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CHILDREN'S SELF-PERCEPTION: INVESTIGATING THE IMPACT OF VICTIMIZATION  
AND THE EFFECTIVENESS OF A STRENGTHS-BASED CAMP INTERVENTION

by

Amanda J. Hasselle

A Dissertation

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your stories. Thank you for laughter and connection. Thank you for challenging our team to do better. Thank you for sharing your wisdom and vulnerability. Working with the caregivers, campers, and counselors who were part of this project made me a better human being.

## **Abstract**

Victimization exposure can negatively impact children's self-perception, and interventions for children exposed to victimization can improve self-perception among children. However, little is known about how distinct types of victimization are related to unique facets of self-perception and whether camp-based interventions can enhance self-perception among children affected by family violence. The current project consists of three studies that add to the existing literature by exploring associations between three metrics of victimization exposure and three facets of self-perception. These studies also contribute to the existing literature by evaluating whether a camp-based intervention designed specifically for children exposed to family violence enhances children's self-perception, using both a randomized control design and a qualitative case study. Caregivers seeking services from a family justice center and their children aged 7-12 participated in the current study and were evaluated at baseline, two-month follow-up, and five-month follow-up. Children reported on their own self-perception and victimization exposure, and caregivers reported on their exposure to intimate partner violence. Regression analyses in Study 1 demonstrate that direct victimization exposure is negatively associated with children's self-perception. Piecewise latent growth curve models in Study 2 suggest that Camp HOPE has a temporary, negative impact on children's global self-worth. The familial case study in Study 3, however, suggests that Camp HOPE may enhance facets of self-perception among certain children. Results highlight the importance of victimization prevention programs and improving accessibility to interventions for children exposed to victimization experiences. Additionally, this project emphasizes the need for ongoing evaluation of Camp HOPE, modifications to enhance the impact of Camp HOPE, and consideration of whether the intervention represents an appropriate allocation of resources.

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## **Children’s Self-Perception: Investigating the Impact of Victimization and the Effectiveness of a Strengths-Based Camp Intervention**

Victimization exposure during childhood puts youth at risk for a range of problematic consequences, including a negative view of themselves (Chan, Brownridge, Yan, Fong, & Tiwari, 2011; Turner, Shattuck, Finkelhor, & Hamby, 2017; Grych, Wachsmuth-Schlaefler, & Klockow, 2002). While many interventions intended to support children affected by exposure to victimization aim to alleviate emotional and behavioral symptoms, research suggests that interventions designed to promote strengths are more effective at fostering positive functioning (Howell, Schwartz, & Barnes, 2017; McDonald et al., 2016). Despite this finding, few studies have examined interventions designed to bolster strengths among children impacted by victimization experiences. One of the most important strengths identified in promoting resilience among school-aged children is self-perception (Hoyt-Meyers et al., 1995). Self-perception is a multifaceted construct that represents individuals’ sense of general self-worth, as well as an evaluation of their own skills and abilities in various domains (Harter, 2012). Self-perception has been identified as an important, internal resource that impacts individuals’ daily lives, as well as their long-term well-being (Cole et al., 2001; Grant et al., 2006; Harter, 2012). Therefore, it is important to identify interventions that effectively enhance self-perception among youth whose experiences place them at risk for a more negative self-concept. Accordingly, the current project has two goals: 1) to understand how children’s victimization exposure impacts their self-perception, and 2) to assess whether a camp-based intervention developed specifically to promote strengths among children impacted by family violence can enhance self-perception.

Project goals will be accomplished by conducting a series of three studies. The first study examines how children’s own victimization exposure, as well as their caregiver’s exposure to

intimate partner violence (IPV) victimization, impact three facets of self-perception: global self-worth, social competence, and behavioral conduct. The subsequent two studies assess how a camp-based, trauma informed intervention fosters positive change in self-perception among children whose caregivers experienced significant violence. Using a randomized controlled trial design and longitudinal data collection, the second study examines whether camp promotes change in children's overall self-esteem (i.e., global self-worth), their ability to establish and maintain friendships (i.e., social competence), and their ability to behave the way they want to behave/are expected to behave in various situations (i.e., behavioral conduct). The third study is a familial case study that incorporates self-perception data from three siblings, as well as a qualitative interview with the children's caregiver. This study explores how individual child characteristics might interact with the camp experience to promote positive or negative change in each facet of self-perception. These three studies will enhance the existing literature by providing valuable, nuanced information on victimization exposure, self-perception, and strengths-based interventions for youth. The following section presents research on the rates and impact of youth victimization exposure and caregiver IPV victimization. It also presents specific information about the association between victimization experiences and children's self-perception.

### **Victimization Exposure Among Children: Rates and Impact**

#### ***Rates***

Compared to adults, children are exposed to victimization more frequently (Finkelhor, 2008). Using a large, nationally representative sample, Finkelhor and colleagues (2013) conducted one of the most comprehensive victimization exposure surveys in the United States, inquiring about both direct and indirect forms of violence and victimization exposure. Direct victimization experiences are defined by acts of violence or aggression (including property

crime) committed against the child directly, while indirect exposure includes witnessing, hearing about, or seeing evidence of such acts. Data from this survey estimated that 57.7% of children experienced some type of victimization in the last year (Finkelhor, Turner, Omrod, & Hamby, 2009). Focusing on direct forms of victimization among school-aged children, approximately 47.9% endorsed exposure to physical assault, 3.3% endorsed exposure to sexual victimization, 14.2% endorsed maltreatment by a significant adult in their life, and 23.5% endorsed property victimization in the last year (Finkelhor et al., 2009). Regarding indirect forms of victimization, approximately 19.1% of school-aged youth reported that they had witnessed violence in the last year, and approximately 3.0% endorsed other types of indirect exposure to violence (e.g., household burglary, learning that a family member was murdered; Finkelhor et al., 2013).

### ***Impact***

**Direct & Indirect Exposure.** These documented high rates of childhood victimization are troublesome, given the array of negative consequences associated with victimization exposure among school-aged youth. Direct forms of victimization (e.g., maltreatment, bullying) among this population have been associated with mental health difficulties (e.g., emotion dysregulation, internalizing symptomatology, externalizing symptomatology, substance misuse), functional impairment, and impaired social competence and relationships (Fleckman, Drury, Taylor, & Theall, 2016; Lamis, Wilson, King, & Kaslow, 2014; Kim & Cicchetti, 2010; Rogosch, Oshri, & Cicchetti, 2010; Shukla & Wiesner, 2016; Topitzes, Mersky, & Reynolds, 2011; Wallace & Roberson, 2016). Furthermore, psychological difficulties associated with childhood victimization experiences often persist into adulthood (Hill, Kaplan, French, & Johnson, 2010; Kaplow & Widom, 2007). Although indirect victimization experiences may seem more innocuous, research suggests that these experiences are often associated with consequences

similar to those documented for direct victimization. Indeed, children exposed to indirect victimization are more likely to exhibit internalizing and externalizing problems, posttraumatic stress symptomatology, social and emotional adjustment difficulties, and delinquent behaviors (Flannery, Wester, & Singer, 2004; Fleckman et al., 2016; Fowler et al., 2009; Kitzmann, Gaylord, Holt, & Kenny, 2003; Shukla & Wiesner, 2016; Stover & Berkowitz, 2005).

While research has established that direct and indirect forms of victimization each influence psychological functioning among school-aged children, some studies have specifically examined the differential effect of direct and indirect victimization experiences. Multiple studies suggest that direct victimization has a somewhat stronger influence on mental health outcomes, compared to witnessing violence (Fowler et al., 2009; Paxton, Robinson, Shah, & Schoeny, 2004; Shields, Nadasen, & Pierce, 2009). However, Shukla and Wiesner (2016) found only a marginal difference between the effects of direct and indirect family violence exposure on delinquent behaviors. Similarly, Fowler and colleagues (2009) found that direct and indirect community violence exposure equally predicted posttraumatic stress symptoms (Fowler et al., 2009). Finally, Flannery and colleagues (2004) found that indirect violence exposure at school was more predictive of trauma symptoms, compared to direct violence exposure at school. In sum, research regarding the differential effect of direct and indirect victimization experiences is mixed, but indicates that these experiences may uniquely predict psychological functioning.

**Polyvictimization.** Polyvictimization is a construct that encompasses both direct and indirect forms of childhood victimization. Polyvictimization is defined as exposure to multiple victimization categories (e.g., physical assault; psychological bullying; witnessing IPV). This approach to assessing victimization exposure is logical, given that exposure to one type of victimization is associated with significantly higher risk for exposure to other types of

victimization (Finkelhor et al., 2009). Additionally, polyvictimization has been documented as a strong predictor of mental health outcomes, often outperforming other indicators of victimization exposure, including repeated exposure to the same type of victimization (Finkelhor, Ormrod, & Turner, 2007a, 2007b, 2009; Finkelhor, Ormrod, Turner, & Hamby, 2005b; Turner, Finkelhor, & Ormrod, 2010b). Researchers speculate that children who experience victimization across multiple contexts learn that the world is generally threatening and have difficulty identifying safe havens at home, school, or elsewhere (Turner et al., 2017). The current project conceptualizes childhood victimization exposure using the direct versus indirect exposure framework in conjunction with the polyvictimization framework by examining the total number of exposures to various types of direct and indirect victimization experiences.

