

This article was downloaded by:[Simons, Laura E.]
On: 28 April 2008
Access Details: [subscription number 792649070]
Publisher: Routledge
Informa Ltd Registered in England and Wales Registered Number: 1072954
Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



Children's Health Care

Publication details, including instructions for authors and subscription information:
<http://www.informaworld.com/smpp/title~content=t775648097>

Initial Development of the Pediatric Camp Outcome Measure

Laura E. Simons^a; Jordan Gilleland^b; Amanda Hubbard McDanel^c; Ronald L. Blount^b; Robert Campbell^d

^a Department of Psychiatry, Children's Hospital Boston and Harvard University Medical School, Boston, MA

^b Department of Psychology, University of Georgia, Athens, GA

^c North Carolina State University Cooperative Extension, Manteo, NC

^d Children's Healthcare of Atlanta and Emory University School of Medicine, Atlanta, GA

Online Publication Date: 01 April 2008

To cite this Article: Simons, Laura E., Gilleland, Jordan, McDanel, Amanda

Hubbard, Blount, Ronald L. and Campbell, Robert (2008) 'Initial Development of the Pediatric Camp Outcome Measure', Children's Health Care, 37:2, 158 - 169

To link to this article: DOI: 10.1080/02739610802006593

URL: <http://dx.doi.org/10.1080/02739610802006593>

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: <http://www.informaworld.com/terms-and-conditions-of-access.pdf>

This article maybe used for research, teaching and private study purposes. Any substantial or systematic reproduction, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

Children's Health Care, 37:158–169, 2008
Copyright © Taylor & Francis Group, LLC
ISSN: 0273-9615 print/1532-6888 online
DOI: 10.1080/02739610802006593



Initial Development of the Pediatric Camp Outcome Measure

Laura E. Simons

*Department of Psychiatry, Children's Hospital Boston and
Harvard University Medical School, Boston, MA*

Jordan Gilleland

*Department of Psychology
University of Georgia, Athens, GA*

Amanda Hubbard McDanel

*North Carolina State University Cooperative Extension
Manteo, NC*

Ronald L. Blount

*Department of Psychology
University of Georgia, Athens, GA*

Robert Campbell

*Children's Healthcare of Atlanta and
Emory University School of Medicine, Atlanta, GA*

The objective of this pilot study was to develop the Pediatric Camp Outcome Measure (PCOM), an instrument designed to assess children's perception of the pediatric camp experience. Fifty-one children completed the PCOM at the end of a 1-week pediatric summer camp for individuals with complex heart defects. Participants also completed measures of anxiety, depression, and quality of life to

Correspondence should be addressed to Laura E. Simons, PhD, Pain Treatment Service, Children's Hospital Boston, 333 Longwood Ave., Boston, MA 02215. E-mail: laura.simons@childrens.harvard.edu

provide support for the dimensions measured in the PCOM. The resultant 27-item, multidimensional instrument demonstrated strong internal consistency estimates for the total scale ($\alpha = .93$) and each subscale (self-esteem, $\alpha = .84$; emotional functioning, $\alpha = .84$; socialization, $\alpha = .89$; physical activity, $\alpha = .80$). Initial support for the utility of the PCOM and the subscales was provided by significant correlations with concurrent measures of depression, anxiety, and general and cardiac-related quality of life. This study provides initial data and support for the use of the PCOM to measure children's responses to pediatric specialty camps.

The psychosocial needs of pediatric populations have been well-documented in the literature. Research has indicated that children with chronic illnesses are at greater risk for developing psychological, behavioral, and social problems compared to healthy controls (Wallander & Thompson, 1995). Therapeutic camps are among the available programs designed to address a number of the psychosocial needs of pediatric patients. The American Camping Association (ACA) outlines several goals for the camping experience including the encouragement of children's "mental, physical, social, and spiritual growth" (ACA, 1997b); enhancement of self-esteem; and development of social skills (ACA, 1997a). The ACA's proposed goals of camp are congruent with areas of concern identified in children with chronic medical conditions (Plante, Lobato, & Engel, 2001). The camping experience is designed to teach children global independence and self-discipline, in relation to both their condition and their life as a whole (ACA, 1998).

