The Social Implications For Children Attending Children's Health Camps

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Abstract

Three studies are reported which investigated the impact of attendance at health camp on liking by and interaction with peers.

The first study used a group question and answer format to obtain baseline knowledge children held with regard to the nature of health camp and reasons children attend. A majority of children had an accurate understanding of health camp and furthermore, but from an evaluative perspective much of that understanding was negative.

The second study utilized vignettes describing children with different problems (health, behavioral, family) as either attending or not attending health. Attendance at health camp had no impact on liking or difference (from self) ratings. However, the problem type did elicit a significant effect. The child with a behavioral problem children was rated as more different from the self and liked less than the other two target children (with family and health problems) and the control child. From this study it appeared that it was the problem rather than attendance at health camp that resulted in stigmatization, but the hypothetical nature of this study presented some potential limitations, therefore the final study was conducted using actual children.

The final study was conducted 2 weeks prior health camp and 2-3 weeks after the target children returned from health camp. Before health camp the attending children were nominated less often than expected by peers asked to nominate 3 classmates they liked most and nominated more often than expected when peers were asked to nominate 3 classmates they disliked the most. When observed in the playground, the children due to attend health camp were subjected to more negative interactions and fewer positive interactions than matched control children.

Post health camp there was little change in peer nominations, but a marked improvement in observed interactions, with the attending child not significantly different from the control child in interaction patterns, the majority of which were positive.

The findings of the three studies were discussed with reference to the initial question, with a focus on the importance of this research in developing an understanding of the wider impact of children's health camps. Possible limitations of the current research and suggestions for future research were also considered.

CHAPTER 1

Introduction.

The present research examined the social implications (in terms of peer relations), that may arise for children who attend children's health camps. Children's health camps are unique to New Zealand. Their historical development has been from a purely nutritional health camp to an organization coping with a wide range of needs, including health, behavioral, and family problems. The impact and effectiveness of health camps has received no attention, and thus this sets the scene for the overall question considered here: could attending children's health camps have negative social consequences?

Health camps: an historical overview.

Children's health camps were established in 1920 by Dr. Elizabeth Gunn. The initial purpose of the Children's Health Camp movement was to provide nourishment for malnourished children (Tennant, 1994). From a perspective of protection, protecting the child from the world and society in general, health camps grew and have continued to exist in largely the same form until current times. As with any organization, health camps have been influenced greatly by the current societal norms of each generation. This has meant that the focus of health camps has shifted somewhat over the past 75 years, from a focus on health, to one that encompasses the social needs of the society it serves. However, there is still a strong emphasis on 'good' food, 'normal' routines, and 'clean' living (Tennant, 1994).

There are 7 health camps currently operating in New Zealand, all guided by the dictates of the Children's Health Camps Board. The camps usually run for a period of 6 weeks, in which children move into a residential setting and attend an on-site school, thereby maintaining a familiar routine. Currently, children are referred to health camp by the public health nurse who in turn receives referrals from either family members or the child's school. Reasons for referral are various, but tend to fall into one of four broad categories: health; medical; behavioral; and/or home relief (family) with referrals often covering more than one category (Taylor & Baines, 1992). Whilst at health camp, the children have a break from their home environment and participate in programmes designed to educate and help the children with regard to their reasons for referral.

Although health camps have been in existence for many years, there appears to be have been little research undertaken on aspects of health camp. There has been research identifying the demographic elements of children who attend health camp and their subsequent needs (Taylor & Baines, 1992) and research investigating processes, such as referral and follow-up, within the health camp system (Routledge & Johnston, 1984). But from a more person oriented or psychological perspective, such as the potential impact of health camp on children that attend, or the long term impacts of health camp, or the efficacy of health camp in addressing the problem that lead to the referral, no research appears to be available. The apparent lack of research in this area makes for many possible avenues of exploration. The current research was drawn from literature addressing negative social consequences for children that are identified as different or stigmatized. Such literature tends to cover either actual or hypothetical children, and this research combined both methodologies in order to provide a more comprehensive examination of negative social consequences than previously offered.

Furthermore, it was believed the identified gap in research on health camps might offer some valuable insights into the lives of children who attend health camps. Therefore, this research explored the potential social implications arising from attending health camp, in particular whether there were negative social consequences for the children attending, that were independent from the reasons they attended health camp.

Defining socialization.

Before addressing the main thrust of thesis it is pertinent to provide some definition of the central theme. Social interaction is the cornerstone and most strongly defining feature of humanness. The form and quality of social interaction is the result of a continuing interactive transaction between the individual and their environment and the characteristics of all involved (Hinde, 1992; Zahn-Waxler, Ianotti, & Chapman, 1982). From birth, we are almost constantly engaged in interaction with others. The earliest social influence is naturally one's parents or guardians as a model, tutor, and caregiver (Zahn-Waxler et al, 1982), but as a child develops into a more independent entity other socializing influences emerge. Other caregivers, teachers, and particularly other children all contribute to social development.

Peers have a different role in the child's life from other socializing agents and thus offer unique socializing experiences (Bukowski & Hoza, 1989). Child - child relationships are characterized as more egalitarian and based on reciprocity (Bullock, 1992) than other social relations a child has. It is this reciprocal nature that is considered to be of importance in this body of work, as the social exchange derived from reciprocity provides the basis for peer acceptance or rejection.

At this juncture, an important point must be addressed. The term 'peer relations' will encompass both dyadic and group-oriented peer structures, as recognized by Bukowski and Hoza (1989), because both popularity and friendships seem influential in the socialization of a child. Furthermore, the term 'friendship' will be based on the conceptualization offered by Smollar and Youniss (1982), that in middle childhood (aged 8-11) friendship is based on interactions with others, and a friend is with whom a child has positive interactions.

Socialization in middle childhood.

In the middle childhood years there are many aspects of socialization to consider. It is important to develop an understanding of where, who, and what contribute to a child's socialization. Perhaps one of the most predominant forces in the socialization of children is the school environment (Ladd, 1992). The role of the school in shaping the child in all aspects of development is widely acknowledged (French, 1990; Ladd, 1992; Mullen, 1983). Schools are replete with socialization opportunities, from interaction with teachers to the relationships developed in the classroom and the playground. In the middle years of childhood then, school is where the majority of socialization experiences are likely to occur.

The question of who contributes most to a child's social development at this age can be answered by looking at where their development is most prolific. As a child becomes increasingly involved with school, friendships with other children develop. Children, themselves, regard the development and maintaining of friendships as one of their most significant achievements (Hartup, 1992b). From as early as 3 years children begin to segregate on the basis of gender (Lockheed & Klein, 1985) thus children choose friends who are the same sex as themselves.

This pattern continues and is undoubtedly reinforced in the middle childhood years as the structure of children's lives at this age tends to be horizontal, for example: the proximity of same age, same sex children in classrooms (Epstein, 1989; Hartup, 1992a). Other patterns also emerge in school based peer relations. Of note, is the tendency for well liked children to end up together in larger social networks whilst disliked children also end up together, but in smaller groups (Hartup, 1992a).

"Children's relations with one another are necessities in social development, not mere niceties." (Hartup, 1992a; p258). The aspects of development, or the 'what', that are important at this age are identified by Chazan, Laing, and Davies (1994) as the achievement of increasing personal independence and self reliance, the acquisition and consolidation of physical skills, success in basic school subjects, the development of psychological understanding, learning how to interact with peers, and learning to conform to social rules. The function of friendships, within the context of these developmental tasks, can be seen as facilitating the elaboration or acquisition of these social skills and also as an information source regarding the self, others, and the world around (Hartup, 1992b).

For some children however, the above skills can be difficult to acquire, as their interactions with their peers are negative rather than positive. Negative social interaction can occur in a variety of contexts. For example, children who engage in aggressive behaviour with others are less likely to be socially accepted by their peers (Coie, Dodge, & Kupersmidt, 1990) and at the same time, children who are rejected by their peers are more likely to be aggressive (Asher & Dodge, 1986). Socially isolated children are also likely to have less positive socializing

experiences as they engage less in them overall (Whitehall, Hersen, & Bellack, 1980).

In the above examples, the peer problems children face may not be a caused by their identified problem, rather they may be an indication that the child has an ongoing inability to socially adapt to their environment (Campbell, & Cluss, 1982), indeed research suggests that socially rejected children possess inadequate social skills (Price & Dodge, 1989). Thus, there could be a certain circularity to be observed in children's peer relations and social interactions that must be acknowledged. This self perpetuating cycle of interaction may mean that children who are rejected, adapt their behavior according to the treatment they expect to receive from others. They thereby, fulfill the role they were initially rejected for and again are rejected accordingly.

The consequences of poor peer relations may be far reaching as longitudinal research suggests such relationships are a risk factor for poor social development and emotional adjustment in later years (Cowen, Pederson, Babigian, Izzo, Trost, 1973; Coie, Christopoulos, Terry, Dodge, & Lochman, 1989; Asher and Parker, 1989; Hartup, 1992a). For example, low acceptance and aggressiveness have been found to be predictive of dropping out of school and later criminality (Parker & Asher, 1987). Indeed, aggressiveness is well identified as a risk factor for later problems such as delinquency and criminality (Robins, 1993). Therefore, the need to understand poor peer relations and their possible causes or correlates becomes apparent.

The more immediate effects of being disliked, as identified by Hartup (1992a), are the modification of a child's behaviour in accordance with the treatment they

expect to receive (self perpetuating cycle of behavior); a decline in self esteem and an increase in social alienation; diminishing opportunities for positive social contact or the development of intimacy; and the development of relationships with other similarly disliked children. All of these potential problems are an important consideration in this research, as they essentially refer as a whole to the issue of negative social interaction.

Negative stereotypes and stigma.

It has been found that negative labels, such as behavior problems or learning disabled (Milich, McAninch, & Harris, 1992) or attention-deficit hyperactivity disordered (Harris, Milich, Corbitt, Hoover, & Brady, 1992), can lead to stigmatization. As negative social behaviour is likely to lead to negative labels, then it follows that negative social interaction may also leave any individual open to stigmatization. Understanding stigma first requires a conceptualization of negative stereotyping, as the two are integrally related. Stereotypes are "...oversimplified, rigid, and generalized beliefs held about groups of people..." (Harre & Lamb, 1986; p347) which are generalized to all members of that group as their defining characteristics. Stereotypes can be a valid and even accurate way of processing information about people (Smith & Mackie, 1995). They can however, also lead to prejudice, when stereotypes held about individuals create a negative affective response to such individuals. Leading on from the affective reaction, is the behavior of the individual towards a member of a group that is negatively stereotyped. Discrimination, rejection and or isolation may all result from prejudice, and it is these behaviors that constitute the effects of being stigmatized, hence the inter-relation of negative stereotypes and stigma.

Tajfel's (1981) social identity theory can also contribute to an understanding of stigma. He proposes that individuals derive their sense of self in accordance with their membership in certain groups. Furthermore, an in group, out group perception develops as a result of this. Individuals prefer to regard themselves in a positive light, and thus, members of out groups are less positively viewed as has been demonstrated in previous research on this phenomenon (Vaughan, Tajfel, & Williams, 1981; Vaughan, 1988; Abrams, Jackson, & St Claire, 1990). The difference that is observed in out group members may be partly why stigmatization occurs.

To be stigmatized is to be seen by others as having a spoiled identity (Goffman, 1963: cited in Devine, 1989). A working definition of social stigma for this thesis, is that it denotes attributes that are socially unaccepted (Katz, 1981). To be stigmatized may manifest in poor social relations, such as being socially isolated or even actively disliked.

Two possibilities, which are potentially interlinked, emerge with regard to children attending health camps. One, is that the problem or reason the children are referred to health camp may be stigmatizing, as the reasons identify the children as being different. The second possibility is that by attending health camp the children are further differentiated and thereby more stigmatized. The notion of circularity and the self-perpetuation of stigma again arises, certainly being different may lead to be treated negatively by ones peers, but the response of the stigmatized individual may be that they expect to be treated poorly and behave accordingly.

The concept of stigma has been widely studied, especially with regard to the potential ongoing consequences of stigmatization. For the purposes of this research, the studies reviewed are based on the experiences and or effects of being stigmatized as a child. Negative attitudes can be expressed as early as the preschool years (Sigelman, 1991). There are possible lasting effects of being stigmatized from such an early age that warrant investigation. Rest and Watson (1984) considered the stigmatizing effects of foster care. They found that as an adult, children that had been in foster care and were stigmatized as a result of this, experienced an ongoing impaired self image. This may be especially relevant in this research, given that the children in question do attend a form of residential placement, albeit for a relatively short period.

The type of problem a child has and whether they are perceived as responsible for it, is an important indicator as to the level of acceptance or rejection they are going to experience. In research by Sigelman and Begley (1987), examples of children that were obese, learning disabled, wheelchair bound, and aggressive were used to examine stigma. It was found that the nature of the problem a child had, influenced the level of stigma the child experienced, with aggressive children receiving the least positive response in that they were held more responsible for their problem and evaluative responses were more negative. In instances where the problem was presented as uncontrollable, for example, the problem was not their fault, the target children received more positive evaluations, although again the type of problem had an effect. In later work, Sigelman (1991) again found that low responsibility information reduced the tendency to blame the victim, but didn't find that this altered the affective response to the target child. With regard to

this research, it was believed that the different problems children who attend health camp have, were likely to elicit different levels of acceptance.

Further issues of controllability have been addressed in research on obesity, which as external condition is immediately visually accessible. DeJong (1980) found that if an obese target could not offer a reason for the obesity, they were less liked than a normal weight target. However, obesity as a stigmatizing condition per se has not yet been empirically supported (Jarvie, Lahey, Graziano, and Framer, 1983). Jarvie et al also draw attention to the intrusive and artificial nature of the methodologies utilized in many studies and suggest a combination of both experimental methods and naturalistic observation, a point to be taken into consideration in this research.

More obviously uncontrollable problems, such as disability and or chronic illness, have also been explored with regard to their relationship to stigma. Sigelman and Begley (1987) found a wheelchair bound child was liked most of the four problems they presented to children in their study, however, they did not have a control "normal" child and so it is difficult to conclude stigma on that basis. Nevertheless, earlier work by Richardson (1970; 1971) looking at stigma associated with disability has found that disabled children are liked less than able bodied children. Similarly, illnesses have also been found to be stigmatizing. Potter and Roberts (1984) presented children with vignettes regarding two illnesses, diabetes and epilepsy. Two interesting findings emerged: the observability of an illness had an effect on liking, that is, epileptic children were less accepted; and the more information a child was given regarding the target child and their illness, the less they were liked.

Another potentially stigmatizing childhood problem is being labeled learning disabled. Milich et al (1992) review the literature concerning this label and the resulting stigma. There is found to be a consistent stigma attached to children with negative labels which leads to poor peer relations. Not only is there the potential that a learning disabled child will be stigmatized for their disability, but they may also be stigmatized as a result of the special help, or special education they receive (Dowling, 1985). This relates well to the current research, as going to health camp is intended to be a positive break for children, but it could be regarded as special help or intervention, highlighting the problems they already have and exacerbating any existent stigma.