**Childhood Victimization and Self-Perception.** The outcome of interest in the current project, children's self-perception, has received some empirical attention in the childhood victimization literature. Existing research suggests that direct victimization experiences in childhood can result in shame, helplessness, self-blame, and lower self-esteem (Chan et al., 2011; Isaacs, Hodges, & Salmivalli, 2008; Turner, Finkelhor, & Ormrod, 2010a; Wallace & Roberson, 2016). Similarly, indirect victimization exposure among children has been linked to diminished self-esteem and feelings of self-blame (Chan et al., 2011; Hughes and Barad, 1983; Kolbo, 1996). Very little research has focused on the link between polyvictimization and self-concept (Turner et al., 2017), but the few studies that have been published suggest that polyvictimization significantly influences children's self-perception, resulting in lower levels of self-liking, self-esteem, and mastery (Soler, Paretilla, Kirchner, & Forns, 2012; Soler, Kirchner, Paretilla, & Forns, 2013; Turner et al., 2017). Finally, the few studies examining distinct facets of self-perception suggest that victimization is consistently associated with reduced self-liking

and less consistently associated with constructs reflecting self-competence (Soler et al., 2012; Turner et al., 2010a; Turner et al., 2017). Theories about the link between childhood victimization and self-perception are discussed in more detail below (see Theoretical Frameworks: Victimization Exposure and Self-Perception).

### **Caregiver Victimization Exposure: Rates and Impact**

Intimate partner violence (IPV) is defined as acts of physical, sexual, and psychological or emotional abuse between romantic partners (Black, Sussman, & Ungar, 2010). Unlike many forms of violence, there is often a relationship between the perpetrator and victim before, during, and after violent incidents (Jouriles et al., 2001; Wallace & Roberson, 2016). Additionally, IPV often involves power differentials, where the perpetrator exerts control over the victim (Tjaden & Thoennes; Wallace & Roberson, 2016). Other common features of IPV include occurrence in private settings, co-occurring substance use/abuse, and feelings of social isolation, reduced agency, and increased helplessness for the victim(s) (Durose et al., 2005; Gilbert et al., 2015; Wallace & Roberson, 2016). For children, violence occurring within the family system (e.g., IPV) can be especially confusing because it violates the notion of family as a stable, secure, and positive developmental resource (APA, 1996).

#### ***Rates***

Rates of IPV exposure are difficult to ascertain because decisions about how to define violence impact estimations (Tjaden & Thoennes, 2000; Tolan, Gorman-Smith, & Henry, 2006), as does underreporting (Tjaden & Thoennes, 2000; Emery, 2010). A recent report from the U.S. Bureau of Justice estimated that criminal domestic violence occurs at a rate of 4.1 per 1,000 persons, with IPV constituting approximately 73.2% of those incidents (Truman & Morgan, 2016). The National Intimate Partner and Sexual Violence Survey estimated higher rates of

exposure to IPV: 5.5% of women and 5.2% of men endorsed IPV victimization (i.e., sexual violence, physical violence, and/or stalking by a romantic or sexual partner) during the previous year (Smith et al., 2018). Lifetime IPV victimization estimates were 36.4% for women and 33.6% for men (Smith et al., 2018). Finally, 36.4% of women and 34.2% of men endorsed lifetime exposure to psychological aggression by an intimate partner (Smith et al., 2018). In a comprehensive assessment of IPV exposure that captures psychological, physical, and sexual abuse between romantic partners, Black, Sussman, & Unger (2010) estimated that nearly 60% of women in the United States experience IPV in their lifetime.

### ***Impact***

Regardless of whether children witness violence that occurs within their family system, caregivers' exposure to adversity can trickle down to impact children's functioning. Indeed, caregiver IPV exposure has been associated with increased psychopathology (Ehrensaft, Knous-Westfall, & Cohen, 2017; McFarlane, Groff, O'Brien, & Watson, 2003) and difficulties with emotion regulation (Katz, Hessler, & Anest, 2007), social interactions (Katz et al., 2007; Kitzmann et al., 2003), and academic performance (Jayasinghe, Jayawardena, & Perera, 2009; Kitzmann et al., 2003) among children. Importantly, children living in homes characterized by violence are at-risk for emotional and behavioral difficulties, regardless of their endorsement of witnessing the violence (Kitzmann et al., 2003). The spillover hypothesis suggests that emotions and moods experienced within the parental relationship can transfer to the parent-child relationship (Sturge-Apple, Davies, Cicchetti, & Mammen, 2010). Research supports this idea, documenting how negative psychological consequences of IPV exposure (e.g., depression) can impact children's adjustment both directly and indirectly (Levendosky & Graham-Bermann, 2001; Morrel, Dubowitz, Kerr, & Black, 2003).

**Caregiver Victimization Exposure & Self-Perception.** Although few studies have examined the association between caregiver IPV exposure and children's self-perception, El-Sheikh and colleagues (2001) found that parents' report of physical marital conflict was linked to lower global self-worth among their children. Using a narrative approach to understanding children's self-perception, Grych and colleagues (2002) presented children with story stems designed to elicit children's mental representations of the family system. Children's representations of themselves were coded as positive (e.g., competent, obedient, and empathetic) and negative (i.e., lacking power, oppositional, and aggressive). Results showed that children whose mothers had experienced IPV victimization were less positive in their self-representations, compared to children from nonviolent families (Grych et al., 2002). Theories about the link between caregiver IPV victimization and children's self-perception are discussed in more detail below (see Theoretical Frameworks: Victimization and Self-Perception).

### **Multifinality in the Face of Victimization Exposure**

To date, studies examining the effects of victimization exposure on children have largely focused on negative consequences, such as behavioral difficulties, low self-esteem, and psychological disorders (Bogat, DeJonghe, Levendosky, Davidson, & von Eye, 2006; Graham-Bermann et al., 2008; Grych et al., 2002; Osofsky, 2003; Wolfe et al., 2003). While victimization exposure during childhood represents a significant risk factor for negative outcomes in adolescence and adulthood, many children fare well (i.e., average to below average levels of mental health symptoms; resilience; preserved psychosocial resources) in the face of compounding adversity (e.g., Graham-Bermann, Gruber, Howell, & Girz, 2009; Lang & Stover, 2008; Masten, 2014). Thus, it is critical to understand how victimization experiences impact malleable developmental resources and to identify interventions that effectively preserve or



foster these assets. Equipped with such knowledge, psychologists can increase the number of children that maintain adaptive functioning, even in the context of compounding victimization exposure.

### **Theoretical Frameworks: Victimization and Self-Perception**

#### ***Children's Victimization Experiences: Shattered Assumptions Theory***

Self-perception is one potentially malleable developmental asset that has received empirical attention in research on children impacted by victimization exposure. Such experiences impact how children perceive themselves and the world in which they live. Childhood victimization experiences create an environment of insecurity and systematic control, which can engender feelings of humiliation and shame (Banyard, 1999; Brown, Craig, & Harris, 2008; Turner & Butler, 2003). Exposure to victimization may also teach children that they are personally helpless, powerless, worthless, inadequate and unlovable (Graham-Bermann, 2002; Kendall-Tackett, 2002; Irving & Ferraro, 2006; Shaw & Krause, 2002; Wekerle & Wolfe, 2003). When children experience polyvictimization in multiple contexts (e.g., school, home, community), the inability to escape pervasive threats can exacerbate feelings of powerlessness and self-blame (Turner et al., 2017). Therefore, individuals experiencing polyvictimization are more likely to believe that they are personally responsible for their negative experiences, resulting in reduced feelings of self-competence and self-worth (two key components of self-perception; Turner et al., 2017).

One guiding framework for considering the influence of victimization exposure on children's self-perception is the theory of shattered assumptions. This theory posits that trauma exposure "shatters assumptions" that individuals previously held about themselves and the world (Janoff-Bulman, 1985). Specifically, victimization experiences can challenge individuals' beliefs

that they are safe, that they are valuable, and that the world is a meaningful place (Janoff-Bulman, 1985; Janoff-Bulman, 1992). During formative childhood years, children are rapidly developing their conceptualizations of self, others, and the world (Bhana, 2010). As such, victimization experiences during this developmental period may be particularly impactful on children's assumptions about themselves and the world. Because polyvictimization involves exposure to multiple traumatic events, it repeatedly teaches children to view themselves and the world in a more negative light, sometimes resulting in long-lasting alterations in children's initial assumptions (Janoff-Bulman, 2010).

### ***Caregiver Victimization Experiences: Spillover Hypothesis***

While children's own victimization experiences can alter their self-perception, research has also linked caregiver violence exposure to children's self-perception (El-Sheikh, Harger, & Whitson, 2001; Grych et al., 2002). Because school-aged youth remain largely dependent on their caregivers, caregivers' experiences and functioning can significantly impact their children. The spillover hypothesis suggests that emotions and moods experienced within caregivers' adult relationships can transfer to their relationship and interactions with their child (Sturge-Apple et al., 2010). As such, it is important to consider how caregiver functioning in the context of violent adult relationships might influence their children's self-perception.

One pathway through which caregiver IPV exposure might affect children's self-perception is directly through reduced caregiver self-esteem. IPV exposure can erode victims' self-esteem and sense of self, identity, and self-efficacy (Matheson et al., 2015; Zlotnick, Johnson, & Kohn, 2006). It is possible that this reduction in self-esteem is reflected within the parent-child relationship via negative self-talk, difficulty with social interaction, discomfort with positive statements about the self, and demonstrated lack of self-efficacy. That is, children may

learn to view themselves in a negative light by interacting with a primary caregiver who consistently models low self-worth and self-competence.