The results of research examining the association between improved psychosocial functioning and camp attendance for pediatric populations is promising. Parents have indicated that camp increased their child's self-sufficiency and independence (Powars & Brown, 1990; Primack & Greifer, 1977; Punnett & Thurber, 1993). In addition, parents have observed increases in the frequency of their children's physical and social activities following camp (Smith, Gotlieb, Gurwitch, & Blotcky, 1987). Also, parents identified camping as a method for teaching their children how to cope with new experiences and learn valuable social skills (Powars & Brown, 1990).

Campers have also reported benefits from the camp experience. In one study examining pediatric camps in Ireland, camp outcomes were reported through qualitative evaluations from the children (Kiernan, Guerin, & MacLachlan, 2005). Many campers reported positive outcomes including, "I learnt to listen to others and communicate with them, and learnt to work as part of a team," "I feel I am more adventurous. I am more willing to try things," and "Even though I had cancer, I can still do exactly the same things as everyone else and enjoy myself" (Kiernan et al., 2005). Briery and Rabian (1999) investigated the relation between camps, self-reported attitudes toward illness, and self-reported state-trait anxieties. At the end of the 1-week camps, the children reported more positive

attitudes toward their illnesses and decreased state–trait anxieties. Campers at oncology camps have also reported significant psychosocial improvements on questionnaires after their camp experiences (Meltzer & Rourke, 2005; Wellisch, Crater, Wiley, Belin, & Weinstein, 2006). In addition to benefiting patients, siblings of cancer patients have shown improvements on quality-of-life measures after attending a sibling oncology camp (Packman et al., 2005).

Although parents, siblings, and campers have reported positive outcomes associated with pediatric camps, quantitative measures developed specifically for assessing children's response to camp are rare. In an attempt to address this deficit, Punnett and Thurber (1994) adapted the Child Evaluation Inventory (CEI) for use at a camp for children with asthma (S. Thurber, Snow, & Thurber, 1990). The CEI is a 19-item scale that was originally constructed to evaluate therapeutic progress and the acceptability of individual psychotherapy for children (Kazdin, Esveldtdawson, French, & Unis, 1987). Punnett and Thurber (1994) retained the original CEI items with the substitution of three words for children with asthma to evaluate their camp experience (e.g., How much do you think you learned from camp?; How interesting was camp?).

Forty-six children with asthma (30 boys; 16 girls) between the ages of 10 to 13 years completed the CEI after a 1-week residential camp. Results indicated that campers generally had positive reactions to the camp experience. The scale indicated suitable scale homogeneity with the mean item-total correlation of .57 ($p < .01$), and the alpha reliability coefficient was .91 (Punnett & Thurber, 1994). Although the adaptation of the CEI seems to be a reliable, homogeneous scale that measures overall satisfaction at camp (Packman et al., 2005), it does not indicate specific areas of benefit that are targeted by therapeutic pediatric camps (e.g., anxiety, activity level, self-esteem; Briery & Rabian, 1999; Punnett & Thurber, 1993; Smith et al., 1987).

In a study examining homesickness, the My Time at Camp questionnaire was developed to assess well children's general, social, and environmental satisfaction of camp (C. A. Thurber & Sigman, 1998). The sample consisted of 293 boys, ages 8 to 16 years, who spent 2 weeks at an overnight summer camp. Campers were asked to rate their overall quality of their stay on an 11-point Likert scale ranging from 0 (*terrible*) to 10 (*excellent*) to determine a general satisfaction score. Good internal consistency was found for both multi-item subscales, with a reliability coefficient alpha of .84 for social satisfaction (8 items; e.g., In general, the kids in my *cabin* were . . . ; rated from *terrible* to *excellent*) and an alpha of .73 for environmental satisfaction (7 items; e.g., How did you like living in a cabin in the woods?; rated from *not at all* to *a whole lot*; C. A. Thurber & Sigman, 1998). As noted, the questions from this measure were directed toward general camp satisfaction and did not assess the specific benefits potentially offered by pediatric camps to children with chronic illnesses (e.g., self-esteem enhancing, mood enhancing, increasing physical activity).