Related to Hartup's (1992a) notion that children who are disliked will modify their behavior accordingly, Milich et al (1992) found an expectancy effect occurring for disliked children, whose behavior contributed to the maintenance of negative relationships with others. This point is pertinent to this research, as the children that attend health camps participate in programmes designed to improve their problems. If an expectancy effect exists for these children, this may mean that any improvements in behavior lead to improved peer relations. Harris et al (1992) further consider expectancy effects in relation to behavior problem children. Comparing the interactions of boys in a no expectancy condition with those in a condition who had been told their partner had behavior problems, specifically describing behaviors that fit into attention-deficit hyperactivity disorder (ADHD) categorization, it was found that perceived ADHD children were treated less positively than the control children. Harris and colleagues, also provided further support for expectancy effects, in that children labeled ADHD, regardless of whether they were or not, had a less enjoyable interaction and liked their partners less also.

All of the aforementioned stigmatizing conditions offer valuable understandings on the nature of stigma as experienced by children. Many of these are particularly relevant to this research as they broadly refer to many of the reasons children are likely to attend health camp, such as behavior problems and illness, both mental and physical. It would seem a strong in-group, out-group perception exists from an early age, and that the stereotypes and associated stigmas so prevalent in the adult world permeate the lives of children also.

The present research

As indicated, children who are thought of as different often experience stigma. Furthermore, children who have different needs from the norm, often come into contact with social organizations and authorities designed to help them in some way. Children's Health Camps are unique to New Zealand, and given this, and also further given, that the reasons children attend may be viewed as negative in themselves, it seems possible that all children regardless of their reasons for attending health camps may be generalized into a stigmatized position by their peers, whose understanding of health camps may be limited to the negative evaluative perceptions they associate with health camp. This leads as the rationale for the ensuing studies. It is believed that the studies outlined below, were unique and therefore offered a new area of possible understanding in children's peer relations in a unique New Zealand environment.

Three studies were conducted which aimed to explore children's perceptions of health camp and whether stigma was attached to children who attended health camp. The first study established the baseline knowledge held by children with regard to children's health camps.

The second study examined whether children who attended health camp were stigmatized as a result of doing so. This study utilized vignettes to portray children with different problems and either health camp attendance or non-attendance. Questionnaires assessed liking and perceived difference across the two main variables and their interaction.

The final study evaluated the same question as Study 2: does attending health camp lead to stigma, however as a complement to the former study, actual children about to attend health camp and their peers participated. A further question of whether there would be any change in interactions after health camp was also examined in post health camp follow-up. The methodology employed in this study was same sex peer nominations and observation of target and matched control children in the playground.

CHAPTER 2.

What is a Health Camp: Establishing the baseline knowledge held by children regarding health camps and why children attend.

Abstract

Fifty nine 9 and 10 year old children participated in this study. The primary aim was to examine the extent of knowledge a cross section of children had about children's health camps. It was predicted that there would be some knowledge, and that this would predominantly be a negative conceptualization. Three-quarters of the responses regarding the what health camps were and why children attend were accurate. However, a negative evaluative perception was found to be prevalent with 70.37% of all responses phrased negatively. These findings are discussed as a rationale for further research in this area, and the implications of a negative perception of health camp are also considered.

Introduction

To begin it is important to reiterate the important concepts and issues mentioned in the main introduction. The establishment of children's health camps was pioneered by Dr. Elizabeth Gunn. At that time she was witness to an increasing number of malnourished children and the health camp movement was primarily established to provide nutritional health care, or rather a nutritional boost, for these children (Tennant, 1994). As such, then, health camps were established to provide help to children in need. While still following these guidelines, the role of

health camps has changed to encompass the broader social needs of present society. The most common current reasons for referral are behavioral, home relief (family), health, and medical (Taylor & Baines, 1992), with the aim of health camp being to provide a break for the child and their family, and to address referral reasons through programmes participated in at health camp.

Although health camps have existed for over 75 years and were established for positive reasons, there is a tendency for adult evaluations of health camp to be largely negative, a common criticism being that the child is removed from home only to be returned 6 weeks later to the same environment (Woods & Gasteiger, 1996). It is believed that the contribution of health camp is often undervalued (Tennant, 1994; Woods & Gasteiger, 1996), and it may be that the reasons children attend could be considered in a more positive light such as a positive break from their current environmental situation.

In order to address perceptions of health camp, it is important examine those that children, who might attend or know another attending child, may develop. Of particular interest, is how much knowledge they have of health camp and what the essence of that knowledge is. The purpose of this study therefore, was to determine the baseline knowledge children aged 9 -10 years old had with regard to children's health camps.

Negative perceptions of health camps and the children who attend them raise the possibility of stigmatization of children attending health camp. Studies 2 and 3 of the present research investigated this possibility, but any claims that attendance at health camp leads to stigma were predicated on children having some knowledge of health camps and holding negative views of them. Therefore, developing a sense of the level of understanding and the form in which it occurred was

essential. It was not known whether children surveyed would know what a health camp was, but given the prevalence of negative attitudes to health camps amongst adults (Woods & Gasteiger, 1996), it was felt that if they did know, then what they knew might be negatively conceptualized. Thus it was predicted that children, if aware of health camps would hold negative perceptions about them and the children that attend.

Method

Participants:

Using a taxonomy devised by Taylor and Baines (1992), which classified schools on the basis of the number of health camp referrals made each year, a cross-section of schools was approached to participate in this study. One school from the 'many' category (over 40 referrals); 2 from the 'medium' category (20-40 referrals); none from the 'some' category (5-20 referrals); and 3 from an additional 'none or few' category, (consisting of schools not on any of Taylor and Baines aforementioned categories) were involved in this study.

Fifty nine children (33 females and 26 males) from classes in the schools selected volunteered to participate in the study. They were in Year 5 in Christchurch, New Zealand primary schools, and aged 9-10 years.

Procedure:

Verbal consent was first obtained from the children invited to participate. Those that indicated consent were given letters to take home to their parents / guardians seeking their permission also (See Appendix 1). Only those children who indicated consent and who obtained written consent from their parents/guardians completed the study.

In small groups within each school involved, the children were asked three questions about health camp. This was in a group format with the researcher directing the questions verbally to the group as whole. The children's responses were tape recorded.

The questions used by the experimenter to direct the dialogue were *"Do you know anyone who has been to health camp?"*, *"What is a health camp?"*, and *"Why do you think children go to health camp?"*.

The children were debriefed at the end of the session and thanked for their participation.

Results

Inter-rater reliability.

Two raters coded the data to ensure inter-rater reliability. All responses were recorded as either positive or negative in content, based on the overall 'sense' of the statement. They were then further classified into three categories which were a modification of those identified by Taylor and Baines (1992) as the most common referral reasons: behavioral; family; health (encompassing medical). Reliability was found to be high at 95%, with any disputes discussed until agreement was reached.

Do you know anyone that has been to health camp?

In three of the schools surveyed all the children knew someone who had been to health camp, but at one of the 'none or few' category schools there was no knowledge of anyone that had attended health camp, thus 74.58% of those surveyed knew a person that had attended.

What is a Health camp?

Of the 59 children surveyed there seemed to be reasonably accurate knowledge of what a health camp was. Accuracy was defined as knowing the basic structure or tenets of health camp. Thirty children gave responses to this question, 76.67% of these indicated an accurate understanding of what health camps were. The remaining responses tended to have some idea, but with some confusion of what a health camp might be, with suggestions that it was a place where children went who "...eat too many lollies...", to being a place where "...children go to live after divorce...".

Why do children go to health camp?

There were 37 spoken responses to this question. The reasons that the participants gave for attending health camp often fitted into the three main reasons for admission, behavioral; family (home relief); and physical health. For example, one child suggested that health camp was for "...people who have bad asthma...". There was another suggestion that health camp was a place children went if "...they need a break from their family..." and there were a number of children who believed health camp was for "...bad children...". these three types of responses accounted for 83.93% of all reasons given. Within this figure, health problems were mentioned least (19.64%), next were behavior problems (28.57%), and family or home relief issues were most often cited (35.71%).

General Perceptions

The two questions that asked for the children's thoughts and beliefs, *"What is a health camp?"* and *"Why do children attend health camp?"* were collated to give a total of 67 perception responses. A higher percentage of negative responses

(70.37%) over positive responses was found, thus indicating children may have negative perceptions of health camps and the reasons children attend.

Discussion

It was predicted that if there was some knowledge of health camp, the evaluative perceptions would be predominantly negative. The data supported this hypothesis, with the majority of those questioned knowing what a health camp was, but also holding negative evaluative perceptions regarding the reasons children might attend.

This is not surprising, given that many of the reasons for referral may reflect negatively on a child or their family. However, to reiterate an earlier point, negative labels can lead to stigmatization (Milich et al, 1992). Accordingly, this finding does raise the issue of whether such a negative perception of health camps may engender stigma as a result of health camp attendance, regardless of the reason for attending.

As a pilot exploration study upon which studies 2 and 3 were to be based, it was felt that this study provided the justification for further research examining whether there may be a stigma attached to going to health camp for the children that attend. The subsequent studies are covered in chapters 3 and 4 and cover both hypothetical and actual children attending health camps.

CHAPTER 3

Hypothetically Speaking: Could attendance at Health Camps have negative social effects?

Abstract

This study sought to determine whether attendance at children's health camps influenced the extent to which children with behavioral, health or family problems were liked by their peers. One hundred and thirty 10 and 11 year old children read a vignette about a child with one of the specified problems who either did or did not attend health camp as a consequence of that problem. They then rated the extent to which they thought they would like the target child and the extent to which they thought the target child was similar to themselves. No significant differences were found in liking ratings between attendance and non attendance, however the type of problem in the vignette yielded different levels of liking, with children with behavioral problems liked least. The more different from the self the target child was perceived to be, the less they were liked, with children with behavior problems considered to be most different from the self. The implications of these findings for future research are considered.

Introduction

The previous study established that most children (aged 9-10), regardless of the category for health camp admissions into which their school fitted (Taylor & Baines, 1992), had an understanding of what a health camp is and that much of this understanding was conceptualized within a negative framework. This leads to

the possibility that negative perceptions of children that attend health camps, regardless of their accuracy, could lead to such children being stigmatized beyond, that is, any stigmatization that results from the reasons they attend.

As previously mentioned the effects of stigma can have potentially negative long term consequences, especially when one considers children and their experience of stigma. The stigma associated with obesity (Jarvie et al, 1983), physical disability (Richardson, 1970), medical problems (Potter & Roberts, 1982), and aggressive or behavior problems (Harris et al, 1992, Sigelman & Begley, 1987) leads to children with these problems being liked less by their peers. Negative peer relations are in turn, considered a risk factor for later social maladjustment (Parker & Asher, 1987; Coie et al, 1989; Hartup, 1992a).

The current study, then, was developed to explore the potential occurrence of stigma for children attending health camp given the negative perceptions found to be surrounding these institutions in Study 1. The methodology employed was vignettes followed by questionnaires, both widely used in research with children (Potter & Roberts, 1984; Sigelman & Begley, 1987). These allow the child to read or hear about a hypothetical child, usually described as similar to themselves but with the addition of the problem in question. These may be useful for a number of reasons. It allows a simple manipulation in the classroom, without the child being subjected to an intrusive experimental manipulation. In asking the children to imagine how they would feel about a hypothetical child one enters a world children are often at ease; that of the pretend. It also objectifies the subject matter as the child does not have to think about another child they know and contend with the subjectivity of their past experience with that child.

This study used vignettes to describe a child similar to those that might attend health camp. The problems they were described as having were expected to be stigmatizing in themselves, to varying degrees. The addition of a sentence explaining the child was to attend health camp examined stigma as a result of health camp attendance over problem. These were followed by questionnaires measuring the degree of liking and difference. Liking was taken to directly assess the question of peer acceptance or rejection. The difference measure was included as findings in research based on Tajfel's (1981) social identity theory suggest persons viewed as similar to the self, in-group members, are treated more positively than out-group members (Vaughan et al, 1981; Vaughan, 1988; Abrams et al, 1990).

It was predicted that children attending health camp would be liked significantly less than those not attending. This would be most readily observed in a planned comparison between attendance and non-attendance in the control child who was described as having no problem. Following the findings of Sigelman and Begley (1987), it was also predicted that of the vignettes, the behavioral problem child would be liked least of all the children. Finally, it was predicted that the more similar the child was perceived to be to the respondent the higher liking ratings would be with children attending health camp perceived as more different.

Method

Participants:

The schools that were approached in Study 1 were concurrently invited to participate in this study. One hundred and thirty children (69 females and 61

males) in Year 6 in Christchurch primary schools volunteered to participate. The children were 10-11 years old.

Design:

A 2 (Health Camp: Attending / Not attending) x 4 (Problem: family / behaviour / health / control) factorial design was utilized in this study.

Stimulus Materials:

Eight vignettes were created, based on previous research with children on stigma (Potter & Roberts, 1982; Sigelman & Begley, 1987). Reasons for referral to the local Health Camp fit into four general areas: health, medical, family, and behavioral (Taylor & Baines, 1992). For this study health and medical were combined to form one category. Hence, vignettes were developed that focused on a child with either health, family, or behavioral problems. A control vignette was also constructed about a child with no apparent problems. The vignettes each described a boy, Dylan, aged 9 years old. In each vignette, Dylan's problem was explained and specific examples of problem behavior given. For example, the vignette for the behaviour problem was as follows:

> *Dylan is a nine year old boy. He is just like you, except that sometimes he gets really angry and is very naughty. Sometimes he hits other kids and even his teacher. He ran away from home once and often stays out way past his bedtime.*

In the attending health camp versions of the vignettes the phrase, "Because of this Dylan is going away to stay at health camp for six weeks.", was added to the end of the vignette (See Appendix 3 for copies of the vignettes).

Seven questions formed the questionnaire that followed the vignette. These questions addressed the extent of liking for the target child, and the perceived difference between the hypothetical child and the respondent. The questions were developed with reference to previous research on liking (Potter & Roberts, 1982; Sigelman & Begley, 1987). The first 5 questions assessed actual liking, for example: *"How nice is Dylan?"; "How much do you want to be Dylan's friend?"*. The final 2 questions directly asked for perceived levels of difference: *"How different is Dylan from you?"*. The questions were responded to on a 5 point Likert Scale (1 - 'not at all; 5 - 'very much'). See Appendix 4 for the full list of questions used.

Procedure:

Verbal consent was obtained from the children invited to participate. Those that indicated consent were given letters detailing the nature of the study to take home to their parents/guardians seeking their permission also (See Appendix 5). Parents/guardians who did not consent to their child participating returned a form indicating thus.