Caregiver victimization exposure may “spillover” to influence child self-perception through a range of other negative emotions associated with IPV. Negative psychological sequelae of IPV exposure among parents (e.g., depression) have been shown to impact children both directly and indirectly via parenting (Levendosky & Graham-Bermann, 2001; Morrel, Dubowitz, Kerr, & Black, 2003). As IPV severity increases, caregivers may exhibit increased hostility, disengagement, and harsh-intrusive parenting (Gustafsson & Blair, 2012; Sturge-Apple et al., 2010). Additionally, experiencing IPV is associated with parental engagement in physical punishment strategies, psychological and physical aggression, and neglectful disciplinary behaviors (Miranda, de la Osa, Granero, & Ezpeleta, 2013; Murray, Blair-Merritt, Roche, & Cheng, 2012). In their narrative methods study, Grych and colleagues (2002) found that children whose mothers had experienced IPV victimization portrayed their mothers as less nurturant, affectionate, and authoritative, compared to children from nonviolent homes.

To the extent that children internalize feelings of distance and hostility from their caregiver, they may question their own self-worth and ability to navigate relationships (i.e., social competence). Indeed, parental warmth and effectiveness have been linked to more positive self-perception among children from families impacted by violence (Graham-Bermann et al., 2009). More generally, authoritative parenting has been linked to higher self-esteem (Milevsky, Schlechter, Netter, & Keehn, 2007), while verbally aggressive parenting has been associated with reduced self-esteem (Donovan & Brassard, 2011). Thus, caregiver IPV exposure may negatively impact a child’s self-esteem through parental modeling or negative parent-child interactions.

## **Self-Perception: An Important Psychosocial Resource**

As noted above, while various forms of victimization exposure increase risk for negative socioemotional outcomes, many children evince resilience, few mental health difficulties, and/or preserved psychosocial resources amidst compounding adversity (e.g., Graham-Bermann, Gruber, Howell, & Girz, 2009; Lang & Stover, 2008; Masten, 2014). In addition to the acknowledgement of multifinality in the face of adversity, there has also been increased recognition that the presence of social, emotional, or behavioral difficulties is not always indicative of children's ability to develop important skills, competencies, and resources (Roth & Brooks-Gunn, 2003). That is, children experiencing mental health difficulties may simultaneously be establishing friendships, meeting behavioral expectations in school and at home, and developing a coherent and positive sense of identity. Similarly, children who are not experiencing these difficulties may also not be developing strengths and skills in important domains. Acknowledging the reality of multifinality in the face of adversity and co-occurring positive and negative outcomes, the positive youth development (PYD) literature has shifted focus from a deficits-based perspective to an examination of experiences and settings that promote positive youth outcomes (Catalano et al., 2002). Using a strengths-based approach, PYD focuses on five key developmental characteristics: competence, confidence, connection, character, and caring (Lerner et al., 2005). These characteristics promote mutually beneficial interactions between children and their environments (Lerner et al., 2005). Central to the PYD framework is children's development of a positive sense of self, which is represented across the "five C's" of PYD.

In recent decades, research on the "self" has proliferated, based on growing acknowledgment that conceptualizations of the "self" influence individuals' daily lives and how

people navigate the world (Harter, 1999; Harter, 2012a). Self-perception refers to how children evaluate themselves, their competency, and their adequacy across various domains (Harter, 2012a, 2012b). For children, “competency” refers to adaptive functioning and mastering developmental tasks (Masten & Coatsworth, 1995). In addition to domain-specific evaluations of self-competence, self-perception includes an individual’s overall self-worth or self-esteem. As a construct, “self-worth” refers more broadly to how much children like themselves as people (Harter, 2012b). Both self-perceived competence and self-esteem have been conceptualized as important internal assets for children (Grant et al., 2006; McDonald et al., 2016). Consistent with assertions about the importance of self-competence and self-esteem during middle childhood, these constructs have been positively linked to long-term happiness and life satisfaction, as well as inversely related to subsequent depression, anxiety, and maladjustment (Cole, Jacquez, & Maschman, 2001; Harter, 1993; Muris, Meesters, & Fijen, 2003).

Importantly, domains of children’s perceived competence and self-worth are interrelated but distinct. That is, children self-report different levels of competence within social, academic, athletic, behavioral, physical, and global domains (Muris et al., 2003). Therefore, children with high self-regard in one area may not necessarily endorse high self-regard in other domains. Furthermore, longitudinal research has demonstrated that domains of self-perception differentially impact subsequent psychological functioning (McGrath & Repetti, 2002; Vannucci & Ohannessian, 2018). These findings highlight the value of a multidimensional conceptualization of self-perception. Therefore, in this project, we will capture self-perception across three domains, including general self-worth (i.e., how much children like the way they are living their lives and are happy with themselves as people), social competence (i.e., children’s ability to establish and maintain friendships and engender liking/acceptance among their peers),

and behavioral conduct (i.e., the extent to which children like the way they behave, do the right thing, act how they are supposed to act, and avoid getting into trouble).

### ***Self-Perception in Middle Childhood***

Because participants in the current study are 7-12 years old, it is important to consider the role of self-perception during the developmental stage termed “middle childhood.” During middle childhood (i.e., ages 6-12), children experience significant cognitive, social, and emotional development (Bhana, 2010). They are better able to integrate and grow existing socioemotional skills, develop some higher-level cognitive processes, and establish more relationships outside the family system (Bhana, 2010). Reflecting the emergence of new cognitive, emotional, and social abilities and experiences, middle childhood appears to be a crucial time for the development of self-concept (Harter, 1989; 2012a). Indeed, Erikson identified sense of industry and development of competence as the crucial developmental tasks of middle childhood (Erikson, 1993). During middle childhood, children develop the capacity to differentiate their sense of competence across specific domains (Harter, 1989; Marton, Golombek, Stein, & Korenblum, 1988; Ruble, Boggiano, Feldman, & Loebel, 1980), consider how task difficulty and personal ability impact success and failure, make social comparisons, and identify objective versus subjective definitions of “success” (Nicholls & Miller, 1983, 1984a, 1984b; Ruble, Feldman, & Boggiano, 1976; Stipek & MacIver, 1989). Perhaps reflecting these new sources of information, middle childhood is marked by more realistic self-perceptions compared to early childhood (Eccles, Wigfield, Harold, & Blumenfeld, 1993; Shavelson, Hubner, & Stanton, 1976).

### ***Self-Perception in the Context of Childhood Victimization***

Although childhood victimization and caregiver IPV have both been linked to erosion of internal assets, such as self-perception, some children exposed to these adversities maintain a positive view of themselves in one or more domains of self-perception (e.g., Graham-Bermann et al., 2009). Such positive self-perceptions have been identified as building blocks for resilience (Daniel & Wassell, 2002; Goodman, Gravitt, & Kaslow, 1995; Grant et al., 2006; Martin, 2002; McDonald et al., 2016) that bolster children's ability to cope with adversity more effectively (Guille, 2004). One of the most compelling findings for the importance of self-perception comes from a meta-analysis that identified positive self-perception, among an array of potential protective factors, as having a medium positive effect on resilience among children exposed to violence (Yule et al., 2018). Similarly, research links preserved self-perception to better mental health outcomes amidst adversity (Hill et al., 2010; Masten, Herbers, Cutuli, & Lafavor, 2008; Alba, Justicia-Arreaez, Pichardo, & Justicia-Justicia, 2013; Farrington, 2005; Ostrov et al. 2009; Patterson, Capaldi, & Bank, 1991). Finally, several studies have explicitly examined the buffering role of self-perception against victimization and adversity, finding that domains of self-perception can attenuate the association between adversity exposure and negative consequences (Hill et al., 2010; Kessler, House, Anspach, & Williams, 1995; Masten et al., 2008; Alba et al. 2013; Farrington 2005; Ostrov et al. 2009). Hill and colleagues (2010) synthesized findings from several studies and speculated that self-esteem buffers against distress and fosters resilience by promoting positive dispositions and stress appraisals, facilitating constructive coping strategies and behaviors, and easing feelings of worthlessness and shame.

### ***Self-Perception: A Target for Intervention***

Existing literature suggests that self-perceptions of competence and self-worth represent internal assets that not only promote adaptation among children impacted by victimization

exposure but also are amenable to change (Alba et al. 2013; Farrington 2005; Ostrov et al. 2009; Patterson et al. 1991). Because these internal assets are considered malleable, they represent excellent candidates for interventions aiming to improve long-term outcomes among children exposed to adversity. Promoting a more complete understanding of these internal assets and how interventions can effectively foster them is important, considering that promoting resilient functioning by bolstering assets among children exposed to adversity may be more effective than traditional forms of psychotherapy focused on reducing negative outcomes (Luthar & Cicchetti, 2000).