Unlike the CEI that measures overall camp satisfaction and the My Time at Camp that measures social and environmental satisfaction with the camp experience, the aim of this investigation was to develop a psychometrically promising instrument specifically designed for measuring the effects of therapeutic camps for pediatric patients. Four rationally determined face valid subscales included (a) self-esteem, (b) emotional functioning, (c) social functioning, and (d) physical activity. It was predicted that higher total scale and subscale scores on the camp outcome measure would be inversely related to poor emotional functioning (e.g., anxiety, depression) and positively associated with quality of life.

METHOD

Participants and Setting

Of the 60 camp attendees, 54 were eligible for inclusion in the study (6 campers who were younger than 8 years of age were excluded due to their lower reading ability). A total of 51 children diagnosed with a congenital heart defect participated, resulting in participation rate of 94%. Participants ranged in age from 8 to 18 years ($M = 12.3$, $SD = 2.6$), and 59% were male. The ethnicity of the sample was 75% Caucasian, 14% African American, 6% Asian, and 5% who did not endorse an ethnicity. With regard to family income, 23% of the families reported earning less than \$30,000 annually, 35% earned between \$30,000 and \$60,000, and approximately 42% earned greater than \$60,000 annually.

Seventy-two percent of the participants were returning campers. Disease severity was assessed by a pediatric cardiologist who reviewed patient charts and assigned disease severity ratings ranging from 1 (*mild*), 2 (*moderate*), to 3 (*severe*) based on criteria that included the following: medication regimen, number and type of previous and potential future surgeries, and frequency of outpatient follow up. The majority of the campers were in the mild (34%) to moderate (49%) range of disease severity, with 17% in the severe range.

The camp was held in a rural area in a facility that was built specifically for children with special needs. The staff at camp included medical professionals and other unpaid volunteers. There were also paid camp employees who assisted with horseback riding, archery, boating, and other activities. The camp is designed for children ages 7 to 18, and there was no charge to the families for participation. Their mission is, "To create a positive life experience for all children with complex heart defects through an educational camping program that promotes: self-esteem, socialization among peers, support from families, and so much fun" (Children's Healthcare of Atlanta, 2001). At camp, children participate

in activities such as swimming, horseback riding, arts and crafts, archery, and mountain biking.

Pediatric Camp Outcome Measure (PCOM)

The main objective in developing the PCOM was to create a quantitative measure capturing children's perceptions of the camp experience. The measure assesses areas of psychosocial functioning (e.g., socialization) that potentially can be addressed at camp. Thirty-nine items were developed to be independently completed by children age 8 years and above. The items were reviewed by pediatric researchers and medical personnel for face and content validity. Their suggestions were incorporated into the scale, which underwent several revisions before being piloted. The measure was administered to a group of healthy children to assess for item clarity and readability. From this administration, 4 items were dropped, resulting in a 35-item measure. The PCOM was designed to be a multidimensional instrument, providing a total scale score and four subscale scores. Children are asked to respond to each question on a 5-point Likert scale regarding their perceptions of camp. The total scale score reflects an overall perception of the camp experience; and the four hypothesized subscale scores reflect social functioning, emotional functioning, physical activity, and self-esteem. Twelve items are negatively worded in an effort to increase the likelihood of valid responding. These items are reverse scored for computing scale scores. Internal consistency analyses were conducted in this study to provide initial psychometric properties for this scale.

Measures of Psychosocial Functioning

Children's Depression Inventory (CDI). The CDI is a 27-item scale assessing self-reported symptoms of depression (Kovacs, 2003). It is designed for school-age children 7 to 17 years old. CDI total *t* score is reported in this study. The CDI has excellent internal consistency, extensive normative data, and correlates positively with self-reported depressive cognitions and negatively with self-esteem (Kovacs, 2003).

Revised Children's Manifest Anxiety Scale (RCMAS). The RCMAS is a 37-item, self-report instrument designed to assess the level and nature of anxiety in children and adolescents from 6 to 19 years old (Reynolds & Richmond, 1985). Children respond to each item by marking a "yes" or "no" response. The RCMAS total *t* score is reported in this study. Reliability and validity are well-established for this popular measure (Reynolds & Paget, 1983).

Pediatric Quality of Life Inventory (PedsQL). The PedsQL is a 23-item measure assessing health-related quality of life in children and adolescents (Varni, 1998). Respondents answer each question on a 5-point Likert-type scale. The total scale score was used in this study. Internal consistency for the total scale score ($\alpha = 0.88$ child) is acceptable (Varni, 1998).