The children were randomly assigned to one of the eight vignette conditions, with approximately equal proportions of males and females in each condition. Before the children completed the study, two issues that might influence the results were attended to. First, the Likert scale used in the questionnaire was explained in detail to the children to counter any difficulties with comprehension. The explanation used an innocuous question: *"How much do you like cabbage?"*, followed by a detailed explanation of what each number in the scale might mean in relation to the question, to convey the intention of the scale. This ensured that all the children

understood how to use the scale before they completed the study. Second, the children were told that even if they were a girl, they may be reading a story about a boy, or if they were a boy, they may be reading a story about a girl and they were to think of the child they were reading about as just another child, just like themselves.[1] The children then read the vignette and completed the questionnaire.

At all times the researcher was present to answer any questions or difficulties the children had regarding understanding the vignette and scale. The children were fully debriefed and thanked for their participation at the conclusion of the study.

Results

Liking ratings

One question was reverse coded so that, for all questions, a higher score represented greater liking. The five questions were tested for internal consistency using Cronbach's alpha. An alpha score of 0.81 was obtained, indicating a high level of consistency across the questions. Accordingly, responses were summed across the 5 questions to produce an overall liking score (possible range 5 - 25). See Table 1 for mean scores of liking for attending and non-attending children.

Table 1. Mean liking score for hypothetical children based on problem type and health camp attendance.

	Behavioral	*Family*	*Health*	*Control*
non-attending	7.44	17.63	17.18	15.78
attending	8.94	18.38	16.19	16.00

[1] Although all vignettes were about a boy, it was felt this knowledge might be a complicating factor, in that at this age children tend to have same sex friends and often hold negative attitudes towards cross sex peers (Daniels-Beirness, 1989).

A 2 (health camp: attending / not attending) x 4 (problem: behavioral / family / health / control) factorial analysis of variance (ANOVA) was conducted on the overall liking score. A main effect of problem was found, $F(3, 122)=53.83$, $p<0.0001$. Post-hoc tests (Fisher PLSD, $p<0.05$) showed the child with behavioral problems was liked significantly less than the children with family problems, health problems, and no problems (Ms=8.19, 18.00, 16.69, and 15.88 respectively). It was also observed that the family problem child was liked significantly more than the control child (Ms=18.00 and 15.88 respectively).

There was no significant difference found between those vignettes that mentioned health camp attendance, and those that did not. Furthermore no interaction effects were observed between health camp attendance and non attendance and overall liking score.

As a pure test of the effect of health camp attendance, a planned comparison was conducted for the control child (attending vs. non-attending), but this revealed no significant difference.

Perceived levels of difference:

The two questions were tested for internal consistency using Cronbach's alpha. An alpha score of 0.80 was obtained, indicating a high level of consistency across the questions. This meant the more different from the self the target was perceived to be, the more different from other children they were also thought to be. The two questions were collated and one score of 'difference' obtained (possible range 2-10) . See Table 2 for mean scores of difference for attending and non-attending children.

Table 2. Mean difference score for hypothetical children based on problem type and health camp attendance.

	Behavioral	*Family*	*Health*	*Control*
non-attending	7.75	6.50	6.13	6.06
attending	8.06	7.56	6.94	6.00

A 2 (health camp: attending / not attending) x 4 (problem: behavioral / family / health / control) factorial analysis of variance (ANOVA) was conducted on the overall difference score. A main effect of problem was found, $F(3,121)=4.78$, $p<0.01$. Post-hoc tests (Fisher PLSD, $p<0.05$) revealed the children with behavioral problems were thought of as significantly more different from the self than the children with health problems and the control children (Ms=7.91, 6.55, and 6.03 respectively). No interaction effect was observed between health camp attendance and problem type on the scale of difference.

Pearson's product moment correlations between difference and liking revealed a significant negative correlation. The more different to the self target child was perceived to be, the lower overall liking score for that child, $r = -0.218$, $p<0.05$.

Discussion

It was hypothesized that children who attended health camp would be liked less than children with the same problems who did not attend health camp. The results offered no support for this hypothesis, there was no significant difference between the liking ratings of children who attended health camp and those that did not. However as expected, there was a significant difference in the liking ratings given for the problems, with the behavioral problem child liked significantly less than the other three children. In contrast to the hypothesis, a positive

discrimination was found in that the child with family problems was liked more than the control child.

Finally, the hypothesis that children who were considered more different from the self would be less liked was supported, with children with behavioral problems perceived as most different and liked least. Health camp attendance, again, had no effect on difference measures.

The finding that children with behavioral problems were less liked than other children is consistent with previous research which has demonstrated that children with behaviour problems are liked less than those with physical disabilities, learning problems, and controls (Sigelman and Begley, 1987; Harris et al, 1992). That children with behavior problems were also thought to be most different and concurrently liked least is in accordance with social identity theory which postulates intergroup discrimination occurs (Tajfel, 1981). These findings coupled with the lack of difference between attending and non-attending conditions leads to the conclusion that it is possibly the problems that are stigmatizing, not health camp attendance per se. Considering this finding, it would seem there is a potential positive impact of health camps in reducing stigma, by improving the extent of the problem through teaching attending children better social skills. Whether this might occur will be partly addressed in Study 3 and a more detailed discussion will cover this in the final chapter.

Regarding the lack of significant findings comparing children attending health camp and those not attending, a number of possible extraneous factors need to be considered. These factors relate to use of hypothetical vignettes and raise the question of the limited scope of such a methodology. Although the responses were anonymous, it was felt there was a potential issue regarding social

desirability response bias (Rosenberg, 1969), in that the children might respond according to the social mores they are conditioned to. In doing so, their responses may have had an element of wanting, or feeling they should, like the child described and thus rating them more favorably than they might like them in reality. For example, the positive discrimination observed with child with family problems suggests the participants may have felt sorry for, or felt they should feel sorry for the target child. There may have also been some difficulties with hypothetical samples, in that children of this age may possess concrete reasoning skills, but not necessarily abstract reasoning skills. Finally, it could be that there was a feeling that by going to health camp the children were going to be helped and thereby fix their problem.

The limitations of research based solely on vignettes suggests that it may be advisable to conduct research that encompasses both hypothetical situations and actual situations. To this end the study in the next chapter, involving actual children due to attend health camp, was developed as a complement to this study.

CHAPTER 4

The Social Interactions and Stigmatization of Children Attending Children's Health Camps.

Abstract

Seventy-six children participated in this study which was designed to further test the hypothesis that children who attend health camp are liked less than children who do not attend health camp. The methodology involved the use of sociometric nominations of liked and disliked peers, and naturalistic playground observation. The results indicated that children who were soon to attend a health camp were treated differently by their peers than control children, matched for age and sex, in the playground. In peer nominations, they were nominated more than expected in the dislike category, and less than expected in the like category. A post health camp follow up revealed a significant change in interaction patterns. Post health camp, the target children were treated more positively in interactions. Sociometric nominations remained largely unchanged, however, with target children remaining disliked and/or socially isolated. These findings are discussed with consideration being given to reasons for referral and how these might effect social interactions.

Introduction

The results of the previous study showed that there was a more negative response to children described as having behavioral problems, than children with family or health problems and control children, however the addition of health camp attendance did not have any further stigmatizing effect. This finding coupled with

the findings of Study 1 which showed that the knowledge also contained negative evaluations of health camp and of children who attend health camp, suggests some potential inconsistencies. If there was a negative perception of health camps than one might expect that would manifest in liking ratings, as it didn't two possibilities emerge. One, is that children might believe that although the reasons for attending are negative, the camp itself might help the target child. The other possibility is that hypothetical samples may be somewhat limited. It was believed that further investigation of the stigmatization of children attending health camp, using different methodologies may yield somewhat different results. This study, then, assessed children about to attend health camp with the use of peer nominations and naturalistic observation, rather than hypothetical vignettes. A further difference was the absence of a comparison group not attending health camp with the same problems.

The question considered in this study was similar to that in Study 2, that children who were attending health camp would be less socially accepted than their peers. A second question was also explored in this study, whether there was any change in patterns of interaction after health camp attendance. By using actual children, in their environment, the tendency for participants to respond in a more socially appropriate manner (social desirability response bias) was likely to be reduced in the following ways. In the first part of the study children were asked to name actual children they disliked as well as liked. In this way it was certain that they could not respond according to social appropriateness, as in particular, they were naming children they did not like. Furthermore, the observation was covert, the children did not know they were being observed, or at the very least, who in particular was being focused on. It was expected that the behavior of the children

in the playground would also not conform to a social desirability bias as being unaware of observation would not put them on their 'best behavior'.

The use of sociometric techniques is common with children and considered an appropriate heuristic tool for studying social preferences (Elliot & Gresham, 1987; Asher & Dodge, 1986). Sociometric choices have been found to be relatively stable over time (Renshaw & Asher, 1982) with good test-retest reliability (Asher & Hymel, 1981). Of importance to this study is the findings of Asher and Hymel (1981) and Daniels-Beirness (1989) whose reviews of studies utilizing this method found a tendency for same sex biases to occur in sociometric ratings. This is to be expected, when one considers that prefer same sex children from an early age (Lockheed & Klein, 1985). With regard to cross sex peers they were most likely to be negatively nominated (Asher & Hymel, 1981; Daniels-Beirness, 1989). In line with these findings this study involved only same sex peers. There are two common sociometric techniques, this study utilized peer nominations rather than rating-scale measures, as they enable differentiation between children that are socially isolated and those that are rejected (Asher & Hymel, 1981).

Playground observation has also featured frequently in research with children. Elliot and Gresham (1987) state that naturalistic observation "...is the most ecologically valid method of assessing children's social skills." (p.97). Some of the reasons for this are considered to be a) that observation provides the most accurate account of a child's behavior, b) there is minimal interference in children's lives with intrusive experimental manipulations by researchers, using these techniques, and c) for research with a goal of change, the natural environment is the where the change needs to happen (McIntyre, Bornstein, Isaacs, Woody, Bornstein, Clucas, & Long, 1983). The latter point provides a

solid justification for this research as when observing actual children, it would be unethical not to consider the potential for helping or improving a child's life. The first two points are also salient for this research, as examining actual interactions is hoped to yield an accurate portrayal of how children attending health camp are treated. The unobtrusive nature of this method is useful for two reasons: first, it is believed the children will not modify their behavior if they are unaware of observation, and second, for those children about to attend health camp, it is the researcher's intention that they do not feel further isolated as this in itself could be potentially stigmatizing. With children, direct observation has been used widely to assess many different behaviors, such as social isolation (Whitehall, Hersen, & Bellack, 1980; Greenwood, Todd, Walker, & Hops, 1976: cited in Hops & Greenwood, 1982; Hops, Fleischmann, Guild, Paine, Street, & Walker, 1978: cited in Hops & Greenwood, 1982), conduct disorder (McIntyre et al, 1983), ADHD (Harris et al, 1992), and socially negative or aggressive behaviors (Asher & Hymel, 1981; Walker, Street, Garrett, Crossen, Hops, & Greenwood, 1978: cited in Hops & Greenwood, 1982).

Finally, an important consideration, is that the way a child behaves greatly effects the way they are treated by their peers (Foster, 1989). Therefore, when considering the potential effects of attending health camp on a child, it is also important to consider that child's effects on their environment. Any stigma therefore, could possibly be a result of the reason the child is attending health camp. Of the common reasons for referral, behavioral, home relief (family), health and medical, the majority of referrals in the last decade have been behavioral and family based (Taylor & Baines, 1992). The behavior one might expect from a child with any of these referral reasons is likely to differ greatly. As programmes designed to improve children's social skills are undertaken at health

camp by those attending, upon their return to school one might expect an improvement in peer acceptance and to this end post health camp follow-up was included to assess any changes.

It was predicted that children who attended health camp would be liked significantly less than those who did not attend health camp. This would be evident in the sociometric ratings with the target children being named less often in the 'like' nominations and more often in the 'dislike' nominations, and in the playground with the target children receiving fewer positive and more negative and or isolating social experiences than their matched control peers. There was no prediction made regarding post health camp interactions and acceptance, rather the question posed: would there be an improvement in social acceptance on peer nomination measures and interactions for these children upon returning from health camp?

Method

Participants:

The participants were recruited in 5 primary schools where a child was due to attend a health camp within the subsequent two weeks. The target children were 1 female and 4 males. Information about reasons for referral to health camp was unavailable for privacy reasons. To ensure that the target child was not isolated by the experimenter, all children who were in the class of the child health attending camp were invited to participate. However, data was only used from children of the same sex as the target child, resulting in 12 female and 64 male participants aged between 9 and 12 years. Of these 1 female and 4 males were further used in observational data collection as a matched control.

Materials:

The coding schedule used in the observational data collection stage was derived from that devised by Hops, Fleischmann, Guild, Paine, Street, Walker, and Greenwood (1978: cited in Hops & Greenwood, 1982). It involved assigning behaviors to 6 discrete categories: 3 negative/alone behaviors (being teasing, being ignored, or being subjected to aggressive behaviour) and 3 positive/social behaviors (starting interaction, answering positive interaction initiated by another, or ongoing interaction between subject and another child or children). Full details of the coding schedule are in Appendix 5. The target child and control child were observed for a period of up to 30 minutes during which time the type of behavior they were predominantly engaged in over intervals of up to a minute was recorded. These intervals were not always immediately one after the other, as at times the were children running around and being covertly followed.

Procedure:

The target children were identified through Glenelg health camp. With the permission of the camp, the parents/guardians of children selected for the forthcoming camp intake were approached and their permission sought for their child to participate in the study (See Appendix 6). All those approached gave their consented to participate. The principal of the school which each target child attended was then contacted and their permission for the study to be conducted at the school also sought (See Appendix 7). The children in the class of the target child were then invited to participate in the research.

The nature of the research made it necessary that all participants remained blind to the aims of the research until all data had been collected. Thus the participants

were simply told that the aim of the study was to look at how children 'get along' with each other. The parents/guardians of children who verbally consented to participate were sent a private letter informing them of the purpose of the study, asking for consent for their child to participate, and requesting that they kept this information confidential until the study had been completed (See Appendix 8). Only 2 letters indicating a lack of parental consent were received.

The study had two stages. The first involved all the children in the class and the second involved only the child about to attend health camp and a control child matched for age and sex. Both stages of the study were conducted twice, once 1 - 2 weeks before the child attended health camp and then 3 weeks after they returned from health camp.

The first stage was conducted in the classroom as a general class exercise. The standardized instructions given to the class by the researcher were as follows:

> *This study is looking at how children get along. I want you to treat this like a test and keep the information you write down to yourself, please do not discuss this with anyone else, I want to know what you think by yourself. Everything you write is completely confidential and I am the only person who will look at what have written.*

The children were then instructed to write their name on a sheet of paper. Below this they were asked to write "like" and to then name the three children of the same sex as themselves that they liked the most in their class. The next instruction was to write "don't like" and again, to write the names of the three children of the same sex as themselves that they liked least in the class. The order of the 'like' and

'don't like' instructions were reversed in alternate classes. The pieces of paper were then collected and the children thanked for their participation.