## **Interventions for Children Impacted by Victimization/Violence Exposure**

### ***Fostering Resilience versus Reducing Psychopathology***

There is a growing body of literature documenting the effectiveness of interventions specifically designed for children impacted by victimization exposure (e.g., Tolan et al., 2006). Traditional evidence-based interventions for this population typically focus on reducing psychopathology and behavioral problems, rather than increasing positive functioning (Howell et al., 2017). Such interventions have documented improvements in externalizing behavior, conduct problems, anger, and anxiety among children (Cohen, Mannarino, Murray, & Igelman, 2006; Johnston, 2003; Jouriles, 2009; Kolko, Iselin, & Gully, 2011). However, there is increasing acknowledgment that interventions should aim to foster resilience and that promoting positive outcomes, rather than reducing negative outcomes, may represent a more effective approach for enhancing resilience amidst adversity (Howell et al., 2017; Kinniburgh, Blaustein, Spinazzola, & Van der Kolk, 2017; McDonald, 2016). Specifically, Kinniburgh and colleagues (2017) suggest that effective interventions should foster children's developmental competencies that have been eroded by victimization experiences. This approach is consistent with the PYD framework,



which focuses on providing environments and experiences that help children development important life skills, resources, assets, and individual strengths (Lerner et al., 2005)

### ***Enhancing Strengths/Self-Perception Among Children Impacted by Victimization/Violence Exposure***

The internal asset of self-perception represents a worthwhile intervention target. Existing research suggests that interventions can effectively enhance developmental competencies and self-perception among children impacted by victimization exposure (e.g., Whitson, Connell, Bernard, & Kaufman, 2012). A recent meta-analysis of interventions for children exposed to violence concluded that cognitive-behavioral programs in schools and mindfulness-based interventions improve children's self-perceptions (Yule et al., 2019). Two specific studies demonstrated that group interventions for children from violent families, coupled with a separate parent-focused component, can improve children's social competence (Johnston, 2003; Howell et al., 2017). Similarly, weekly skill-building groups for children who had been directly victimized or influenced by caregiver IPV engendered improvements in emotional and behavioral strengths, including positive self-identity, relationship tools, family involvement, and capacity for closeness (Noether et al., 2007). To understand how a 10-week support and education group would impact children's self-perception, Sullivan and colleagues (2002) recruited families seeking services related to domestic violence and administered the Harter Self-Perception Profile to examine changes across various domains of children's self-perception. This intervention significantly improved children's self-reported athletic competence and global self-worth but did not improve scholastic or social competence domains (Sullivan, Bybee, & Allen, 2002). These findings highlight the importance of examining unique domains of self-perception in intervention research, as results may vary by domain.

Unfortunately, traditional interventions are characterized by time and financial constraints that make them difficult to disseminate, especially when considering the level of instability that often characterize families exposed to violence (Howell et al., 2017). Furthermore, evidence-based treatments often require substantial training, which increase financial burden and barriers to dissemination (Howell et al., 2017). Camp-based interventions may offer a useful alternative to traditional interventions, improving the health and functioning of families in ways that are not practical in the context of traditional family counseling (Dipeolu et al., 2016).

### **Camp Interventions**

In recent years, summer camps and other recreational activities have gained increasing recognition as an ideal space for fostering positive youth development (Allen et al., 2006). The American Camp Association defines camp as “a sustained experience that provides a creative, recreational, and educational opportunity in group living often occurring in the outdoors. It utilizes trained leadership and the resources of the natural surroundings to contribute to each camper’s mental, physical, social, and spiritual growth” (ACA, 2012). Camp is a unique setting for youth development because children spend a significant amount of time outdoors, become immersed in the camp experience, interact with adult staff for a sustained amount of time, and benefit from a low staff to camper ratio (Henderson, Thurber, Scanlin, & Bialeschki, 2007). Indeed, camps may represent an important therapeutic resource, especially for campers from traditionally underserved or under-resourced communities (Guerra & Bradshaw, 2008).

### ***Positive Youth Development: Theoretical Underpinnings of Camp Interventions***

The positive youth development model (PYD) provides a useful framework for understanding why the camp experience may foster positive outcomes among youth (Catalano,

Berglund, Ryan, Lonczak, & Hawkins, 2002). Rooted in human development theories that link positive youth outcomes with environmental conditions (Lerner et al., 2005), PYD emphasizes strengths-based approaches and aligning children's strengths with environmental resources (Zarrett & Lerner, 2008). PYD programs have been defined in various ways but generally include supportive relationships, the development of life skills, and opportunities for youth belongingness and leadership in the context of safety, support, and appropriate structure (ACA, 2006; Eccles & Gootman, 2002; Lerner, 2004; Roth & Brooks-Gunn, 2003). Camp experiences often represent an ideal PYD setting. Researchers have found that key components of the camp experience (e.g., support, new experiences, structured opportunities, safety, and acceptance of self/others) reflect PYD features (Dipeolu et al., 2016). Essentially, the camp experience offers necessary building blocks for learning and developing important life skills: safety, support, and new opportunities (Dipeolu et al., 2016; Gambone & Connell, 2004; Thurber et al., 2007). Such growth may help children perceive themselves in a more positive light.

### ***Camp Interventions and Self-Perception***

In response to increasing recognition of camp as a potentially therapeutic milieu, camps have emphasized: developmental perspectives, targeted outcomes, intentional curricula, and program evaluation (Allen et al., 2006). Such evaluations have established that camp experiences can promote growth and positive developmental outcomes (e.g., Henderson, Bialeschki, & James, 2007; Garst, Browne, & Bialeschki, 2011). Despite the recent proliferation of research documenting positive outcomes related to traditional and specialized camps (e.g., Devine, Piatt, & Dawson, 2015; Hill, Gagnon, Ramsing, Goff, & Kennedy, 2015), as well as evidence recommending intentional camp programming (Garst & Ozier, 2015), relatively few camps evaluate theory-driven camp curricula developed for specific populations (ACA, 2011). While

no studies, to our knowledge, have examined camps for youth impacted by victimization experiences, a small but noteworthy body of literature offers useful information about how the camp experience might impact self-perception among school-aged youth more generally.

Regarding global self-perception, studies demonstrate an association between summer camp experiences and improved confidence (Seal & Seal, 2011), self-esteem (Michalski et al., 2003; Readdick & Schaller, 2005; Thurber et al., 2007), self-worth (Kiernan et al., 2004), and positive identity (Thurber et al., 2007) among various child populations. Other studies have examined specific domains of competence to understand how camp experiences impact self-perception. For instance, camp can improve perceived self-competence (Seal & Seal, 2011) and self-efficacy (i.e., care for self; managing stressors; Allen et al., 2011). Additionally, several multi-site studies have identified social skill development as a key developmental outcome associated with camp (ACA, 2005; Garst & Bruce, 2003; Thurber et al., 2007). Finally, multiple studies have demonstrated positive changes in children's values and prosocial behavior (i.e., respect for others; sound character values) following the camp experience (Allen et al., 2011; Merryman et al., 2012; Thurber et al., 2007).

Using principles of PYD in a 5-week day camp developed for 10-13-year-olds from socioeconomically disadvantaged neighborhoods, Merryman and colleagues (2012) found improvements in campers' belief in a good future for themselves, social skills, and positive values. Their data suggest that youth deemed "at-risk" can benefit from occupation-based camp programming that promotes engagement in an enriched environment and that these gains can persist after returning to potentially high-risk environments (Merryman et al., 2012). Qualitative data indicates that engagement influences skill development, that the camp environment

highlights positive choices and available occupations, and that informal physical activity helped develop skills and resilience among male campers (Merryman et al., 2012).

### **Camp HOPE America**

Camp HOPE America is the first camping and mentoring initiative in the United States developed for children impacted by family violence, and it is implemented in various cities across the country in partnership with local family justice centers. The program is rooted in trauma-informed care and aims to promote resilience and break cycles of violence. Camp HOPE implements several recommendations from the literature described above. It was designed with specific social and developmental outcomes in mind, and it intentionally evaluates the camp's effectiveness (Allen et al., 2006; Henderson et al., 2007). Additionally, because emotional support, self-esteem, and social support can attenuate the consequences of violence exposure, Camp HOPE aims to improve long-term psychological well-being among children who have experienced victimization by enhancing supportive relationships and self-esteem (e.g., Hill et al., 2010; Lamis, Wilson, King, & Kaslow, 2014). Finally, Camp HOPE takes a developmental approach, enhancing positive change by fostering domains that are most relevant to the developmental level of the campers (Howell et al., 2017; McDonald, 2016). Consistent with positive youth development principles, Camp HOPE couples a foundation of safety and support with opportunities for skill development.

The foundation of safety and support is established through the three fundamental rules of Camp HOPE: kindness and respect towards all, staying with two other people at all times, and listening for instructions during all activities. There are several components of the Camp HOPE experience that may promote a greater sense of self-competence and self-worth (key elements of self-perception) within children in this environment of safety and support. For instance,

counselors receive trauma-informed training, which includes providing consistent positive reinforcement for campers' skills, strengths, behaviors, and demonstration of prosocial skills. The camp environment is designed to recognize each child's strengths, through praise and Character Trait Awards, which are provided to each child throughout the week.

Additionally, Camp HOPE offers children a variety of activities that create opportunities for demonstration and development of various strengths. These daily activities are designed to promote important developmental skills, including teamwork, creative thinking, problem-solving, self-esteem, agency, self-management, and trust. Using "challenge by choice," Camp HOPE encourages children to push themselves towards daily goals while allowing them to opt out if the challenges become overwhelming. Campers are encouraged to support one another through various challenges and to acknowledge effort and steps towards goal attainment, regardless of goal completion.

Another strategy for enhancing campers' self-competence is through the Camp HOPE daily curriculum. This curriculum includes a theme for each day (e.g., "I am becoming my best self."; "My future is brighter than my past."; "We need each other."). These positive affirmations are intended to promote feelings of future orientation, perseverance, and personal progress. The themed daily curriculum is completed within each cabin during the afternoon. With their cabinmates, campers complete worksheets and activities that encourage the children to actively integrate the daily theme into their own lives. The theme for each day is also woven into nightly campfire discussions, during which campers answer questions like, "Where did you see hope today?" Finally, the curriculum teaches children about historical figures and role models who have overcome adversity. Campers are encouraged to identify similarities between the stories they hear and their own lives, reflecting on how they might also overcome adversity. These

components of the Camp HOPE curriculum encourage campers to set goals and envision steps towards those goals by drawing on their own strengths and fostering a sense of self-efficacy.