Pediatric Quality of Life Inventory–Cardiac Module (PedsQL–Cardiac Module). The PedsQL–Cardiac Module is a 27-item measure assessing health-related quality of life in children and adolescents living with cardiac conditions across domains of functioning specific to their condition (Varni, Seid, & Kurtin, 2001). The total scale score was used for this study. Respondents answer each question on a 5-point Likert-type scale. Preliminary reliability and validity data comparing the PedsQL with the PedsQL–Cardiac Module demonstrate adequate internal consistency and validity (Uzark, Jones, Burwinkle, & Varni, 2003).

Procedure

All children who attended camp were invited to participate. All aspects of this study were approved by the institution's institutional review board. Packets were mailed to families prior to camp describing the study. Parents and children turned in consent and assent forms and demographic information sheets at camp registration. Participants completed all study measures on the evening of the last day of camp. Psychosocial measures were completed first, and the PCOM was completed last for all participants. All measures were completed at one time, and data was collected at one camp session. Camp staff members monitored administration to maintain reliability and clarify any questions for the campers.

RESULTS

PCOM Item Selection

Each of the 35 original items was examined to determine its contribution to the scale using item-total correlations (delete items with $r < .30$; criteria outlined by DeVellis, 2003). This resulted in dropping 6 items. The internal consistency for the total scale with 29 items was high ($\alpha = .93$). Next, the item-total correlation for each hypothesized subscale was examined. The item-total correlations for all scale items are detailed in Table 1. As noted in Table 2, the internal consistency for the self-esteem subscale with 5 items ($\alpha = .83$), the 8-item emotional functioning subscale ($\alpha = .84$), and the 9-item social functioning subscale ($\alpha = .89$) all demonstrated high internal consistency. The final subscale, physical functioning, consisted of 5 items with adequate internal consistency ($\alpha = .80$).

TABLE 1
The 27-Item Pediatric Camp Outcome Measure Item-Total Correlations

<i>Items</i>	<i>M</i>	<i>SD</i>	<i>Corrected Item-Total Correlation</i>	<i>Alpha if Item Deleted</i>
16. What was it like to play with kids you did not know very well?	3.51	1.10	.765	.927
13. How often did you spend time with your friends at camp?	4.15	1.10	.740	.928
20. How often did you get along with the other kids at camp?	4.10	1.14	.735	.928
5. How often did you feel like you could do the activities the other kids at camp were doing?	3.86	1.25	.710	.928
6. How happy or sad were you at camp?	4.10	.878	.686	.929
12. How often did you feel sad or blue at camp? ^a	4.16	1.05	.681	.929
15. What was it like to make friends at camp?	3.92	1.02	.673	.929
9. How often did you worry about your <i>heart</i> condition at camp? ^a	4.20	1.20	.654	.929
18. How often did you feel you were part of the group at camp?	4.08	1.11	.650	.929
27. How much did you like or dislike camp?	4.27	.961	.620	.929
22. How often did you feel like you had energy at camp?	3.75	1.13	.580	.930
21. How often were you active at camp?	3.90	1.17	.570	.930
24. How often did you exercise at camp?	3.49	1.38	.566	.930
17. How often did you play with the other kids at camp?	4.08	1.29	.566	.930
3. How often were you proud of yourself at camp?	3.96	.979	.549	.930
11. How often did you worry about what the other kids at camp thought about you? ^a	4.20	1.06	.545	.930
14. How often did you have someone to talk to at camp?	4.08	1.21	.527	.931
19. How often did you feel left out at camp? ^a	4.25	.997	.521	.931
4. How often did you like yourself at camp?	4.18	1.07	.506	.931
26. How often did you feel homesick at camp? ^a	3.90	1.15	.492	.931
2. How did you feel about yourself at camp?	4.06	1.14	.486	.931
7. How often were you nervous at camp? ^a	4.02	.969	.479	.931
10. How often were you lonely at camp? ^a	4.25	.977	.467	.931
8. How often did you worry at camp? ^a	4.10	.944	.432	.932
1. How often did you feel like yourself at camp?	4.29	.986	.392	.932
25. How often did you get tired and have to sit down at camp? ^a	3.29	1.15	.346	.933
23. How often did you do sports activities at camp?	3.55	1.22	.325	.934

^aReverse coded for computing full scale. Can replace heart for other pediatric populations.