In the second stage of the study, the target and the matched control child were observed simultaneously in the school playground over a period of thirty minutes during either lunch or morning break, using the coding schedule previously outlined.

At the conclusion of the second data collection session the children were thanked for their participation. Full debriefing of the nature of the research for the children was available if requested by school and/or any parents. In no instance did a parent or school request that the children be fully informed as to the reason behind the study. It therefore remained, for the children, that the research was looking in general terms at how children got along, which also means that at no time was the target child subject to potentially stigmatizing information being revealed to their peers.

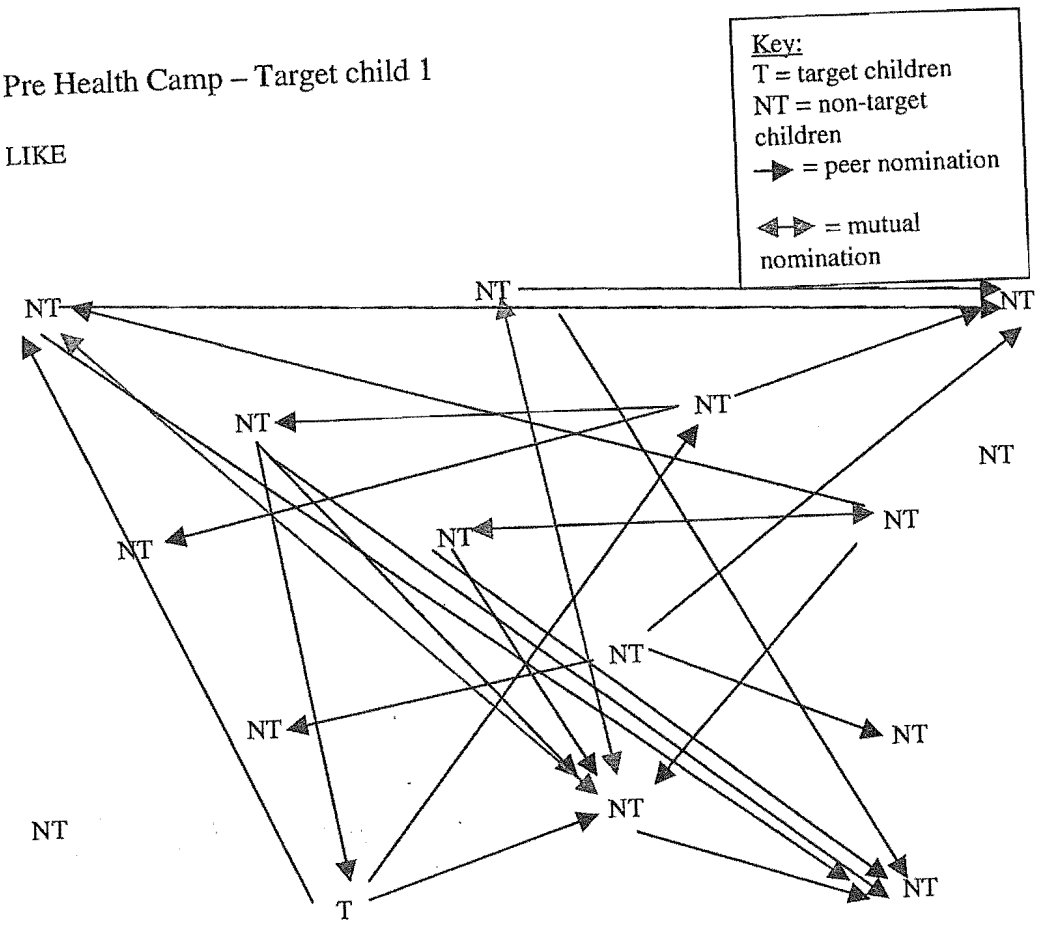
Results

Peer nominations:

Individual class sociograms were constructed after both testing sessions (2 weeks before the target child attended health camp and 2-3 weeks after they returned). The sociograms for the target children (T) and their peers (NT) before the child attended health camp are presented in Figure 1. The mean scores below appear low, but due to extraneous factors such as incomplete responses, absence, and abstinence, such means are usually less than 3 (Newcomb & Bukowski, 1983). In this instance the overall means were M=1.73, M=1.54 respectively.

Broken down to compare target and non-target children, it was found that before the target children attended health camp they were more likely to be named in the dislike (M= 2.4) than the like (M= 0.17) category. The non-target children were named in both categories almost equally often (like: M= 2.01; dislike: M= 1.49). from another perspective, the target children were named more often in the dislike category, than the non-target children (Ms=2.4, 1.49 respectively) and they were named less often in the like category than the non-target children (Ms=0.17, 2.01 respectively).

Pre Health Camp – Target child 1



Pre Health Camp – Target child 2

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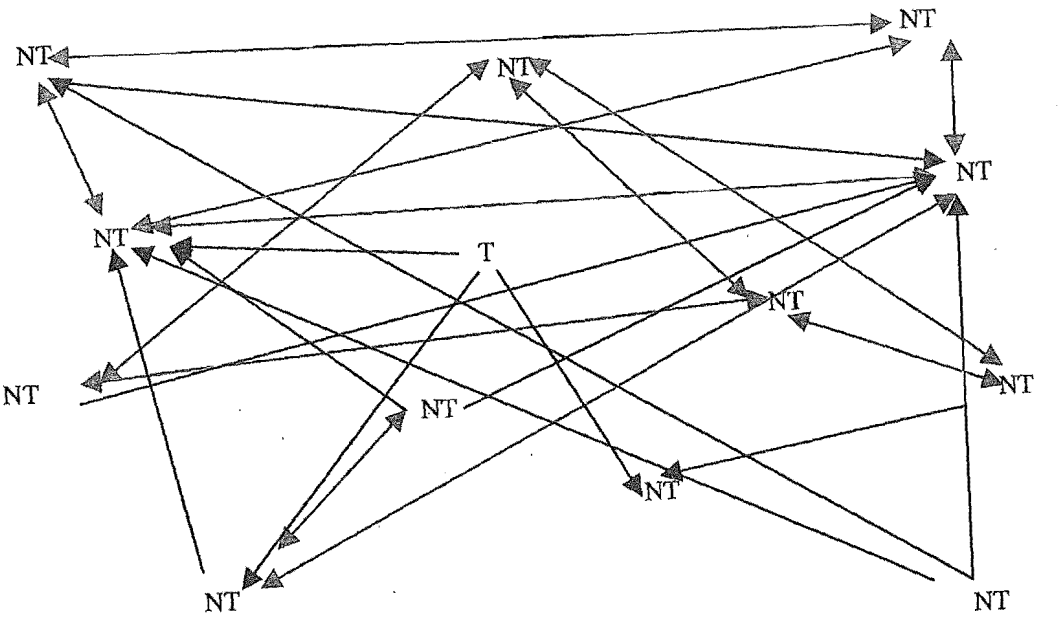

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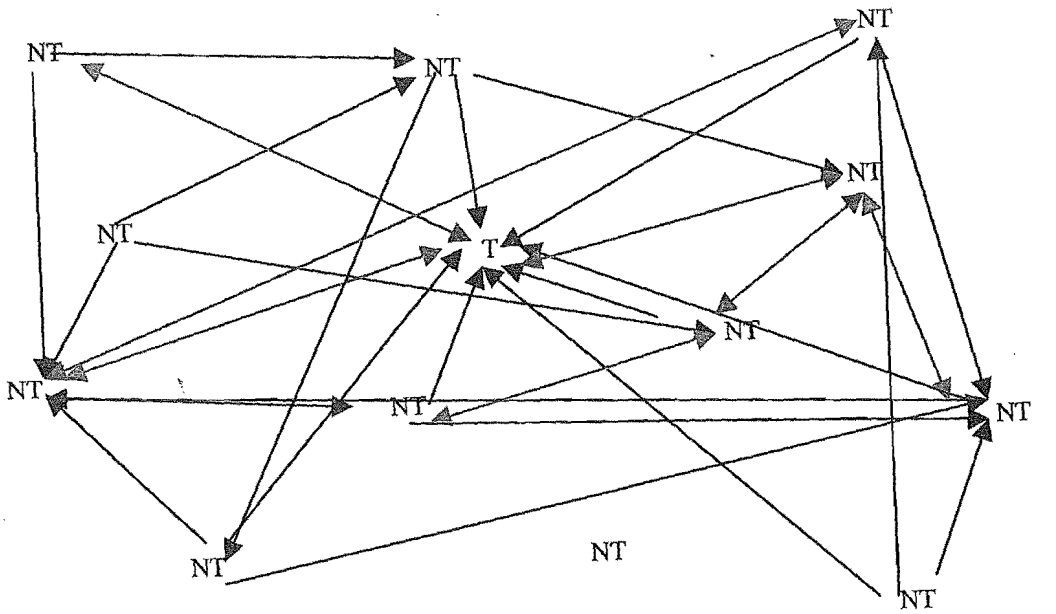

Pre Health Camp – Target child 3

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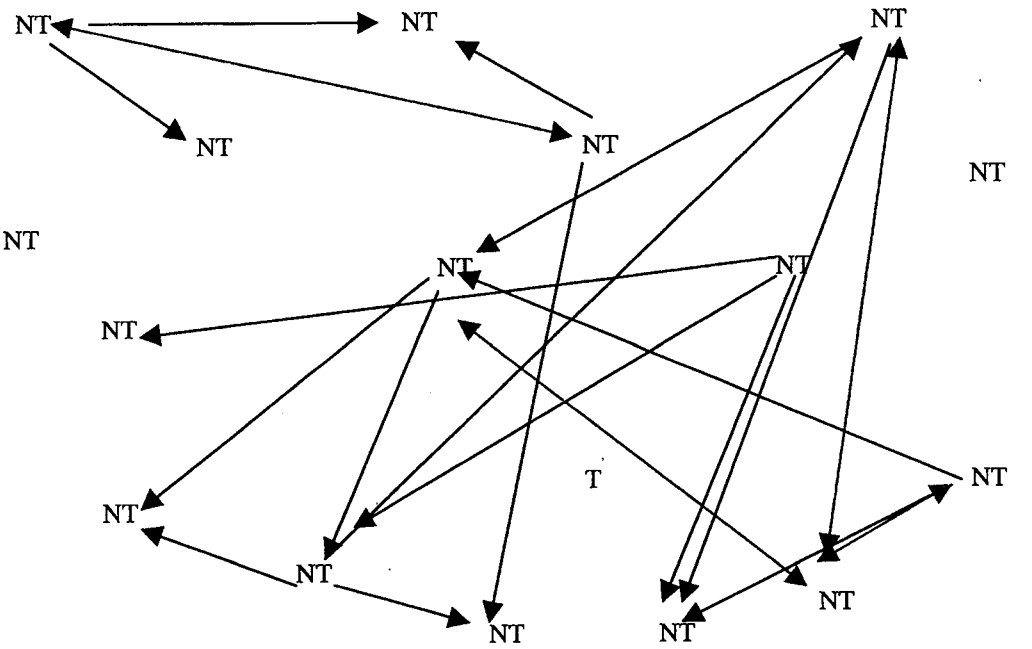

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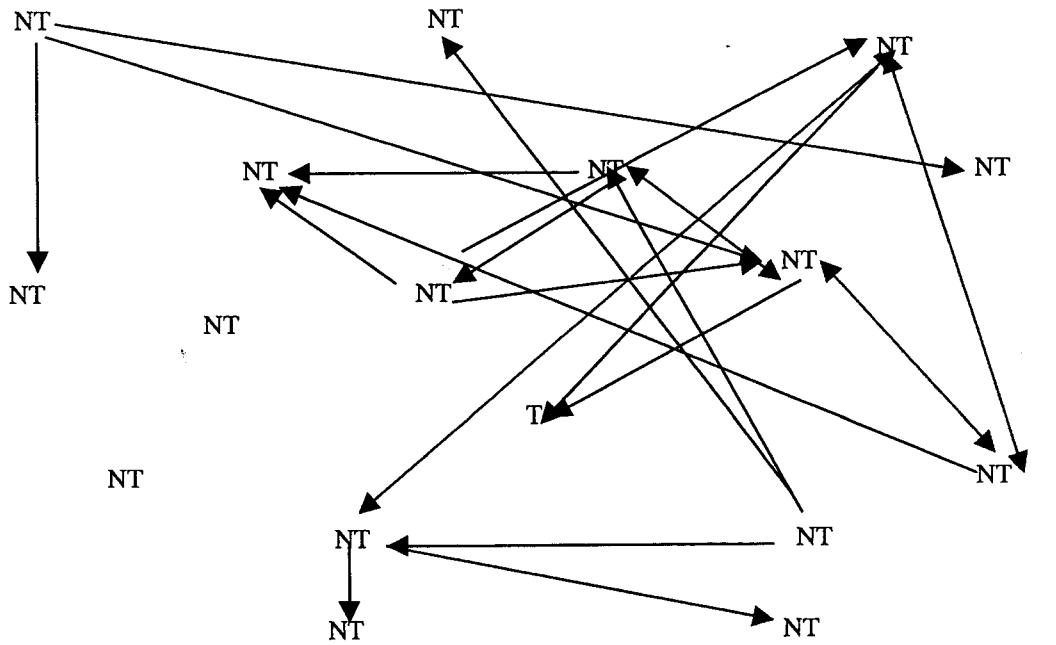

Pre Health Camp – Target child 4

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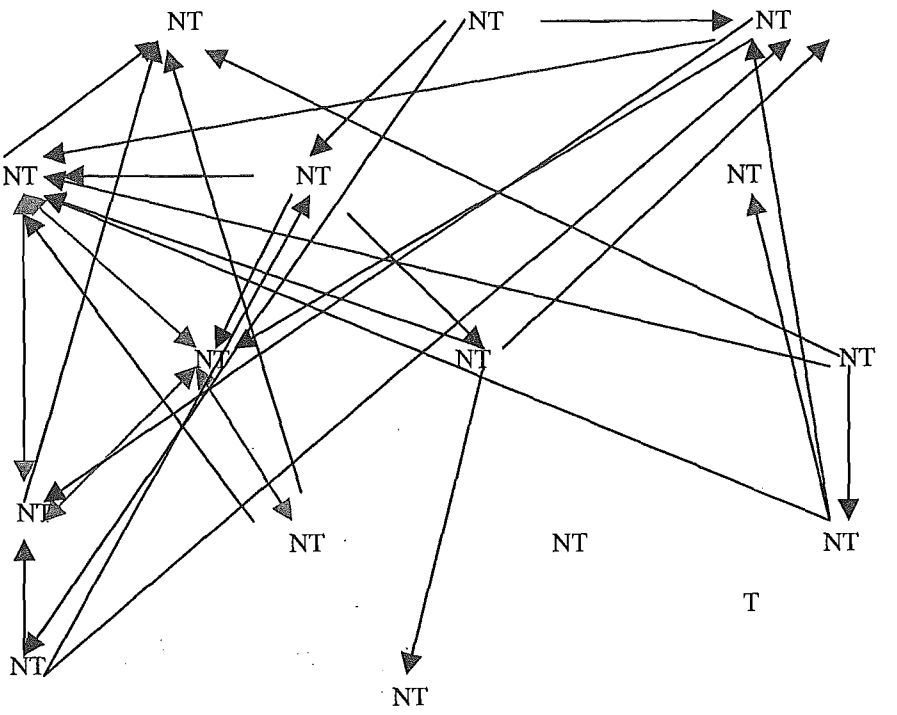