### **Current Project**

Among families who sought services related to victimization exposure from a family justice center, the current project aims to address several gaps in the existing literature on children's victimization exposure and self-perception. Using a 3-study model, this project will add to the literature by providing more nuanced information about the association between different types of victimization exposure and facets of children's self-perception. Further, it will explore the effect of a strengths-based camp intervention on children's self-worth and sense of competence. For an overview of evaluation dates, intervention dates, and participant flow across the three studies, see Appendix B. Figure B1 provides a timeline of the evaluation points and intervention dates across three years of Camp HOPE Tennessee, while Figure B2 presents information about the flow of participants from Study 1 to Studies 2 and 3.

Study 1 examines associations between victimization exposure and specific domains of children's self-perception (i.e., global self-worth, social competence, and behavioral conduct). This study extends the small body of literature linking victimization exposure to children's self-esteem more broadly (e.g., Gunnlaugsson et al., 2011; Wallace & Roberson, 2016). Study 1 also assesses children's victimization exposure using three different metrics: caregivers' exposure to IPV victimization, children's direct victimization experiences, and children's indirect victimization exposure. This information allows Study 1 to explore how each layer of victimization exposure is uniquely related to children's self-perception. Disentangling this association is important, given that children exposed to one form of victimization are frequently exposed to multiple types of victimization, and these accumulated experiences can have a

compounding negative effect (Finkelhor, Ormrod, & Turner, 2007a, 2007b, 2009; Finkelhor, Ormrod, Turner, & Hamby, 2005b; Turner, Finkelhor, & Ormrod, 2010b). It is hypothesized that victimization exposure (i.e., higher scores on each metric of victimization) will be inversely associated with each facet of self-perception.

Study 2 evaluates the impact of Camp HOPE on children's self-perception. Using a randomized controlled trial, this study aims to understand whether a week-long, intentional camp intervention enhances self-perception among children who have been impacted by family violence. Study 2 adds unique value to the existing literature by merging the body of research demonstrating the positive impact of camp experiences (e.g., Garst & Ozier, 2015; Thurber et al., 2007) and the body of research demonstrating that interventions designed to support children impacted by violence and victimization exposure can effectively promote positive change (Howell et al., 2017; Yule et al., 2019). To our knowledge, Study 2 is the first study to examine how the camp experience influences self-perception among campers exposed to family violence. Including a control group allows for firmer conclusions about the impact of Camp HOPE. It is hypothesized that, compared to children in the control group, children in the camp condition will demonstrate higher levels of self-perception across all three domains at the two-month follow-up evaluation and the five-month follow-up evaluation.

Analyses conducted in Study 1 and Study 2 will control for relevant demographic factors: child sex, child age, and family income. Evidence demonstrates that family violence can impact males and females in different ways (e.g., McFarlane et al., 2003; Wood & Sommers, 2011) and that self-perception may vary by sex (Gacek, Pilecka, & Fusińska-Korpik, 2014; Van den Bergh & Marcoen, 1999). Similarly, children's self-perception often changes with age (Harter, 2012a;



Jacobs, Lanza, Osgood, Eccles, & Wigfield, 2002), and family socioeconomic status can influence how children view themselves (Stadelmann et al., 2017).

Study 3 presents a familial case study that examines changes in self-perception among three siblings who participated in Camp HOPE during two consecutive summers. The primary aim of this study is to provide preliminary information about how camp impacts children's self-perception by examining fluctuations in self-perception across three time points. Information from the case study will be used to explore why the camp experience may be more beneficial to some children than others, based on their age, gender, and personality traits. Secondly, Study 3 will consider how fluctuations in self-perception correspond with ongoing victimization exposure and adversity in the family system.

## **Study 1**

### **Methods**

#### ***Participants***

All families participating in this project must have sought services from the Family Safety Center of Memphis and Shelby County (FSC) at some point during the year prior to their study enrollment. FSC is a family justice center that supports individuals who have experienced domestic violence. Clients presenting to FSC are often seeking orders of protection, other legal support, or referrals to treatment providers, shelters, and other "victim services." Families for the current study were recruited via: FSC staff referrals, FSC partner site referrals, contacting families from the FSC database, speaking with families at FSC events, and cross-referral from another study (PI: Howell) conducted as part of a partnership between University of Memphis (UM) and FSC. Participants were 96 children aged 7-12 and one of their caregivers. For families with multiple children in the age range, the sibling closest to the middle of the age range was

selected. Caregivers were required to be 18 years of age or older and the primary guardian to the child participating in the study. Per Camp HOPE America protocol, children with severe behavioral problems (i.e., behaviors that could undermine the safety of the child or other children at camp) were excluded (n = 2).

On average, child participants were 9.34 years old (SD = 1.45). Slightly more than half of the children participating in the study were female (55.2%; N = 53). The majority of the children (76.0%; n = 73) identified as Black/African-American, 9.4% (n = 9) of the sample identified as White/European American, 7.3% (n = 7) identified as Bi-racial/Multiracial, 1.0% (n = 1) identified as American Indian/Alaskan Native, and 6.3% (n = 6) identified as “Other. All caregivers in the current study identified as female, and the average age among caregivers was 35.20 (SD = 8.08). Most of the caregivers (90.6%; n = 87) were the biological mother of the child participating in the study, while five (5.2%) caregivers identified as the child’s grandmother, two (2.1%) identified as the child’s adoptive mother, and one (1.0%) identified as the child’s stepmother. The sample was comprised primarily of caregivers identifying as Black/African-American (76.0%; n = 73), followed by White/European-American (9.4%, n = 9), Biracial/Multiracial (6.3%, n = 6), and “Other” (6.3%, n = 6). Regarding relationship status, 49 (51.0%) women in the current study reported that they were currently single, 14 (14.6%) were separated, 13 (13.5%) were married, 6 (6.3%) were divorced, 6 (6.3%) were dating someone but living separately, and 6 (6.3%) were living with a partner. Most of the families were living below the federal poverty line, with 65.2% of caregivers reporting an annual household income below \$20,001.

Endorsement of victimization exposure was relatively common within the current sample, with 95.8% of youth experiencing at least one of the three types of victimization under

investigation in the current project (i.e., direct victimization, indirect victimization, caregiver IPV victimization). Per caregiver and child report of victimization exposure, 40 children (41.7%) were exposed to all three types of victimization, 33 children (34.4%) were exposed to two of these types of victimization, and 19 (19.8%) were exposed to one type. Regarding exposure to different forms of victimization, 77.7% of youth endorsed direct victimization exposure in the previous year, and 62.1% of youth endorsed indirect victimization exposure in the previous year. The majority of children (n = 64, 66.7%) endorsed more than one item on the JVQR. Finally, 78.7% of youth had caregivers who endorsed IPV victimization in the previous year.

### ***Procedures***

This study was reviewed and approved by the UM IRB. The study procedures were developed as part of a collaboration between the UM research team and the FSC Camp HOPE staff. The goal of this partnership was to evaluate the quality and effect of Camp HOPE Tennessee. At the point of initial contact with potentially eligible families, Camp HOPE staff from the UM research team spoke with caregivers about the nature and purpose of the Camp HOPE evaluation. Staff also worked with families to identify secure and preferred methods of study contact.

Study 1 included all families enrolled in the Camp HOPE Tennessee evaluation from 2017-2019. This represents three waves of camp, with camp taking place for one week each summer during these three years. Study 1 focused on data from participants' baseline assessment. Before starting the baseline assessment, caregivers provided written consent, as well as permission for their child to participate in the project. Children provided written assent. Families were given the option to complete assessments at their home, FSC, or a research lab on UM campus. Trained study staff conducted one-on-one interviews with the caregiver and child in

separate, private rooms. Interviewers read all items aloud to participants while participants were provided with a copy of the interview survey to follow along. Participants provided verbal responses to each question, and interviewers recorded these responses in an online database (i.e., Qualtrics) or a blank interviewer copy of the survey (when internet was not accessible). Surveys completed on paper were entered into the online database and checked for accuracy by trained research assistants. Each interview lasted approximately 45 minutes.

Families were assigned to the camper condition or a control group condition (details provided in Study 2). After completing their initial assessment, control families received a \$25 gift card to compensate them for their time. Camper families did not receive direct monetary compensation. Instead, they were compensated with a free week of overnight summer camp for their eligible children, as well as free camp reunion activities throughout the year with gifts and meals provided at the reunion events. At the baseline assessment, all caregivers completed a consent for future contact form granting permission to be contacted for subsequent assessments.

### ***Measures***

**Demographics.** Caregivers provided demographic information about themselves and their children, including age, race, sex, and family income (i.e., estimate of annual dollar amount). In the current analyses, child sex, child age, and family income were used as covariates.

**Childhood Polyvictimization.** The Juvenile Victimization Questionnaire – 2<sup>nd</sup> Revision Reduced Item Version, Youth Past-Year Form (JVQR2-RIV) is a 12-item measure assessing exposure to polyvictimization: property victimization, physical assault, maltreatment, peer victimization, sexual victimization, and witnessing/indirect victimization (Finkelhor, Ormrod, Turner, & Hamby, 2005b). For the current study, youth participants reported on their own

adversity exposure by responding to items on a dichotomous “Yes” or “No” scale. Children were asked to report on victimization experiences in the past year. See Appendix A for full measure.