TABLE 2
Item-Total Correlations for Each Rationally Derived
Pediatric Camp Outcome Measure Subscale

<i>Items</i>	<i>Corrected Item-Total Correlation</i>	<i>Alpha if Item Deleted</i>
Self-esteem ($\alpha = .83$)		
1	.695	.777
2	.629	.793
3	.711	.773
4	.652	.786
5	.486	.841
Emotional functioning ($\alpha = .84$)		
6	.691	.801
7	.569	.814
8	.527	.819
9	.582	.813
11	.563	.814
12	.627	.806
26	.467	.829
27	.509	.821
Social functioning ($\alpha = .89$)		
10	.510	.884
13	.722	.867
14	.565	.881
15	.618	.876
16	.734	.866
17	.585	.880
18	.732	.866
19	.527	.883
20	.773	.863
Physical functioning ($\alpha = .80$)		
21	.760	.703
22	.601	.754
23	.508	.782
24	.657	.734
25	.400	.812

With each subscale established, the resultant PCOM total scale consisted of 27 items with a high Chronbach's alpha ($\alpha = .93$). The sample means and standard deviations for the overall PCOM and each subscale are detailed in Table 2. The possible total scale score could range from 27 to 135. The range of total scores in this sample was 72 to 135 ($M = 107.7$, $SD = 17.9$). The correlations between the subscales were all significant, and ranged from $r = .39$ to $.79$.

Following item selection and calculation of internal consistencies, one-way analyses of variance and Pearson product-moment correlation coefficients were

TABLE 3
Intercorrelations, Means, and Standard Deviations for Pediatric Camp Outcome Measure Scale Scores and Psychosocial Constructs

Variable	1	2	3	4	5	6	7	8	9	M	SD
Camp outcome											
1. Overall camp outcome	—	.75**	.89**	.91**	.71**	-.32*	-.35**	.36**	.54**	107.7	17.9
2. Self-esteem	—	—	.59**	.57**	.39**	-.18	-.30*	.36**	.53**	20.4	4.19
3. Emotional functioning	—	—	—	.79**	.50**	-.32*	-.35**	.40**	.59**	32.9	5.61
4. Social functioning	—	—	—	—	.52**	-.29*	-.32*	.20	.36*	36.4	7.73
5. Physical functioning	—	—	—	—	—	-.23	-.18	.28*	.35*	18.0	4.51
Psychosocial constructs											
6. Anxiety	—	—	—	—	—	—	.29*	-.57**	-.49**	51.0	11.9
7. Depression	—	—	—	—	—	—	—	-.38**	-.42**	49.3	9.61
8. Generic quality of life	—	—	—	—	—	—	—	—	.77**	69.6	18.5
9. Cardiac quality of life	—	—	—	—	—	—	—	—	—	70.5	15.6

* $p < .05$. ** $p < .01$.

conducted to examine for differences or significant correlations between PCOM scores and age, gender, disease severity, and camper status (returning or new camper). No significant differences or correlations were detected for the PCOM scores and these factors.

Results of the correlational analyses between the PCOM total score and subscales and measures of the campers' anxiety, depression, generic quality of life, and cardiac quality of life are displayed in Table 3. Fewer anxiety symptoms were associated with higher PCOM total, emotional functioning, and social functioning subscale scores. Also, fewer depressive symptoms were associated with higher PCOM total, self-esteem, emotional functioning, and socialization scores. Better overall quality of life was positively associated with the PCOM total, self-esteem, emotional functioning, and physical functioning scores. Finally, better cardiac quality of life was positively associated with the PCOM total scores and each of the PCOM subscales scores.

