically, the HL child was rated as more sociable than either the RCL or RCTL child. Also, the HL child was rated more physically potent than the RCTL child. Contrary to expectation, the
RCTL child was not rated more negatively than the RCL child. The above ratings reflect the physical integrity of the child and social interactions. Intuitively, these represent potential problem areas for the child with cancer. Considering the small effect sizes associated with these findings and the work of Orf (1994) and Fischer (1996), this stereotype appears weak when undergraduates are asked to respond to children and may be of lesser significance in an actual setting where another child or situational features may dominate in producing perceptions of the child. However, this study provides tight experimental control, and the results suggest that stereotyping may occur to some extent in actual interactions between adults and children with cancer.

As in previous studies (Fischer, 1996; Orf, 1994; Stern et al., 1991b), these young women rated the children more positively regardless of health status. Women rated the child stimulus as more likable, attractive, sociable, and likely to have better future adjustment than did the young men. This result may reflect the observation that women generally enjoy children more than men do (Orf, 1994).

Our findings using all eight subscales are similar to previous findings by Stern and colleagues (Stern & Arenson, 1989; Stern & Karraker, 1989; Stern et al., 1991b) showing that the HL child was perceived as more sociable and behaviorally mature than the RCL child. However, the Behavior subscale may be suspect due to consistently poor reliabilities. Although somewhat larger, Stern’s effect sizes were similar to those we found. Accounting for the different findings supporting the presence or absence of a stereotype is an intriguing exercise. Findings from this study demonstrate that a cognitive stereotypic schema for cancer exists and is expressed in situations in which person and situation factors are unclear. However, the stereotype may functionally dissipate as person and situation factors become more apparent (e.g., videotape of child playing) (Fischer, 1996; Orf, 1994). As in the gender stereotyping literature (Deaux & Major, 1987), the addition of more specific person and situation factors may reduce the reliance on global stereotypic information when making judgments. Stern et al.’s findings (Stern & Karraker, 1989; Stern et al., 1991b) also fit this model. The use of medical students in Stern and colleagues’ (1989, 1991b) studies may have resulted in a stronger stereotype effect since medical students’ mental representations of patients with cancer might be stronger due to exposure to more devastating aspects of the disease. Thus, their medical-derived schemata may have influenced their judgments of the child stimulus to a greater extent.

Although our study found support for a childhood cancer stereotype, several limitations can be noted. First, the use of an undergraduate sample results in a restricted range of ages and the lack of generalizability to other samples. This limited generalizability may restrict potential clinical applications of the findings. However, although young, undergraduates are a reasonable cross-section of the population and are readying themselves to become adult members of society. Also, as we said earlier, over 90% of these students have had contact with friends, family members, or other individuals who have had cancer. Finally, using an undergraduate sample in this study kept our sample consistent with previous samples. We chose to further examine the existence of a stereotype with undergraduates in order to confirm that one could be found with young adults before extending the research to other samples. The next logical step is to investigate this stereotype in a natural setting with teachers, physicians, and other professionals who work with these children.

Second, the use of a vignette methodology may limit the generalizability of findings to real life situations. Vignettes often appear to be contrived and provide little in terms of information used by individuals in the real world to make judgments of people. Thus, the stereotype effect found in this study may only generalize to situations in which the participant is asked to make abstract judgments of hypothetical children. On the other hand, the vignette paradigm was actually chosen with this in mind since this study was attempting to look at a stereotype in the “abstract.” Finally, the inappropriate use of one scenario for the RCTL condition (i.e., receiving a flu vaccination) should be eliminated in future studies since live vaccinations are not administered to children in active cancer treatment. The influence of this oversight is unknown (see footnote 1).

The ROCQ showed several psychometric weaknesses suggesting the need for some revision. At least one of the subscales (Behavior) has consistently shown poor reliability across studies, and two items have been analyzed as separate subscales since they did not load on any of the multi-item subscales. Also, alphas for two of the subscales in our study improved when items were left out (Behavior and Future Adjustment).
Socially, the implications of this research are that children with cancer may be stereotyped on some dimensions relevant to social interaction (physical potency and sociability in this study) but not on others (likability, attractiveness). Although the differences found in this study were small in magnitude, they are consistent with the magnitude of findings found in other social science research and may have implications for how children are perceived in situations in which little specific information is available and more automatic cognitive processing takes place. Indeed, Stangor and Lange (1994) indicated that even minor automatic processes out of our awareness can have a harmful impact on our decisions and actions. Thus, teachers, parents, and other adults prominent in the lives of these children should be educated that these stereotypes exist and may influence the behavior of peers and adults. This might be even more true if the child has visible long-term physical side effects of treatment or is experiencing psychosocial difficulties. Health care professionals and psychologists can provide advice to parents and families on ways to cope with other people’s reactions to the child. Also, professionals can work to educate other members of the public about the possibility of stereotypes and how these might potentially affect interactions with these children.

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