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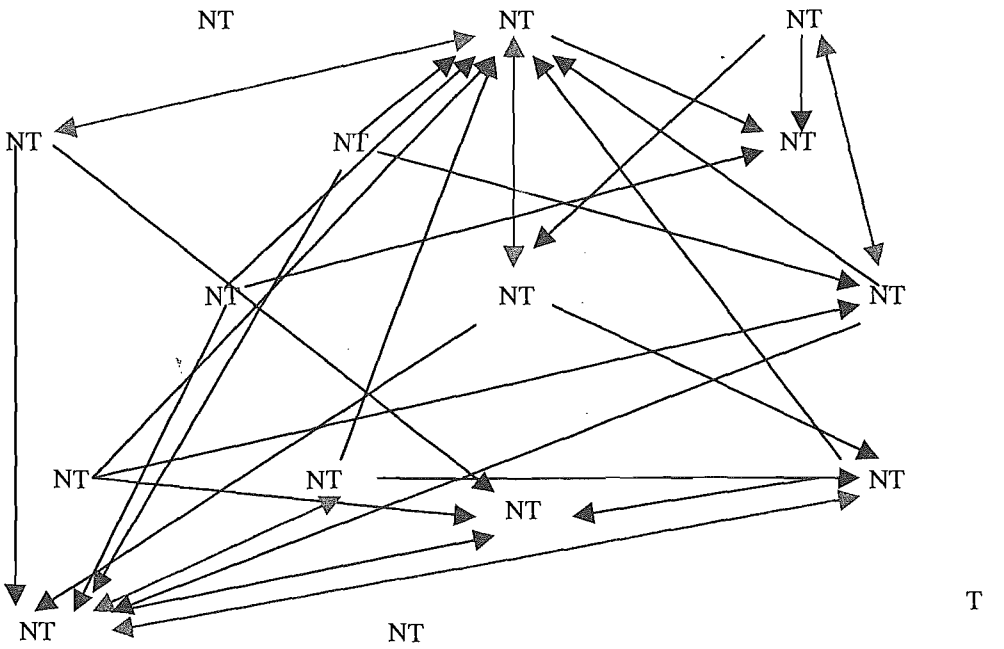

Pre Health Camp – Target child 5

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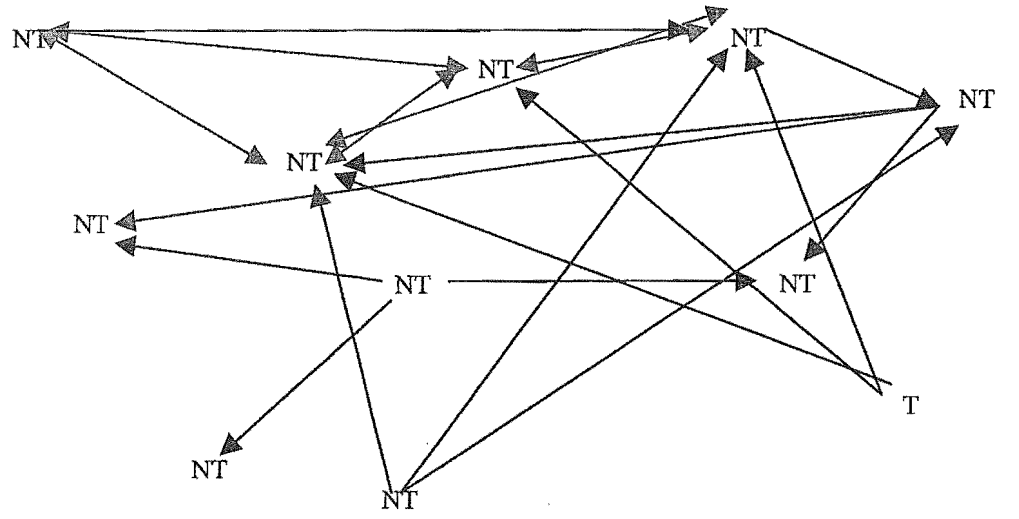

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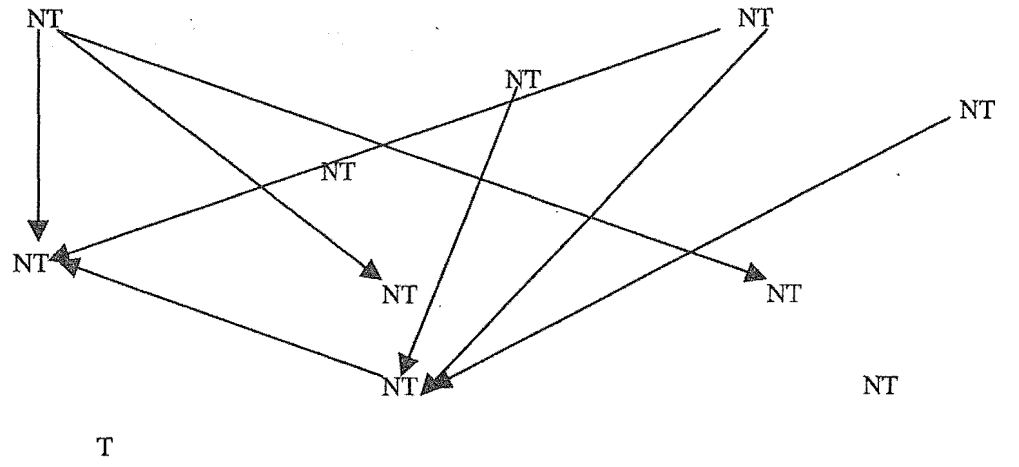


Figure 1: Sociograms of peer nominations for all children before health camp attendance on like and dislike dimensions.

The sociograms for the target children (T) and their peers (NT) after the child attended health camp are presented in Figure 2. The rise observed in these means presented below was a result of increased responses, as there was less incompletion and less absence in the participating classes (Ms=2.37, 2.48 respectively).

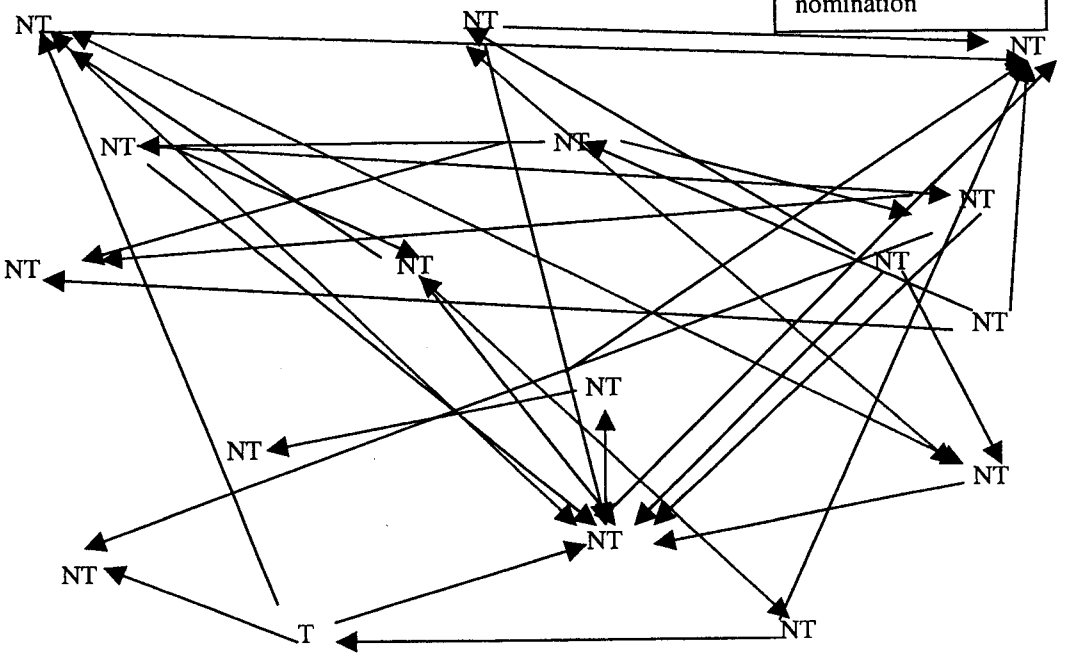
In the post health camp follow up there appeared to have been little change in the sociometric nominations. Again the children that had attended health camp were more likely to be named in the dislike (M= 4) than the like (M= 0.60) category, whereas the mean ratings for non attending children were again approximately equal for both categories (like: M= 2.69; dislike: M=2.38).

The difference observed before health camp between target and non-target children was again observed, with target children named more often in the dislike category, than the non-target children (Ms=4.00, 2.38 respectively) and target children named less often in the like category than non-target children (Ms=0.60, 2.69 respectively). Thus over time it would seem the sociometric ratings were quite stable.

Post Health Camp – Target child 1

Key:
T = target children
NT = non-target children
→ = peer nomination
↔ = mutual nomination

LIKE



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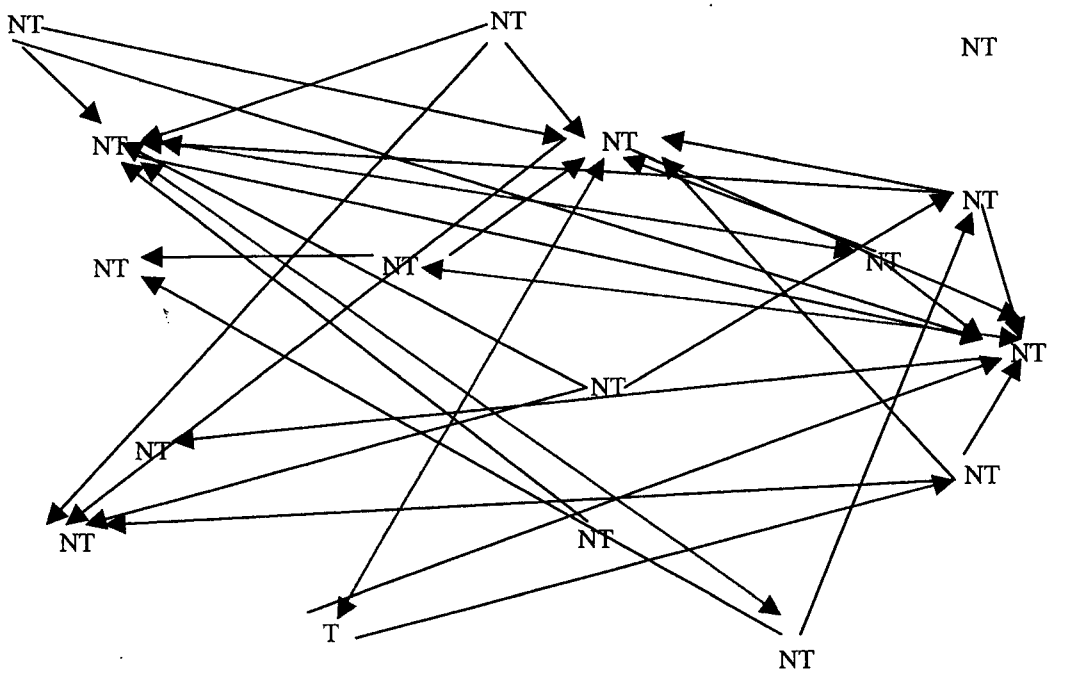

Post Health Camp – Target child 2

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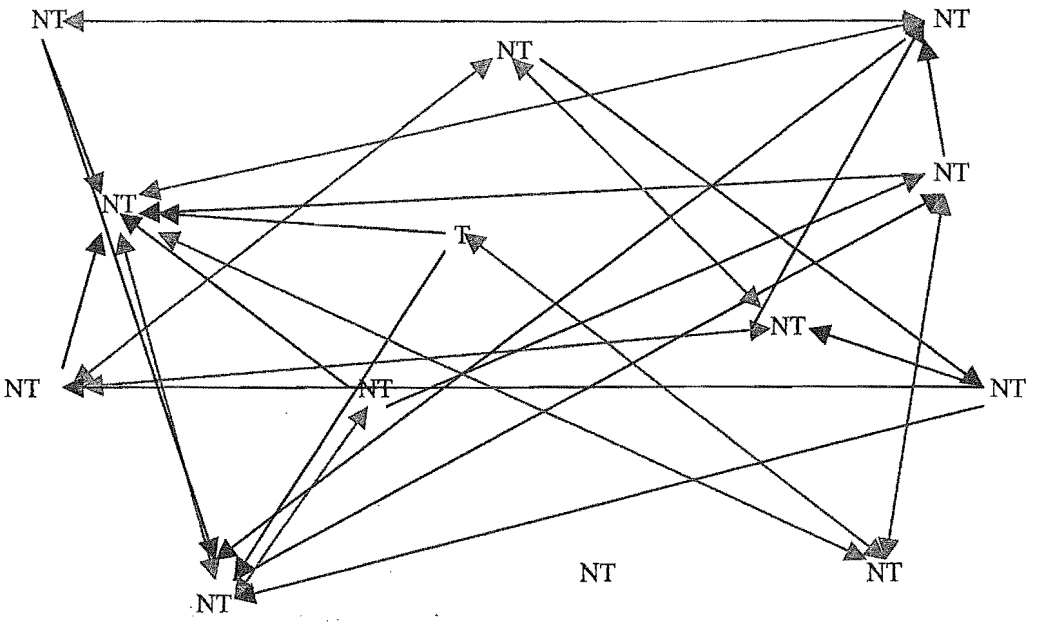

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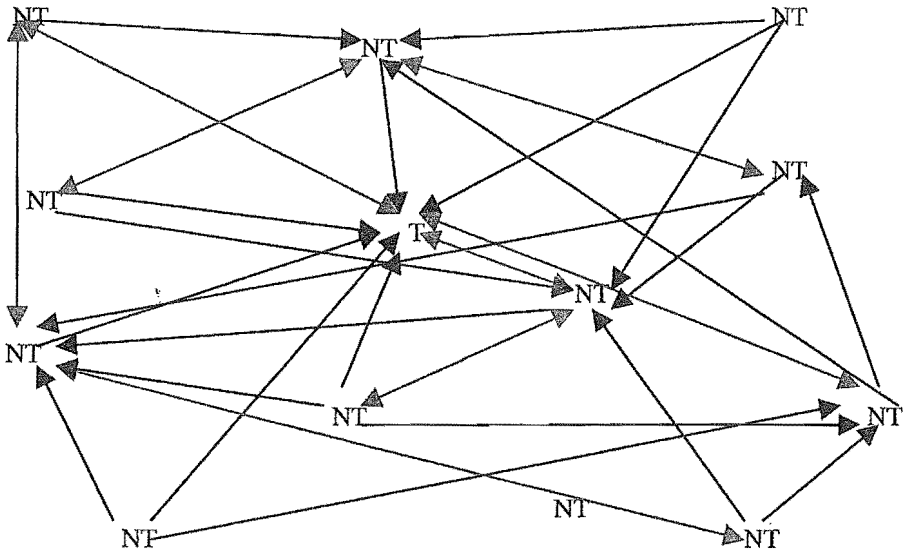