DISCUSSION

The purpose of this study was to initially develop a measure for assessing children's perceptions of the pediatric camp experience. The scale was designed to be multidimensional, emphasizing the psychosocial aspects of camp. The subscales of the PCOM include self-esteem, emotional functioning, socialization, and physical activity. This instrument demonstrated adequate to strong internal consistency for each subscale and the total scale score. The measure was not influenced by demographic factors (e.g., age) or disease severity; this suggests that the child's perception of their camp experience is not necessarily subjective to chronological age or severe disease states. It will be important to examine these same variables with larger samples to determine the stability of these non-significant findings. Significant associations between PCOM scale scores and

well-established measures of child anxiety, depression, and general and cardiac-specific quality of life support the utility of the PCOM. Specific associations between the self-esteem subscale and depressive symptoms and the physical functioning subscale and quality-of-life measures also provide initial evidence of discriminant validity. Creating a measure specific to camp outcome decreases the number of assessment instruments that may otherwise be needed to evaluate the benefits of camp. Further, whereas past camp evaluation measures addressed only general satisfaction with camp (Punnett & Thurber, 1994; C. A. Thurber & Sigman, 1998), the PCOM appears to measure the major dimensions of potential benefit that children may experience as a result of attending camp (e.g., socialization with peers, self-esteem). This assessment measure represents the first psychometrically promising, multidimensional pediatric camp outcome scale in the literature.

Although pediatric camps are available to patients in multiple locations, the positive impact of camp has often been supported by only anecdotal reports (Mosher, 2006; Thomas & Gaslin, 2001). As a psychometrically promising assessment instrument, the PCOM has the potential to foster empirically based research on the value of pediatric camps. Empirical data supporting the utility of pediatric camps could be provided to patients and parents as a recruitment tool, helping to overcome reluctance, over-protectiveness, or other factors that might otherwise hinder enrollment. Further, empirical evidence supporting the value of camps could increase the likelihood that potential donors would financially support ongoing camps and the development of new camps.

Despite the promising psychometric properties of the PCOM, there are limitations in the study that deserve mention. This measure is still in a preliminary stage of development. Administering this measure to larger samples will allow for more complex statistical procedures, such as factor analyses. It is possible that factor analyses will slightly alter the structure of the subscales, as they were rationally derived in this study. The limited sample size in this study is a common obstacle in the pediatric literature. Fortunately, pediatric camps continue to grow in popularity and size each year, resulting in a greater likelihood of obtaining a sufficient sample size to conduct more sophisticated measurement statistics. Finally, this measure was developed with children with complex heart defects; therefore, the generalizability of the PCOM must be tested with other groups of pediatric patients. These issues should be addressed in future research.

Implications for Practice

In addition to calling for further empirically based research on the value of pediatric summer camps, we offer the following suggestions for how the PCOM may be used in practice:

1. The PCOM is a multidimensional instrument for assessing pediatric patients' reactions to participating in summer camps. Data derived from the subscales may be used to inform the development or refinement of camp programs to obtain a greater therapeutic benefit in particular domains.
2. We have observed a range of parental responses to their child attending summer camp, including parental encouragement, hesitance, and prohibition. It is possible that data derived from the PCOM will be helpful in encouraging reluctant parents to allow their child to attend. Empirical results supporting the benefit of attending a local pediatric camp could be disseminated through hospital-based or particular pediatric service-based newsletters to increase enrollment and decrease parental concern. This may facilitate the development of greater self-esteem, psychosocial functioning, and even physical competencies in children who might otherwise miss the therapeutic benefits of camp. Further, providing parents with encouraging data about their own child's reactions to camp may have a general effect of decreasing overprotectiveness in some parents.

ACKNOWLEDGMENT

This study was supported by a grant from the Cardiac Research Committee at Children's Healthcare of Atlanta.