The JVQ scoring manual places each item into one or more categories that represent different types of victimization experiences (Hamby et al., 2005). As such, a variety of categorization systems for items on the JVQR exist. Each of these systems results in distinct constructs and offers a meaningful way to conceptualize victimization experiences. The JVQR developers provide several commonly used aggregate scoring options, including indirect and witnessed victimization exposure (Finkelhor et al., 2009). Measure developers also advise that researchers can create their own scores for the specific goals of their research project. Similar to the approach used by Peterson and colleagues (2019), the current study grouped victimization experiences into direct and indirect exposure categories using specific guidance from the JVQ manual about which items belong to which category. Affirmative responses on the JVQR2-RIV were summed to generate two total scores representing direct polyvictimization (9 items; e.g., “In the last year, did anyone hit or attack you WITHOUT using an object or weapon?”) and indirect polyvictimization (3 items; e.g., “In the last year, in real life, did you SEE anyone get attacked on purpose WITH a stick, rock, gun, knife, or other thing that would hurt? Somewhere like: at home, at school, at a store, in a car, on the street, or anywhere else?”).

The JVQR2-RIV has demonstrated strong correlations with longer versions of the JVQR2. It also demonstrated predictive validity via associations with trauma symptoms that were comparable to longer versions of the JVQR2 (i.e., depression, anxiety, and anger; Finkelhor et al., 2005b). This study was conducted with a large sample, with post-stratification weights to adjust for race proportion differences between the study sample and the United States national sample (Finkelhor et al., 2005a). The JVQR2 has been used with other diverse samples,

including a racially and socioeconomically diverse sample of urban youth (Holt et al., 2007). Furthermore, the JVQR2 developers were committed to ensuring that the concepts and language of the measure were accessible and understandable for a variety of audiences (Hamby et al., 2005). To ensure that the language was appropriate for the intended audience, the scale was reviewed by victimization experts, parents, and teens, and young children completed an in-depth administration with the research team (Hamby et al., 2005). Although exposure to one form of victimization is associated with increased odds of experiencing other forms of victimization, victimization exposure is not a unidimensional construct (Gray et al., 2004; Netland, 2001). Rather, victimization measures assess exposure to disparate events that do not necessarily co-occur (Gray et al., 2004; Netland, 2001). Because participants may experience one form of victimization without necessarily experiencing another, JVQR items need not be related. Therefore, internal consistency is not provided for this measure.

**Intimate Partner Violence (IPV) Victimization.** Caregivers completed the Revised Conflict Tactics Scale (CTS2), a measure of psychological, physical, and sexual violence in a dating, cohabitating, marital, or previous romantic relationship (Straus, Hamby, Boney-McCoy, & Sugarman, 1996; Straus, 1979). The original CTS2 includes 78 items that assess both victimization and perpetration. For the current study, caregivers responded only to items assessing victimization exposure (39 items). The CTS2 is comprised of the following subscales: Negotiation (e.g., “My partner showed care for me even though we disagreed”), Physical Assault (e.g., “My partner twisted my arm or hair”), Psychological Aggression (e.g., “My partner swore or insulted me”), Sexual Coercion (“My partner used force (like hitting, holding down, or using a weapon) to make me have sex”), and Injury (e.g., “I had a sprain, bruise, or small cut because of a fight with my partner”). Caregivers responded on a 7-point scale ranging from 0 (“This has

never happened”) to 6 (“Happened more than 20 times in the past year”). They could also select an alternative response: “Has not happened in the past year, but it did happen.” Caregivers were instructed to refer to their most recent violent relationship and indicate how often each type of violent event occurred in the past year. IPV victimization frequencies were summed to create four subscales: Physical Assault, Psychological Aggression, Sexual Coercion, and Injury. Higher scores indicate greater frequency of psychological, physical, and sexual IPV and injury related to IPV. See Appendix A for full measure.

The CTS2 has demonstrated good internal consistency, with alpha coefficients ranging from .79 to .95, as well as adequate construct and discriminant validity (Straus et al., 1996). This measure was intentionally developed with a simple vocabulary and sentence structure, reading at a 6<sup>th</sup> grade reading level (Straus et al., 1996). It has been deemed reliable and valid across a variety of populations (Chapman & Gillespie, 2019) and has been used with African American/Black women (Fincher et al., 2015). In the current study, alpha was .97 for the Total Victimization scale, .80 for the Injury subscale, .88 for the Sexual Coercion subscale, .92 for the Psychological Aggression subscale, and .96 for the Physical Assault subscale.

**Self-Perception.** The Self-Perception Profile for Children (SPPC; Harter, 2012b) measures global self-worth and five specific domains of self-perception: Social Competence, Behavioral Conduct, Scholastic Competence, Athletic Competence, and Physical Appearance. The SPPC consists of 36 items using a “structured alternative format” that is designed to offset social desirability response biases and provide children with a range of response choices. The child is first presented with two statements about different types of children – one with a more positive view of self and one with a more negative view of self (e.g., “Some kids are often unhappy with themselves, BUT other kids are pretty pleased with themselves.”). The child first

decides which kind of child he/she is most similar to, between the two options. Then, the child decides whether the description chosen is “Really True” or “Sort of True” for him/her. This procedure results in a four-point scale from 1 to 4, with “1” reflecting the lowest perceived competence/adequacy and “4” reflecting the highest level of competence/adequacy. The SPPC manual instructs that researchers interested in specific domains of self-perception can extract specific subscales (Harter, 2012b). Given the association between camp experiences and changes in self-esteem, social skills, and children’s behavior, the current study included (via self-report) child participants’ self-perception on three subscales: Global Self-Worth (GSW), Social Competence (SC), and Behavioral Conduct (BC). GSW reflects the extent to which children like the way they are living their lives and are happy with themselves as people (6 items; e.g., “Some kids are often unhappy with themselves, BUT other kids are pretty pleased with themselves.”). SC assesses children’s belief in their ability to establish and maintain friendships and get other people to like and accept them (6 items; e.g., “Some kids find it hard to make friends, BUT other kids find it’s pretty easy to make friends.”). BC measures the extent to which children like the way they behave, act the way they are expected to act in various situations, and avoid getting in trouble (6 items; e.g., “Some kids usually do the right thing, BUT other kids often don’t do the right thing.”). Thus, the present study included 18 SPPC items. Item responses were not anchored to a specific timepoint. Each subscale ranges from 6-24, with higher scores reflecting more positive self-perception. See Appendix A for full measure.

The SPPC has demonstrated adequate internal consistency ( $\alpha = .78 - .91$ ) and convergent validity (Harter, 2012). However, because studies with Black/African-American youth have yielded inconsistent findings, multiple authors have recommended that researchers use caution when interpreting the SPPC with this population. Specifically, researchers administering the



SPPC to Black/African-American youth have discovered different factor structures, higher intercorrelations between SPPC subscales, and poorer convergent validity with a self-esteem measure, compared to findings from research conducted with primarily White/European-American samples (Stewart et al., 2010; Schumann et al., 1999). Although these findings raise questions about the content and construct validity of the SPPC for Black/African-American youth, some factors have been replicated with this population, and the subscales comprising the original factor structures have demonstrated good internal consistency (i.e., .77 and above) with this population (Stewart et al., 2010; Thomson & Zand, 2002). In the current study, internal consistency was acceptable for the SC subscale ( $\alpha = .77$ ). However, as cautioned by previous authors, two of the subscales revealed somewhat low alpha values: the BC subscale ( $\alpha = .66$ ) and the GSW subscale ( $\alpha = .66$ ). As such, items comprising each subscale were examined for their correlation with the overall subscale, and items with low factor loadings were removed. After removing item 4 from the BC subscale, the Cronbach's alpha value was .72. After removing items 10 and 30 from the GSW scale, the Cronbach's alpha value was .74. The reduced-item version of these subscales was used in subsequent analyses. The revised version of the BC subscale yields a total score ranging from 5-20. The revised GSW subscale ranges from 4-16.

### ***Analytic Plan***

Preliminary analyses assessed skewness, kurtosis, outliers, and multicollinearity to determine whether the primary variables met key statistical assumptions (Tabachnick & Fidell, 2019). Additionally, missingness patterns were analyzed to ensure data were missing completely at-random (MCAR) or at-random (MAR) and appropriate for multiple imputation. Using IBM SPSS version 25.0, the study hypotheses were evaluated via linear regression models to understand the association between children's victimization exposure, caregivers' IPV exposure,

and children's self-perception. Three regression models were run, one for each self-perception outcome variable: Social Competence, Behavioral Conduct, and Global Self-Worth.

Covariates were selected based on existing literature and prognostic value. Specifically, the current study used the "change in estimate" approach to statistically examine the role of suspected confounders in each regression model (Greenland, 1989). First, a regression was run for each outcome, including only JVQ and CTS scores as independent variables (i.e., the crude models). Then, each potential confounder was added to the model individually, and the author examined change in model estimate when the potential confounder was included. Potential confounders that changed the association between any of the three primary independent variables (i.e., JVQ Direct, JVQ Indirect, and CTS Total) and the dependent variable by at least ten percent were included in the final regression models (Greenland, 1989). As such, confounding variables differed across regression models (See Table 2).