Post Health Camp – Target child 3

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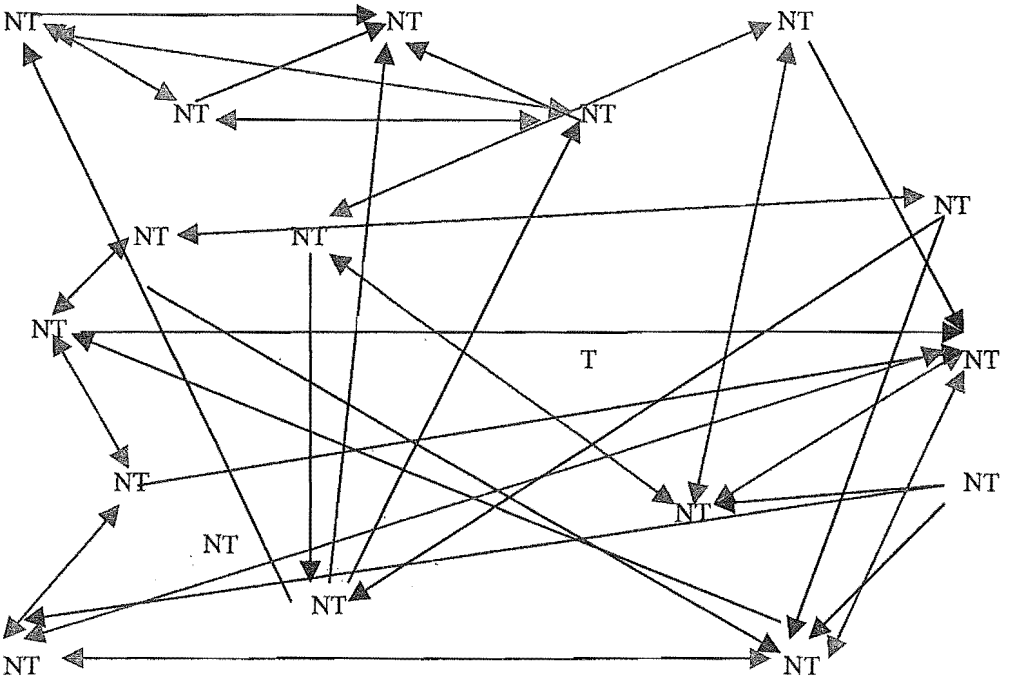

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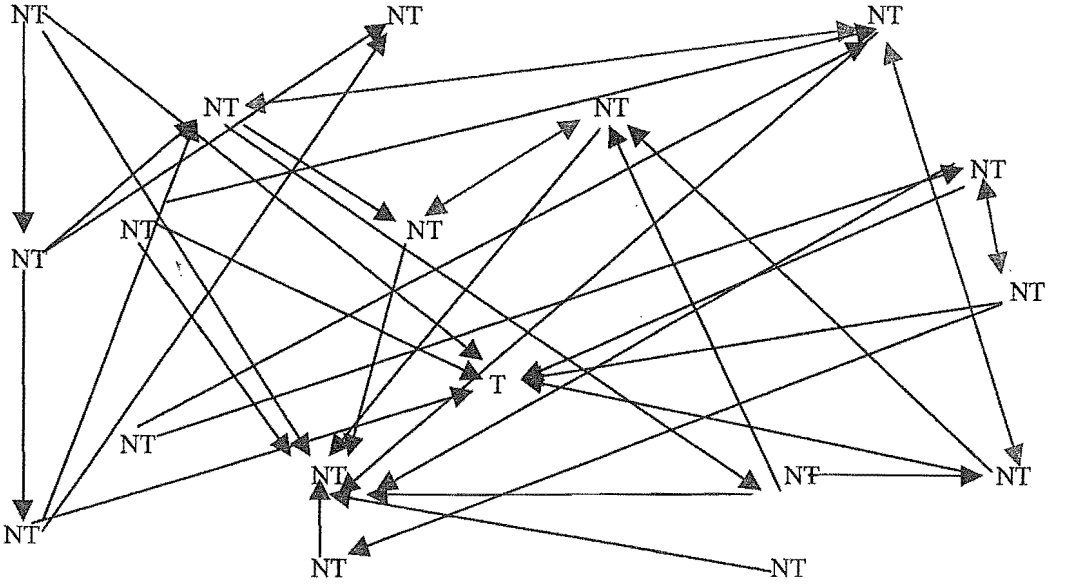

Post Health Camp – Target child 4

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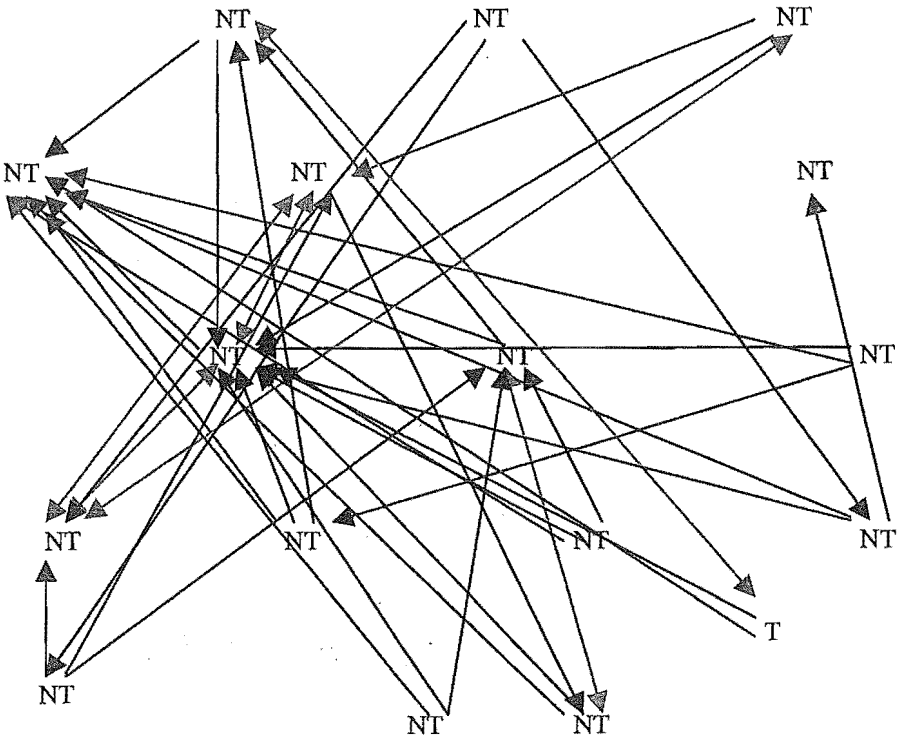

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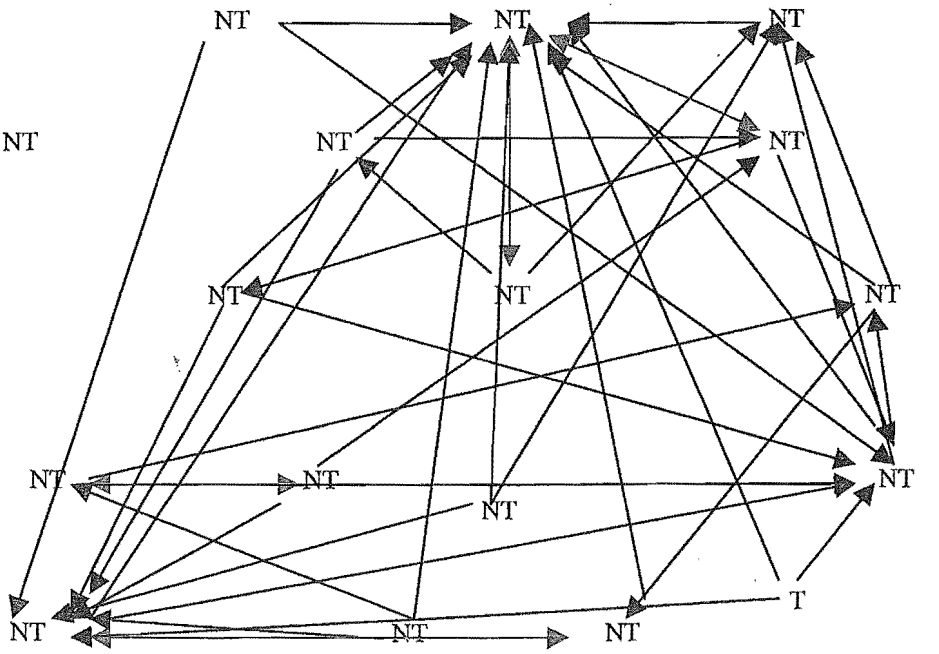

Post Health Camp – Target child 5

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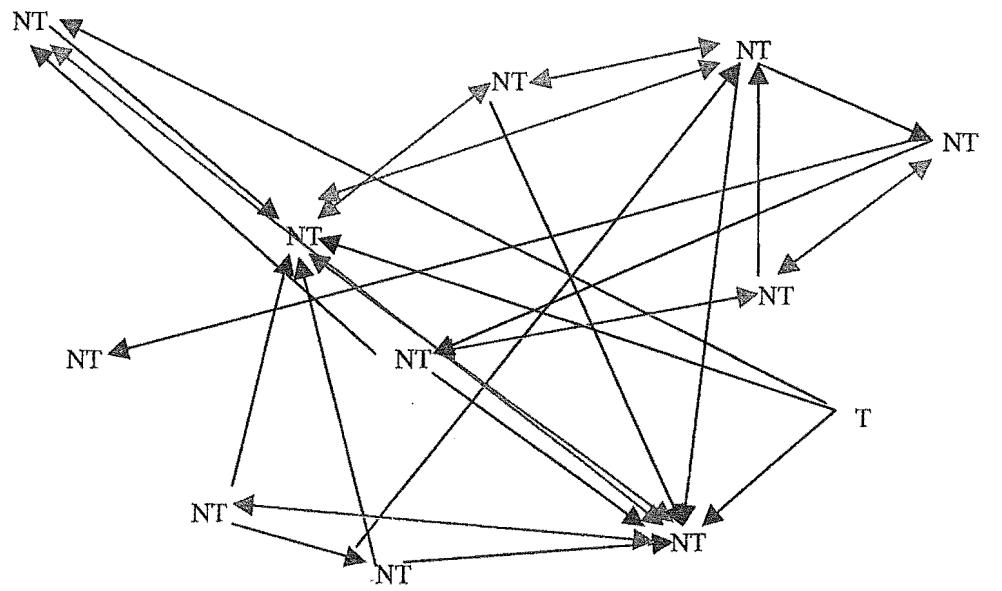

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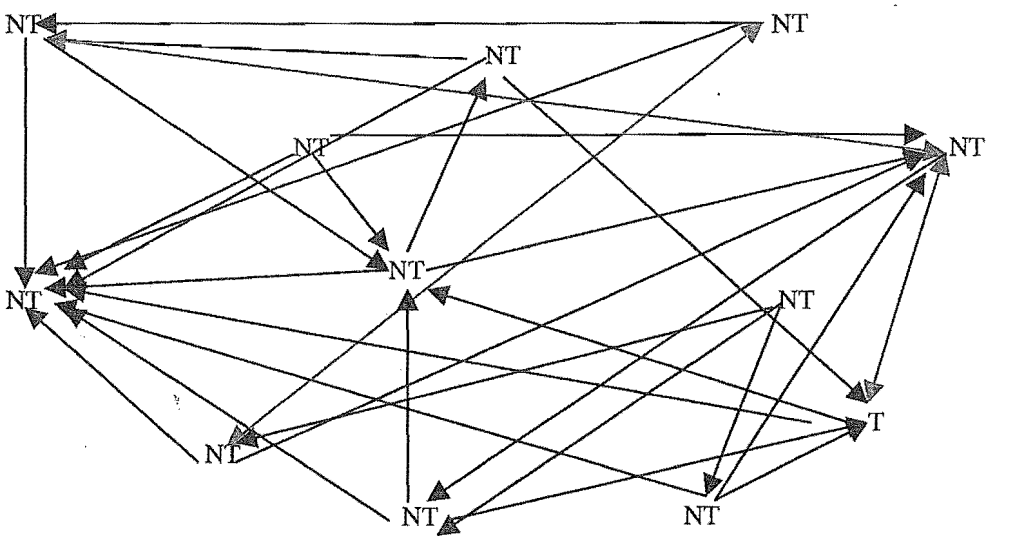

Figure 2: Sociograms of peer nominations for all children post health camp attendance on like and dislike dimensions.

From both sets of sociograms 3 groups of children can be identified, those actively liked (scoring above the average in liking nominations), those actively disliked (scoring above the average in disliking nominations), and those socially isolated (scoring below the average in both liking and disliking nominations).

The target children fall into the actively disliked (Ns=1 pre health camp and 3 post health camp) and the socially isolated (Ns=4 pre health camp and 2 post health camp) categories. Conversely, the non attending children appear to be as often liked as they are disliked, and although there are also social isolates in this group, the distribution appears to be relatively even across all categories.

Observational findings:

The observational data collected in the playground was coded into frequency of individual behaviors as detailed in the coding schedule, and collated for positive and negative totals.

A 2 (attending/ not attending health camp) x 2 (positive/negative behaviors) chi-square analysis revealed that children who were about to attend health camp were treated differently by their peers than the control children, $\chi 2\ (1) = 32.28$, $p<0.001$. The majority of positive social behaviors occurred in the group of children not attending health camp (65.8%) and in the category of negative/alone behaviors, those attending health camp predominated (92.1%).

Further analysis by way of percentage comparisons were undertaken to examine each coded behaviour individually. As can be seen in Table 3, there were significant differences recorded between percentages on one positive dimension: ongoing interaction: 9.68% for attending and 63.64% not attending, $p<0.0001$. and two of the negative dimensions revealed significant differences between

percentages: being ignored: 33.87% for attending and 3.64% not attending, p<0.0001; being subject to aggressive behavior: 20.97% for attending and 1.82% not attending, p<0.01.