REFERENCES

- American Camping Association. (1997a). *Fact sheet* [Brochure]. Martinsville, IN: Author.
- American Camping Association. (1997b). *Getting the word out, 1997/98 edition* [Brochure]. Martinsville, IN: Author.
- American Camping Association. (1998). *Accreditation standards for camp programs and services*. Martinsville, IN: Author.
- Briery, B. G., & Rabian, B. (1999). Psychosocial changes associated with participation in a pediatric summer camp. *Journal of Pediatric Psychology, 24*, 183–190.
- Children's Healthcare of Atlanta. (2001). *Camp Braveheart* [Brochure]. Atlanta, GA: Author.
- DeVellis, R. F. (2003). *Scale development: Theory and applications* (2nd ed.). Thousand Oaks, CA: Sage.
- Kazdin, A. E., Esveltdawson, K., French, N. H., & Unis, A. S. (1987). Problem-solving skills training and relationship therapy in the treatment of antisocial child-behavior. *Journal of Consulting and Clinical Psychology, 55*, 76–85.
- Kiernan, G., Guerin, S., & MacLachlan, M. (2005). Children's voices: Qualitative data from the "Barretstown studies." *International Journal of Nursing Studies, 42*, 733–741.
- Kovacs, M. (2003). *Children's Depression Inventory: CDI technical manual update*. North Tonawanda, NY: Multi-Health Systems Inc.
- Meltzer, L. J., & Rourke, M. T. (2005). Oncology summer camp: Benefits of social comparison. *Children's Health Care, 34*, 305–314.
- Mosher, R. B. (2006). This is the best life yet—Life at Camp Friendship. *Pediatric Nursing, 32*, 84–87.

- Packman, W., Greenhalgh, J., Chesterman, B., Shaffer, T., Fine, J., VanZutphen, K., et al. (2005). Siblings of pediatric cancer patients: The quantitative and qualitative nature of quality of life. *Journal of Psychosocial Oncology*, 23, 87–108.
- Plante, W. A., Lobato, D., & Engel, R. (2001). Review of group interventions for pediatric chronic conditions. *Journal of Pediatric Psychology*, 26, 435–453.
- Powars, D. R., & Brown, M. (1990). Sickle cell disease. Summer camp. Experience of a 22-year community-supported program. *Clinical Pediatrics*, 29, 81–85.
- Primack, W. A., & Greifer, I. (1977). Summer camp hemodialysis for children with chronic renal-failure. *Pediatrics*, 60, 46–50.
- Punnett, A. F., & Thurber, S. (1993). Evaluation of the asthma camp experience for children. *Journal of Asthma*, 30, 195–198.
- Punnett, A. F., & Thurber, S. (1994). The Child Evaluation Inventory: An adaptation for asthma camp. *Children's Health Care*, 23, 69–74.
- Reynolds, C. R., & Paget, K. D. (1983). National normative and reliability data for the Revised Children's Manifest Anxiety Scale. *School Psychology Review*, 12, 324–336.
- Reynolds, C. R., & Richmond, B. O. (1985). *Revised Children's Manifest Anxiety Scale (RCMAS) manual*. Los Angeles: Western Psychological Services.
- Smith, K. E., Gotlieb, S., Gurwitch, R. H., & Blotcky, A. D. (1987). Impact of a summer camp experience on daily activity and family interactions among children with cancer. *Journal of Pediatric Psychology*, 12, 533.
- Thomas, D., & Gaslin, T. C. (2001). "Camping up" self-esteem in children with hemophilia. *Issues in Comprehensive Pediatric Nursing*, 24, 253–263.
- Thurber, C. A., & Sigman, M. D. (1998). Preliminary models of risk and protective factors for childhood homesickness: Review and empirical synthesis. *Child Development*, 69, 903–934.
- Thurber, S., Snow, M., & Thurber, D. (1990). Psychometric properties of the Child Evaluation Inventory. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, 2, 206–208.
- Uzark, K., Jones, K., Burwinkle, T. M., & Varni, J. W. (2003). The Pediatric Quality of Life Inventory™ in children with heart disease. *Progress in Pediatric Cardiology*, 18, 141–149.
- Varni, J. W. (1998). *The PedsQL measurement model for the pediatric quality of life inventory Version 4.0*. Retrieved July 20, 2006, from www.pedsq.org
- Varni, J. W., Seid, M., & Kurtin, P. S. (2001). PedsQL™ 4.0: Reliability and validity of the Pediatric Quality of Life Inventory™ Version 4.0 generic core scales in healthy and patient populations. *Medical Care*, 39, 800–812.
- Wallander, J. L., & Thompson, R. J. (1995). Psychosocial adjustment of children with chronic physical conditions. In M. C. Roberts (Ed.), *Handbook of pediatric psychology* (Vol. 2, pp. 124–141). New York: Guilford.
- Wellisch, D. K., Crater, B., Wiley, F. M., Belin, T. R., & Weinstein, K. (2006). Psychosocial impacts of a camping experience for children with cancer and their siblings. *Psycho-Oncology*, 15, 56–65.