## **Results**

### ***Data Screening***

**Preliminary analyses.** Regarding caregiver's IPV exposure, 95.7% of caregivers endorsed being in at least one violent relationship in their lifetime. Slightly more than half of the caregivers ( $n = 51$ ; 55.4%) reported having been in one violent relationship, while 40.3% ( $n = 27$ ) reported being in more than one violent relationship in their lifetime. Caregivers' average baseline CTS score was 149.20 ( $SD = 193.00$ ), which equates to nearly three IPV incidents each week. In the past year, 78.7% ( $n = 70$ ) of caregivers endorsed at least one instance of IPV. All 70 caregivers who endorsed IPV exposure in the past year reported experiences of psychological aggression ( $M = 66.78$ ,  $SD = 66.71$ ). Of the total sample, 66.3% ( $n = 59$ ) of caregivers endorsed exposure to physical assault ( $M = 46.33$ ,  $SD = 79.05$ ), 53.9% ( $n = 48$ ) endorsed IPV-related

injury ( $M = 14.55$ ,  $SD = 26.75$ ), and 42.7% ( $n = 38$ ) endorsed sexual coercion ( $M = 21.53$ ,  $SD = 40.99$ ).

Child participants' average baseline JVQR score was 3.01 ( $SD = 2.29$ ), with 85.4% ( $N = 82$ ) of child participants endorsing at least one instance of victimization exposure in the last year. More than three quarters of children (77.7%) endorsed exposure to direct victimization, with a mean score of two direct victimization experiences in the last year ( $M = 2.00$ ,  $SD = 1.66$ ). The most commonly endorsed forms of direct victimization were peer victimization (i.e., being hit by another child ( $n = 43$ , 44.8%); feeling scared/bad because other kids were calling the child names or saying mean things;  $n = 39$ , 40.6%) and property victimization (i.e., having something stolen;  $n = 30$ , 31.3%). Sixty-two percent of children endorsed indirect victimization exposure, with a mean score of approximately one indirect victimization experience in the last year ( $M = 0.99$ ,  $SD = .951$ ). The most commonly endorsed forms of indirect victimization exposure were witnessing IPV ( $n = 37$ , 38.5%) and seeing or hearing gun shots, bombs, or riots ( $n = 35$ , 36.5%).

Examination of the SPPC scores revealed that participants' self-perception scores were relatively high. Of note, the scores reported here reflect the total SPPC subscale scores, before removing items to enhance internal consistency. These raw scores are reported for the sake of comparison with normed sample data. Out of a total score of 24, the average Social Competence (SC) score was 16.93 ( $SD = 4.81$ ), the average Behavioral Conduct (BC) score was 18.76 ( $SD = 3.92$ ), and the average Global Self-Worth (GSW) score was 19.63 ( $SD = 3.71$ ). These scores were generally consistent with, although slightly higher than, those from the normed sample with which the measure was developed (Harter, 2012b). Regarding correlations between study variables, children's direct victimization exposure was inversely associated with all three facets of children's self-perception (i.e., SC, BC, GSW). Children's indirect victimization exposure and

caregivers' endorsement of IPV victimization were not significantly associated with SC, BC, or GSW. For additional descriptive information and correlations between study variables, see Table 1.

**Screening.** Data screening revealed no problems with skewness or kurtosis (i.e., no values above an absolute value of 2) for continuous variables. The Shapiro-Wilk test for normality was significant for all continuous variables, suggesting potential problems with normality. However, examination of the normal probability (Q-Q) plots indicated that deviations from normality were minor. Therefore, variables were not transformed. Examination of minimum and maximum values for all variables did not reveal any implausible values, and no outliers were identified (i.e., when standardized values for each data point were created, no values were greater than an absolute value of 3.29). The percentage of missing data on study variables ranged from 0.00% (i.e., child age, child sex) to 7.30% (i.e., CTS2 Total). Little's MCAR test was not significant, suggesting that data were missing completely at random and appropriate for multiple imputation. Therefore, missing data were imputed for SPPC scores, JVQ scores, CTS scores, and household income. The other demographic variables (i.e., age, race, and sex) did not have any missing data points. A post-hoc power analysis conducted in G\*Power indicated that the Social Competence model ( $f^2 = .18$ ,  $\alpha = .05$ ,  $n = 96$ ,  $1-\beta = .95$ ), Behavioral Conduct model ( $f^2 = .12$ ,  $\alpha = .05$ ,  $n = 96$ ,  $1-\beta = .83$ ), and Global Self-Worth model ( $f^2 = .10$ ,  $\alpha = .05$ ,  $n = 96$ ,  $1-\beta = .73$ ) were adequately powered.

### ***Regression Analyses***

**Social Competence.** Because multiple imputation was used to address missing data, F-values and  $R^2$  values will be presented as an average value and a range, representing the lowest and highest values among the 20 imputed datasets. The social competence regression model was

significant,  $F(4, 91)_{\text{Mean}} = 6.80$  (range = 5.42-8.20),  $p_{\text{Mean}} < .001$  (range = .000-.001). Models accounted for 23.0% (19.2-26.5%) of the variance in children's perceptions of their own social competence. In the social competence regression model, higher levels of direct victimization were linked to lower perceived social competence scores ( $B = -1.63$ ,  $p < .001$ ), and higher levels of indirect victimization were linked to higher perceived social competence scores ( $B = 1.22$ ,  $p = .035$ ). Neither caregiver IPV victimization nor family income were associated with social competence scores (See Table 2).

**Behavioral Conduct.** The behavioral conduct model was not significant in 85% ( $n = 17$ ) of the imputed datasets,  $F_{\text{Mean}}(6, 89) = 1.97$  (range = 1.45-2.51),  $p_{\text{Mean}} = .094$  (range = .027-.205),  $R^2 = 11.7\%$  (range = 8.9%-14.5%). Therefore, it will be interpreted as nonsignificant. See Table 2.

**Global Self-Worth.** The global self-worth (GSW) model was significant,  $F_{\text{Mean}}(4, 91) = 5.40$  (range = 4.09-7.25),  $p_{\text{Mean}} = .001$  (range = .000-.004). This model accounted for 19.1% (range 15.2%-24.2%) of the variance in children's GSW scores. Direct victimization experiences were significantly negatively associated with children's GSW ( $B = -.89$ ,  $p < .001$ ), and indirect victimization experiences were significantly positively associated with children's GSW ( $B = .78$ ,  $p = .037$ ). Neither of the other variables included in the model (i.e., caregiver's IPV exposure and child age) were significantly associated with this facet of self-perception. See Table 2.

## **Discussion**

Existing literature documents associations between childhood victimization and self-perception, an important psychosocial resource during middle childhood. However, little is known about the association between unique forms of victimization exposure and unique facets of children's self-perception. The current study contributes to the current literature by examining

associations between three different forms of victimization exposure (i.e., caregiver IPV, child direct, and children indirect) and three domains of children's self-perception (i.e., global self-worth, social competence, and behavioral conduct). Findings provide insight about how these different victimization experience might impact how children think about their own worth and competencies.

As hypothesized, direct victimization exposure was inversely associated with all three facets of self-perception. This is consistent with research demonstrating that direct victimization exposure can negatively impact social competence (e.g., Lamis et al., 2014), behavioral conduct (e.g., Rogosch et al., 2010), and self-esteem (e.g., Isaacs et al., 2008). The current study extended these findings by including other forms of victimization in the model. The fact that direct victimization exposure was significantly associated with self-perception, even after controlling for relevant demographic variables and other forms of victimization, highlights the unique detrimental impact of direct victimization exposure on children's view of themselves. As suggested by the shattered assumptions theory (Janoff-Bulman, 1985), children who are repeatedly victimized can begin to internalize negative beliefs about themselves, believing that they are personally responsible for the experience of victimization. These children may believe that they experience victimization because they are "bad" in a global sense, demonstrate behavior that warrants harsh punishment, or experience victimization because they possess poor social skills.

Contrary to our hypotheses, indirect victimization exposure was positively associated with social competence and global self-worth. This finding is inconsistent with previous literature indicating that indirect victimization experiences are associated with behavioral difficulties (e.g., Fleckman et al., 2016), social difficulties (e.g., Kitzmann et al., 2003), and

diminished self-esteem (e.g., Chan et al., 2011). Because this is the first study to our knowledge to examine the association between indirect victimization exposure, broadly defined, and distinct facets of children's self-perception measured by the SPPC, it is likely that differences in constructs and samples across studies are partially responsible for these contradictory findings. For example, previous studies have been conducted with clinical samples, children living in a shelter for women exposed to physical IPV, and adolescents living in Hong Kong. Furthermore, these studies have focused on witnessing familial violence as an indicator of indirect violence exposure and self-esteem as an indicator of self-perception (e.g., Chan et al., 2011; Hughes & Barad, 1983; Kolbo, 1996). Finally, the current study measured indirect victimization exposure using only three items and thus captured only three types of exposure. It is possible that a measure of indirect victimization that captures exposure to a wider array of indirect victimization experiences would yield different associations with self-perception.

It is important to note that the bivariate correlations between indirect victimization exposure and SPPC subscales were not significant. Thus, the positive, significant finding emerged only after accounting for the variance in social competence and global self-worth explained by other study variables. Research suggests that children repeatedly exposed to violence may normalize violence and become desensitized to its effects (Gaylord-Harden et al., 2016; Ng-Mak et al., 2004; Xia et al., 2018). Findings from Gaylord-Harden and colleagues (2016) suggest that witnessing victimization, in addition to directly experiencing victimization, is associated with increased normalization and desensitization. These authors theorize that “experiencing a wider range of violent events is most likely to lead to emotional desensitization effects” or that witnessing violence facilitates greater desensitization by allowing individuals to process the experience of victimization without experiencing personal threat or fear (Gaylord-

Harden et al., 2016; Russo & Roccato, 2010). Consistent with this desensitization framework, it is possible that current study findings linking indirect victimization exposure to increased GSW reflect a normalization of violence and aggression. This normalization could protect children from internalizing direct victimization experiences as a reflection of their own competence or worth. Indeed, under the shattered assumptions theory, it is likely that witnessing victimization might alter children's beliefs about the world more than their beliefs about themselves.