Table 3: Frequency of behaviors engaged in or subject to, for children attending and not attending health camp, before health camp.

	attending health camp		*not attending health camp*		
	freq.	%	freq.	%	p.
P: starting interaction	11	17.74	14	25.46	n.s.
P: answering interaction	10	16.13	3	5.46	n.s
P: ongoing interaction	6	9.68	35	63.64	p<0.0001
N: teasing	1	1.61	0	0	n.s.
N: being ignored	21	33.87	2	3.64	p<0.0001
N: being subject to aggressive behaviour	13	20.97	1	1.82	p<0.01

Note: P = positive behavior N = negative behavior

Post health camp data revealed a different trend. Due to insufficient numbers chi-square analysis was not possible. The positive interactions for those children attending were almost equal to those for the children not attending (97.7% - attending, 100% - not attending). There were only 2 instances of negative behaviors and both were directed towards health camp attending children.

Further analysis was undertaken to examine each coded behaviour individually. As can be seen in Table 4, there were significant differences recorded between percentages on two positive dimensions: starting interaction: 18.84% for attending and 6.56% for not attending, p<0.05; ongoing interaction: 69.57% for attending and 91.80% not attending, p<0.01. There were no significant differences in percentages of negative behaviors between groups.

Table 4: Frequency of behaviors engaged in or subject to, for children attending and not attending health camp, post health camp.

	attending health camp		*not attending health camp*		
	freq.	%	freq.	%	p.
P: starting interaction	13	18.84	4	6.56	p<0.05
P: answering interaction	6	8.70	1	1.64	n.s.
P: ongoing interaction	48	69.57	56	91.80	p<0.01
N: teasing	1	1.45	0	0	n.s.
N: being ignored	1	1.45	0	0	n.s.
N: being subject to aggressive behaviour	0	0	0	0	n.s.

Note: P = positive behavior N = negative behavior

A comparison of the pattern of behaviors before and after health camp is presented in Table 5.

Table 5: Percentage of overall positive and negative behaviors engaged in or subject to, before and after health camp.

	Pre health camp				*Post health camp*			
	Attending		Not attending		Attending		Not attending	
	freq.	%	freq.	%	freq.	%	freq.	%
Positive	27	43.55%	52	94.56%	67	97.10%	61	100%
Negative	35	56.45%	3	5.45%	2	2.90%	0	0%

A percentage comparison of behaviors before health camp revealed a significant difference between positive behaviors of target (43.55%) and non-target children (94.56%), p<0.001. Similarly, a significant difference was recorded in negative behaviors between target (56.45%) and non-target children (5.45%), p<0.0001. Post health camp follow-up revealed no significant differences between target and

non-target children in either positive and negative behaviors. There was a significant difference between percentages of positive interactions for target children prior to health camp (43.55%) and after health camp (97.10%), $p<0.001$. This pattern was also observed in the negative interactions: before health camp (56.45%) and after health camp (2.90%), $p<0.001$. For the non-attending children there was no significant change in either positive or negative interactions.

Discussion

As hypothesized, children who were about to attend health camp were treated more negatively by their peers than were control children. The sociograms showed a tendency for target children to be more often actively disliked or ignored than liked by their peers. The target children were also subjected to significantly more negative social behaviors in the playground than the matched control children. Following health camp attendance, however, a different picture emerged. Although there was no change in the sociograms for the target children after they returned from health camp, in the playground a marked change in interaction patterns occurred. Children who had recently attended a health camp were now treated no differently than the control children by their peers.

The stability of the sociometric ratings over a period of time replicates the findings of previous research using this method. Renshaw & Asher (1982) have drawn attention to the stability of sociometric status. Over time, children tend to nominate the same peers in such research, so any changes that might have been expected to emerge in the sociometric scales are perhaps to be less expected. The stability of peer rejection has been related to peer expectancies, in that peers attitudes towards stigmatized children are resistant to change, even after the child has made behavioral improvements (Milich et al, 1992; Bierman, 1986). This can be further

related to the findings of Rodin & Price (1995) in that despite a problem a person has being solved, the person may experience ongoing stigma related to having had that problem. For the children that attended health camp, this may mean that although the programmes they participated in at health camp enabled them to develop better social skills, their social status upon return to school was not altered due to peer expectancies.

However, the social behavior in the playground is a departure from these ratings; the post health camp follow-up revealed no differences between the target child and the matched control in social interaction. As could be seen before health camp the target children were stigmatized, but after health camp they were treated as any other child. The reasons for their stigmatization cannot be clearly identified in this research, it could be that health camp was stigmatizing and that after health camp such a stigma was no longer relevant, or alternatively, it could be that the reasons the children were attending health camp were stigmatizing in themselves (as in Study 2) and the post camp improvement was related to their health camp experience. Looking at behaviors individually, there is some consistency with previous literature. The finding that the target children attempted to start more interactions and were involved in less ongoing interactions, after they returned from health camp has some similarity to findings by Coie and Kupersmidt (1983) who found that rejected children attempted to initiate more interactions, however they were less successful with them.

That this occurred only after health camp, suggests that before health camp the children that were attending had inadequate social skills, as they tended not to be involved in ongoing interactions at all. With the change recorded after health camp particularly in starting interactions, these findings could be interpreted as support for the possible efficacy of health camp attendance, in that the programmes

engaged in at health camp may improve the child's ability to interact with other children, a possibly that future research could explore.

Possibly, there is an interaction effect occurring between the attending children, their peers, and the reasons they attend health camp and that it is the behavior the target child exhibited before health camp that caused their stigmatization. Foster's (1989) suggestion that the behavior a child exhibits has an effect on the way they are treated by their peers serves as one explanation for the findings in this study. It may well be that it is the behavior or the problem the child has that is stigmatizing, not health camp, and that after health camp, with improved social skills, these children have an opportunity to stop the cycle of stigma. This study unfortunately did not make a clear distinction between stigma as a result of health camp over stigma as a result of the problems a child might have and it is felt that such an direction would be important for future research.

CHAPTER 5

Discussion

The results of the three studies when considered as a whole give a mixed message. Certainly there is evidence that suggests that children attending health camp may be treated differently, but conversely other findings suggest no difference. In Study 1 there appeared to be a moderately high understanding of the purpose of health camp and although the knowledge was accurate, there was often a negative evaluation in the phrasing of the responses. This lead to Study 2, in which it was found that children with behavioral problems were liked least of four conditions: behavioral problems; family problems; health problems; and no problems (control). There was not however, any interaction observed between the conditions stated and the addition of health camp attendance, meaning that children who were to attend health camp were liked no differently from children with the same problems, who were not attending. Based on the potential limitations of, and as a complement to research conducted of a hypothetical nature, Study 3 was undertaken to examine the actual social acceptance and interactive behaviors of children about to attend health camp. Identical follow up research was also undertaken to test for any post health camp changes. In this study two important findings emerged. One, that children due to attend health camp were treated more negatively than matched controls by their peers before health camp, and two, after health camp there was a significant reduction in negative and an increase in positive interactions.

The application of these findings to the primary question of stigma is uncertain. There is evidence that suggests negative perceptions exist and even that negative treatment of children attending health camps occurs, but they seem to be primarily

embedded in the problems the child has, rather than in attendance at health camp per se (Study 2). In fact, attendance at health camp seems to improve social interactions (Study 3), which may be a result of social skills training received at health camp. Nevertheless, stigmatization in terms of peer nominations was persistent (Study 3), fitting with previous research demonstrating the difficulty in changing stigma and stereotype based beliefs (Rodin & Price, 1995).

Previous findings compared to current findings

Previous research has found that children who are perceived as different for any number of reasons can be stigmatized (Richardson, 1970; 1971; Potter & Roberts, 1984; Dowling, 1985; Sigelman & Begley, 1987). This stigmatization could be a result of in-group favoritism or out-group degradation, which has been demonstrated in many situations with adults and children alike (Tajfel, 1981; Vaughan et al, 1981). Children who attend health camp do so for a variety of reasons, some of which in and of themselves may engender stigma (as shown in Study 2). Consider, for instance that a large proportion of reasons for referral are cited as behavioral problems (Routledge & Johnston, 1984; Taylor & Baines, 1992).

The findings of Study 2, support those of Sigelman and Begley (1987) and Harris et al (1992) with regard to the affective response accorded children with behavioral problems; they are liked least. Intuitively this makes sense, as behavior problems can manifest as aggression (Campbell & Cluss, 1982) and/or ADHD (Harris et al, 1992), with such problems being disruptive and time consuming in the classroom (Klein & Young, 1979), as well potentially threatening to the self. It is not surprising therefore, that their peers do not like them. The other problems included in the vignettes; family and health, did not yield less liking. In fact, the

children with family problems were liked more than the normal control children, which suggested positive discrimination occurred, possibly on the basis of pity or due to the influence of social norms. Research that has previously examined either family or health issues has had quite different results, with both conditions engendering stigma (Rest & Watson, 1984; Potter & Roberts, 1984). A possible explanation for the failure of this study to offer support for these findings may be that the problems appeared as uncontrollable. The family problems occurred to the child, but were not created by the child, and the health problem was asthma, which again is something that occurs to a child and is not within their control. This is consistent with findings suggesting perceived control over a problem has an effect on liking, in that if the problem is presented as a child's own fault, they are liked less than if the problem is presented out of their control (DeJong, 1980; Sigelman & Begley, 1987; Sigelman, 1991).

The hypothesis that health camp attendance would engender stigma has no identical correlate in published research, but a review undertaken by Rest and Watson (1984) with regard to long-term impacts of foster care, found there was a stigma associated with such care. Such a stigma could be considered as having occurred in Study 3 in which it was observed that before children attended health camp the treatment they received from their peers was overwhelmingly negative. However, after health camp, they were treated no differently from matched control children. This gives rise to the need to consider other contributing factors. Children with behavioral problems and health problems have been found to be stigmatized by their peers (Potter & Roberts, 1984; Sigelman & Begley, 1987). With a majority of the reasons children attend health camp falling into these two categories (Taylor & Baines, 1992), it may be that the stigma the children experienced before health camp was more a result of these problems than health

camp per se, which again fits with the findings of Study 2. In particular, if the reasons the children in this study attended health camp were predominantly based on behavioral problems, then stigma before health camp is to be expected. What is more, the post health camp change in the quality of interactions may be attributable to an improvement in social skills attained by the children attending health camp through the programmes they participated in. This offers support for a possible pattern of the self perpetuation of stigma. Children with poor peer relations may have inadequate social skills (Price & Dodge, 1989), and the way they behave effects the way they are treated (Foster, 1989). Therefore, if they return from health camp with improved social skills, by putting these into effect they may be rewarded with increased social acceptance. However, there is also the issue of the resistance of peer attitudes to change (Bierman, 1986; Milich et al, 1992) and the tendency to remain stigmatized even after change has occurred (Rodin & Price, 1995). This may have been evidenced in the peer nominations, which did not change after health camp. There is a possibility, in this research, that although there was an improvement in the playground and the target children were more positively treated than previously, the way that child was thought of was resistant to change because of the operation of peer expectancies.

Research Implications

The need to understand the conceptualization and actualization of stereotyping and stigma in a child's world is paramount. For the children that are recipients of stigma and negative stereotypes, the long term implications could be profound. The contribution of this body of research to current literature that addresses stigma as experienced by children, is a replication of the persistence of stigma for

children with behavior problems, and the possibility of stigma for children who attend health camp.

The potential for the stigmatization or negative treatment of children attending health camp has direct relevance for those directly involved with such children. For teachers and referral agents such a possibility should be addressed, as their actions in referring a child for a health camp stay could have direct consequences, in further exacerbating the social problems that that child may already face. The potential indirect consequences, such as social maladjustment in later years as a result of being stigmatized as a child, further highlight the importance of developing an understanding of the effects of health camp. A simple approach would be educating children and their peers about the purpose and positive possibilities of health camps, but more aggressive interventions, such as behavior modification strategies, may also be required, given the acknowledged resistance of attitudes to change (Bierman, 1986; Milich et al, 1992; Rodin & Price, 1995).

The findings of the three studies are not necessarily limited to children's health camps, they may also be applicable to other forms of residential placements, including hospitals, adolescent remand centres, and psychiatric residential care. These institutions all identify an individual as different, and for children in these situations, such a difference may be all that is required for them to be stigmatized.

Limitations and future research directions

There are many research possibilities that merit exploration with regard to health camps. These studies merely touched on the surface of a well of possibilities. Moreover, the limitations and methodological weaknesses inherent in the studies and outlined below, suggest areas where future research could improve on the findings contained herein. Children who attend health camp are in an important

category: they are different to their peers. It may be that that difference is derived from the unique reasons they attend, such as behavioral problems or family matters, but equally there remains the possibility that attending health camp makes a child even more different in the eyes of their peers. Unfortunately, these studies were limited in the differentiation between the two factors to the hypothetical work, therefore, extricating the role of health camp and the role of the reasons for attendance using actual children, is clearly where the focus in this research needs to head. It would be valuable if reasons for referral were clearly outlined and factored into research that examined the social consequences for actual children attending health camp. Furthermore, future research should include children identified with similar problems who are not attending health camp, as a control group.

The nature of stigma would seem to a complex relationship between the individual that is stigmatized and their environment. To argue for causality on either the part of the stigmatizer or of the recipient would seem to be naive as it would ignore the fundamental interaction that occurs between the two. Achieving an understanding of that interaction with regard to the children who attend health camp would surely help immeasurably in improving peer relations for the stigmatized child. This knowledge could enable intervention addressing the self-perpetuation of stigmatization, through improved social skills and altered peer expectancies.

There are some potential long-term issues that merit attention in this field also. There is the question of the long-term acceptance of children that attend health camp. If they are stigmatized before going to health camp, will they always carry that stigma in the eyes of those that are aware they have attended health camp as found by Rodin & Price (1995) with regard to obesity. Longitudinal impact studies that track a child and their peers or follow-up 6 months later incorporated

into a design that combined both non-attending and attending children would be likely to yield this information.

Another long-term consideration is whether the experience of attending health camp has any lasting effects. Rest and Watson (1984) found there was a risk for an impaired self-image resultant from the stigma of long-term foster care which raises the question: could being removed from one's home environment for an identified problem put an child at risk of an impaired self-image due to being identified as different. Other long-term impacts could also be assessed through questionnaires and archival analysis, for example, whether the programmes engaged in at health camp have any long-term benefits, such as a reduction in risk factors for poor outcomes later in life.

Given the tentative possibility raised in this research that health camp may have some efficacy in enabling a child to develop better social skills, this would seem another area worth further examination. Evaluating the effectiveness of health camp programmes in dealing with problems in the immediate term, may provide some valuable support for the role of health camps in today's society. If this were linked to an evaluation of long-term outcomes, as mentioned above, then health camps might be found to be not only a positive break for children but one that allows them the opportunity to learn skills they can carry forward into their life.

Finally, an area that deserves attention in this field is the interactional aspect between children that attend health camp and their families. It would be beneficial to establish not only whether these children learn better social skills whilst at health camp, but also whether their family enables them to continue the use and development of these skills. This research would place the role of health camps in an even wider context than currently considered.

Conclusion

In order to maximize the potential positive outcomes in a child's future, it is quintessential that there is an understanding of their experience in the present. Social behavior is oft examined and this research has attempted to offer an understanding of social behavior in a hitherto unexplored area: the effects of children's health camps on children's social experience. No experience should be considered in a vacuum, as it occurs in a full and interactive world. This research has provided some valuable understanding of the social implications that may exist for children who attend health camps. It has found that negative social consequences, such as stigmatization, surround children who attend children's health camps, but that these are inter-related with the reasons the children are referred to health camp. Furthermore, this research has provided inaugural support for the possible efficacy of programmes conducted at health camp. It is hoped that future research will continue to consider the impact of unique institutions, such as health camps, in a wider social context.

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APPENDICES

APPENDIX 1

Study 1 and Study 2: Letter to schools

Dear Principal

I am currently completing an MA thesis in psychology at the University of Canterbury. In considering a topic for my thesis, I have decided to look at the social effects of Children's Health Camps. In particular, I would like to examine how children who attend camp are treated by their peers. The question I am asking, is whether children who go to health camp are treated differently, as a result of their circumstances, by other children.

The design of my research is such that no child would be singled out, all questions refer to hypothetical children, nor would it be in any way intrusive. Specifically, what I would like to do at this point is firstly establish a baseline of children's knowledge about health camps. This would be done in a simple question and answer group session, with me asking a class of children what they know about health camps. I anticipate this would take approximately 15 minutes.

Secondly, I would like to present another group of children with hypothetical stories/vignettes (copies attached) about children who may or may not attend health camp. Following this I would have the children complete a simple questionnaire (copy enclosed) about the vignette they read.

I would like to conduct each part of my study in separate classes and ideally would like to use Standard 3 children in the first part and Standard 4 children in the second part of this study. Therefore, I am approaching you in the first instance to discuss this possibility. I would of course seek both parental written permission (copy of proposed letter attached) and the children's verbal permission. Should someone not wish to participate no pressure would be applied in any way to gain participation.

I feel there is much to be gained from conducting this research. It is important to consider the health camp experience in a wider context than currently may occur. The experience of health camp for a child may have many implications outside of the direct health camp experience. Social effects seem a likely possibility, one worth exploring. I will of course be offering feedback at the end of my study to your school and any interested parents.

This project is supervised by Dr. Lucy Johnston in the Department of Psychology, and has been reviewed and approved by the University Human Ethics Committee. Thankyou for your time, I will follow this letter up in a few days to further discuss it with you. I look forward to talking with you soon.

Yours sincerely
Serena Butt

APPENDIX 2

Study 1 and Study 2: Letter to parents

Dear parent

I am currently completing an MA thesis in psychology at the University of Canterbury. In considering a topic for my thesis, I have decided to look at the social effects of Children's Health Camps. In particular, I would like to examine how children who attend camp are treated by their peers.

Your child is in one of the classes I would like to include in my research. The study will place your child in one of two conditions. The first being an oral question and answer session about health camp, with the entire class. The purpose is to find out what children know about camp. The second being a hypothetical story about a child ending with the child in the story either attending health camp or no mention being made of health camp. This will be followed by a short, simple questionnaire about how your child might feel about the hypothetical child. My question in this part of the study is, do children feel differently about children when health camp is mentioned?

I would like to stress that no child is being singled out, but that I am looking at general feelings about health camp. I will be offering feedback at the end of my study to your child's school and any interested parents.

Your child has given verbal consent to participate in this study. I am now seeking your consent for their participation. Participation is completely voluntary, and your child can withdraw from the study at any time. I will also completely debrief the children following the study, with their teacher present. If you DO NOT consent to your child participating in this study, please sign below and return the detached portion to the class teacher before the study commences on _____. Should you have any questions I can be contacted through your school secretary who has my number.

Yours sincerely
Serena Butt

I have read and understood the study proposed.
I DO NOT consent for my child _____ in Room_____ to participate.
Signed _____
Date _____
Please return to your child's class by _____

APPENDIX 3

Study 2: Vignettes

ATTENDING

Dylan is a nine year old boy. He is just like you. He likes playing sport, his favourite sport is rugby. He also likes to go fishing in the weekend. At school he likes maths and writing, he is not the best or anything but mostly he tries at those subjects. He likes watching What Now on Sunday mornings because he thinks Anthony is cool. Next week Dylan is going away to health camp for six weeks.

Dylan is a nine year old boy. He is just like you, except that sometimes he gets really angry and is very naughty. Sometimes he hits other kids and even his teacher. He ran away from home once and often stays out way past his bedtime. Because of this Dylan is going away for six weeks to stay at a health camp.

Dylan is a nine year old boy. He is just like you, except that sometimes he is unhappy. His Mum and Dad don't live together and his Mum gets really tired looking after him all the time. His Mum and Dad used to fight all the time and sometimes his Dad got so mad he would hit Mum and even Dylan. Sometimes his Mum gets really angry with him, but mostly she's just sad. Because of this Dylan is going away for six weeks to stay at a health camp.

Dylan is a nine year old boy. He is just like you, except sometimes he gets really sick. He has asthma and it makes it very hard for him to breathe. Once he had to go to hospital to go on something to help him breathe. He has to take medicine to help him every day, but sometimes he doesn't want to. Because of this Dylan is going away for six weeks to stay at a health camp.

NOT ATTENDING

Dylan is a nine year old boy. He is just like you. He likes playing sport, his favourite sport is rugby. He also likes to go fishing in the weekend. At school he likes maths and writing, he is not the best or anything but mostly he tries at those subjects. He likes watching What Now on Sunday mornings because he thinks Anthony is cool.

Dylan is a nine year old boy. He is just like you, except that sometimes he gets really angry and is very naughty. Sometimes he hits other kids and even his teacher. He ran away from home once and often stays out way past his bedtime.

Dylan is a nine year old boy. He is just like you, except that sometimes he is unhappy. His Mum and Dad don't live together and his Mum gets really tired looking after him all the time. His Mum and Dad used to fight all the time and sometimes his Dad got so mad he would hit Mum and even Dylan. Sometimes his Mum gets really angry with him, but mostly she's just sad.

Dylan is a nine year old boy. He is just like you, except sometimes he gets really sick. He has asthma and it makes it very hard for him to breathe. Once he had to go to hospital to go on something to help him breathe. He has to take medicine to help him every day, but sometimes he doesn't want to.

APPENDIX 4

Study 2: Questionnaires

How nice is Dylan?

1	2	3	4	5
not at all		okay		very much
☹		😐		☺

How bad is Dylan?

1	2	3	4	5
not at all		okay		very much
☺		😐		☹

How much do you like Dylan?

1	2	3	4	5
not at all		okay		very much
☹		😐		☺

How much do you want to be Dylan's friend?

1	2	3	4	5
not at all		okay		very much
☹		😐		☺

How much would you like to sit next to Dylan in class?

1	2	3	4	5
not at all		okay		very much
☹		😐		☺

How different is Dylan from you?

1	2	3	4	5
not at all		a bit		very different

How different is Dylan from most other kids?

1	2	3	4	5
not at all		a bit		very different

APPENDIX 5

Study 3: Coding schedule for naturalistic observation

Name__________________________
School____________________________ **Date**_______
Class_______ **Age**__________ **Attending Y/N**

NA	T I A	NA	T I A	NA	T I A	NA	T I A	NA	T I A
PS	S A T	PS	S A T	PS	S A T	PS	S A T	PS	S A T
NA	T I A	NA	T I A	NA	T I A	NA	T I A	NA	T I A
PS	S A T	PS	S A T	PS	S A T	PS	S A T	PS	S A T
NA	T I A	NA	T I A	NA	T I A	NA	T I A	NA	T I A
PS	S A T	PS	S A T	PS	S A T	PS	S A T	PS	S A T
NA	T I A	NA	T I A	NA	T I A	NA	T I A	NA	T I A
PS	S A T	PS	S A T	PS	S A T	PS	S A T	PS	S A T
NA	T I A	NA	T I A	NA	T I A	NA	T I A	NA	T I A
PS	S A T	PS	S A T	PS	S A T	PS	S A T	PS	S A T
NA	T I A	NA	T I A	NA	T I A	NA	T I A	NA	T I A
PS	S A T	PS	S A T	PS	S A T	PS	S A T	PS	S A T
NA	T I A	NA	T I A	NA	T I A	NA	T I A	NA	T I A
PS	S A T	PS	S A T	PS	S A T	PS	S A T	PS	S A T
NA	T I A	NA	T I A	NA	T I A	NA	T I A	NA	T I A
PS	S A T	PS	S A T	PS	S A T	PS	S A T	PS	S A T
NA	T I A	NA	T I A	NA	T I A	NA	T I A	NA	T I A
PS	S A T	PS	S A T	PS	S A T	PS	S A T	PS	S A T
NA	T I A	NA	T I A	NA	T I A	NA	T I A	NA	T I A
PS	S A T	PS	S A T	PS	S A T	PS	S A T	PS	S A T
NA	T I A	NA	T I A	NA	T I A	NA	T I A	NA	T I A
PS	S A T	PS	S A T	PS	S A T	PS	S A T	PS	S A T
NA	T I A	NA	T I A	NA	T I A	NA	T I A	NA	T I A
PS	S A T	PS	S A T	PS	S A T	PS	S A T	PS	S A T
NA	T I A	NA	T I A	NA	T I A	NA	T I A	NA	T I A
PS	S A T	PS	S A T	PS	S A T	PS	S A T	PS	S A T
NA	T I A	NA	T I A	NA	T I A	NA	T I A	NA	T I A
PS	S A T	PS	S A T	PS	S A T	PS	S A T	PS	S A T
NA	T I A	NA	T I A	NA	T I A	NA	T I A	NA	T I A
PS	S A T	PS	S A T	PS	S A T	PS	S A T	PS	S A T
NA	T I A	NA	T I A	NA	T I A	NA	T I A	NA	T I A
PS	S A T	PS	S A T	PS	S A T	PS	S A T	PS	S A T

NA-negative/alone behaviours to be further categorised as T-teasing, I-being ignored, and A-being subject to aggressive behaviour.
PS-positive/social behaviours to be further categorised as S-starting interaction, A-answering positive interaction initiated by another, and T-ongoing interaction between subject and another child.

APPENDIX 6

Study 3: Letter to parents of attending children

Dear parent

I am currently completing an MA thesis in psychology at the University of Canterbury. In considering a topic for my thesis, I have decided to look at the social effects of Children's Health Camps. In particular, I would like to examine how children who attend camp are treated by their peers. The question I am asking, is whether children who go to health camp are treated differently, as a result of their circumstances, by other children.

As your child is about to attend health camp I am hoping that you will consent to their participation in my research. Firstly, let me stress that although I will be comparing children who attend health camp with those who do not, no child will be singled out i.e. all questions will be directed to all children about all other children in the class, or made to feel they are the focus of this study. Furthermore, my aim is to make my research as unobtrusive as possible.

The first part of this study involves all the children in your child's class 2 weeks before your child goes to camp. Each child, including your own, will be asked to list the three children they like the most. This will of course remain confidential to myself and my supervisor.

The second phase of this study will be observation in the playground of two children, one being your child and the other being a child of same sex and age who is not going to health camp, as a control. I will rate the behaviours relevant to social play, and again let me stress, neither child will know they are being observed.

I have approached Glenelg Health Camp and they have given their consent for this research. I will also, upon your consent, seek permission from your child's school, where the study will take place. If you consent to your child participating in this study, please sign below. I will also seek your child's verbal permission before beginning any research. If you have any questions I can be contacted at 366-7001 ext 8083, or you can also contact my supervisor, Dr. Lucy Johnston at 366-7001 ext 6769.

Yours sincerely
Serena Butt

I have read and understood the study proposed.
I give full, informed consent for my child _____ to participate.
Signed _____ Date _____

APPENDIX 7

Study 3: Letters to schools

Dear Principal

I am currently completing an MA thesis in psychology at the University of Canterbury. In considering a topic for my thesis, I have decided to look at the social effects of Children's Health Camps. In particular, I would like to examine how children who attend camp are treated by their peers. The question I am asking, is whether children who go to health camp are treated differently, as a result of their circumstances, by other children.

I have conducted an earlier study which suggested that children who attend health camp are treated differently, however this was using hypothetical examples. In this stage of my research I want to move on to real case studies. Firstly, let me stress that although I will be comparing children who attend health camp with those who do not, no child will be singled out i.e. all questions will be directed to all children about all other children in the class, or made to feel they are the focus of this study. Furthermore, my aim is to make my research as unobtrusive as possible.

The first part of this study involves all children in a class where a child is due to attend health camp (2 weeks before). Each child will be asked to name their the three children they like the most in their class. This will of course remain confidential to myself and my supervisor.

The second phase of this study will be observation in the playground of two children, one being the child about to attend health camp and the other being a child of same sex and age not attending as a control. I will rate the behaviours relevant to social play. The observation periods will be 30 minutes long (rating scale attached).

I have consent for this research from the parents of the child about to attend health camp, and am seeking consent and hopefully access from your school. I would of course seek both parental written permission (copy of proposed letter attached) and the children's verbal permission. Should someone not wish to participate no pressure would be applied in any way to gain participation.

I feel there is much to be gained from conducting this research. It is important to consider the health camp experience in a wider context than currently may occur. The experience of health camp for a child may have many implications outside of the direct health camp experience. Social effects seem a likely possibility, one worth exploring. I will of course be offering feedback at the end of my study to your school and any interested parents.

This project is supervised by Dr. Lucy Johnston in the Department of Psychology, and has been reviewed and approved by the University Human Ethics Committee. Thankyou for your time, I will follow this letter up in a few days to further discuss it with you. I look forward to talking with you soon.

Yours sincerely
Serena Butt

APPENDIX 8

STUDY 3: Letter sent to all parents

Dear parent

I am currently completing an MA thesis in psychology at the University of Canterbury. In considering a topic for my thesis, I have decided to look at the social effects of Children's Health Camps. In particular, I would like to examine how children who attend camp are treated by their peers. The question I am asking, is whether children who go to health camp are treated differently, as a result of their circumstances, by other children.

Your child is in a class where a child is about to go to health camp. The study will involve your child listing their three best friends and three children they like least. No children will be singled out nor made to feel they are under a microscope, and all information will remain strictly confidential to myself and my supervisor.

There will also be a second part to the study which will involve observation in the playground of two children. Hence, your child may or may not be chosen. However, neither child will know they are being observed and it will simply be a recording of playing alone or with others.

If you DO NOT consent to your child participating in this study, please sign below and return the detached portion to your school. I will also seek your child's verbal permission before beginning any research. If you have any questions I can be contacted through your school secretary who has my number. I also ask that if you do consent, you don not discuss this with your child until after the study has been undertaken, as I am sure you understand, I don't want any child to feel singled out in any way.

Yours sincerely
Serena Butt

I have read and understood the study proposed.
I DO NOT give consent for my child _____ to participate.
Signed _____ Date _____