Findings regarding associations between caregiver IPV exposure and self-perception were also inconsistent with our hypotheses. Caregiver IPV was not significantly associated with children's perceptions of social competence, behavioral conduct, or global self-worth in bivariate correlations or regression models. This finding is inconsistent with research demonstrating a negative association between caregiver IPV exposure and behavioral difficulties (e.g., Katz et al., 2007), social difficulties (e.g., Katz et al., 2007), and self-esteem (e.g., El-Sheikh et al., 2001). However, very few studies have directly examined the association between caregiver IPV and children's self-perception, especially while accounting for other forms of victimization. Again, it is possible that differences between the current study's operationalization of constructs and sample account for some of these discrepant findings. For instance, behavioral difficulties and social difficulties are conceptually related to children's self-perception of their behavioral conduct and social competence, but they are not identical constructs. Thus, it is possible that caregiver IPV impacts children's behavior and social skills but does not impact children's evaluation of their own ability to manage their behavior or interact with their peers. Finally, null findings in the current study may also be attributable to the high rates of caregiver IPV (i.e., 78%) and other forms of victimization exposure in the current sample, as well as the fact that all participants were recruited from an agency supporting victims of violence exposure. Such



homogeneity in the sample reduces variability, which can result in difficulties detecting meaningful associations between constructs.

In sum, findings from the current study highlight the unique impact of direct victimization experiences on children's self-perception, after accounting for other forms of adversity and relevant demographic variables. Findings also suggest that indirect victimization experiences may normalize or desensitize children to violence, which could reduce the likelihood that children will internalize victimization experiences as a reflection of their own competence or self-worth. However, given the novelty of this finding and limitations of the current study, this interpretation must be considered with caution until future research can elucidate the association between indirect victimization and self-perception. Frequency and severity of caregiver IPV exposure does not appear to impact how children view themselves.

Interestingly, while the regression models predicting SC and GSW were both significant, the BC regression model was not significant in most of the imputed datasets. This finding reflects that study variables did not account for as much variability in BC, which suggests that extraneous variables may be stronger predictors of children's behavioral conduct. This finding is unexpected, given the large body of research documenting associations between victimization exposure, difficulties with emotion regulation, and behavioral difficulties (e.g., Fleckman et al., 2016; Kim & Cicchetti, 2010). However, the current study employed a unique operationalization of behavioral conduct (i.e., children's perceptions of their ability to behave the way they want/are expected to behave in various social situations). Thus, it is possible that children's perceptions of their ability to manage their behavior are influenced by a wider array of factors than measures that assess frequency of concrete behaviors. These factors may include level of

insight, behavioral expectations of children in their various personal environments, and children's normalization of disruptive behaviors.

### *Limitations*

Current study findings should be interpreted in consideration of several limitations. The cross-sectional design precludes examination of temporal associations between victimization, caregiver IPV, and children's self-perception. Although the victimization measure assessed past-year exposure and the self-perception measure assessed current views, it is possible that current self-perception impacts children's recollection of past-year experiences. Furthermore, the cross-sectional design limits the ability to investigate potential interactions between victimization experiences and self-perception over time. Future research is needed to examine causal pathways between victimization experiences and self-perception.

Additional limitations are related to the current study's measurement approach. Reliance on self-report data introduces potential for bias, including difficulties with recall, discomfort with sharing sensitive information, and social desirability. Furthermore, previous research and the current study findings introduce questions about appropriateness of the SPPC for use with Black/African-American participants. While the current study addressed concerns related to low internal consistency by removing items from relevant subscales, future research should evaluate cultural adaptations for the SPPC or develop a new measure of self-perception for Black/African-American, urban youth from low-income households. Finally, the current study used a brief measure of children's victimization experiences, relative to the extended JVQR. It is possible that a more extensive assessment of children's victimization experiences would yield different results.

The current study sample is fairly homogeneous, introducing limitations regarding the generalizability of findings. The sample is comprised entirely of families who sought services at a family justice center. Most participants identified as racial/ethnic minorities and reported a household income below the federal poverty line. As such, it is possible that findings may not generalize to families who have not sought organizational support, children from non-violent homes, children from different racial/ethnic groups, or children from different socioeconomic backgrounds.

## **Conclusion**

The present study adds unique values to the existing literature on the association between victimization and self-perception in middle childhood. This is the first study, to our knowledge, to examine the association between unique forms of victimization exposure and three facets of self-perception among children experiencing family violence. Thus, the current study offers a more nuanced understanding of this relationship. Findings highlight the negative impact of direct victimization on children's self-concept and raise questions about the potential impact of indirect victimization exposure and caregiver IPV exposure. Given the importance of developing a positive sense of self during middle childhood, future research should continue disentangling the association between victimization and self-perception. Furthermore, prevention strategies that reduce victimization exposure and intervention strategies that address children's self-perception, particularly in the aftermath of direct victimization exposure, may help preserve or improve this important psychosocial resource.

## **Study 2**

Study 2 will be the first study to examine how Camp HOPE influences children's self-perception. This study will evaluate differences in self-perception (i.e., Global Self-Worth,

Social Competence, Behavioral Conduct) between children in the camper and control groups at two-month follow-up and five-month follow-up. We hypothesize that children in the camper condition will demonstrate higher levels of self-perception at both follow-up evaluations.

## **Methods**

### ***Participants***

A subset of families from the larger participant pool were included in Study 2. These participants ( $n = 47$  caregiver-child dyads) were recruited for the 2019 Camp HOPE evaluation by calling families from the FSC database, approaching families in the waiting room at the FSC, and cross-referral from another study conducted as part of a partnership between UM and FSC. In addition to eligibility criteria outlined in Study 1, children must not have previously attended Camp HOPE Tennessee. Additionally, families with multiple children in the age range had to be comfortable with only one child participating in the study. In such cases, the child closest to the middle of the age range (i.e., nine and a half years old) was selected to participate.

In total, the recruitment team attempted to contact 757 families for inclusion in this study. Of these families, 522 were not assessed for eligibility, primarily because the recruitment team was unable to establish contact with the family ( $n = 503$ ). The other 235 families were assessed for eligibility and of these families, 47 agreed to participate in the study. See the CONSORT diagram (Appendix B, Figure B3) for detailed information about participant recruitment and retention. On average, participants were 9.55 years old ( $SD = 1.63$ ) at baseline. Slightly more than half of the children participating in the study were male (53.2%;  $n = 25$ ). Most of the children (78.7%;  $n = 37$ ) identified as Black/African-American, followed by White/European American (10.6%;  $n = 5$ ), Biracial/Multiracial (8.5%;  $n = 4$ ), and Hispanic/Latino (2.1%,  $n = 1$ ).

At baseline, 60.0% of caregivers reported an annual household income below \$20,001, with a median income of \$15,000-\$20,000 per year. See Table 3 for additional descriptive information.

### ***Procedures***

This study was reviewed and approved by the UM IRB. The present study implemented a randomized controlled trial design and collected data at three time points (i.e., baseline, two-month follow-up, and five-month follow-up) to evaluate differences in self-perception attributable to the camp experience. All families were recruited in the months leading up to camp, with the potential of being randomly assigned to the camper or control group.

Recruitment, screening, and retention procedures mirror those outlined in Study 1, with the addition of monthly check-in calls from study staff, from the point of initial contact to the final evaluation. Additionally, because of the new randomization process, families recruited in 2019 were not made aware of their treatment condition until the week prior to their baseline interview. Prior to the start of camp, families were told that they would be assigned to a camper condition or a control condition. Control families received no services in 2019 but were offered a spot at the top of the waitlist for Camp HOPE in 2020.

**Evaluation.** One week before the baseline evaluation, study staff ( $n = 6$ ) contacted families to inform them of their camper or control condition assignment and schedule the time and location of their baseline interview. Families were assigned to the camper or control condition using block randomization. Block randomization allocates participants within blocks so that an equal number of participants are assigned to each condition. Using the online platform Sealed Envelope™, the current study used block sizes of six and eight to generate a random list of 50 treatment condition assignments. Study staff were blind to the size of each block. When study staff scheduled a baseline interview with a family, they referred to the next condition

assignment on the randomly generated list (i.e., camper or control), told the family which group they were assigned to, and documented the assigned condition.

The recruitment goal for Study 2 was 50 total families ( $n = 25$  control youth;  $n = 25$  camper youth), which reflected Camp HOPE Tennessee's capacity for expansion in 2019, the novelty of the intervention, and a power analysis. Power was set at .80, alpha was set at .05, and effect size was set at .72, based on previous Camp HOPE Tennessee data. The power analysis revealed that a total minimum sample size of 50 would be required to detect statistically significant differences between. Some challenges with recruitment and retention resulted in Study 2 being slightly underpowered. Specifically, 40 children were randomized to participate in the active (camper) condition, 23 of whom completed baseline interviews, and 41 children were randomized to be in the control condition, 24 of whom completed baseline interviews. In sum, 47 participants (23 in the camper condition and 24 in the control condition) completed a baseline evaluation for Study 2. See the CONSORT diagram (Appendix B, Figure B3).

Regardless of condition, the identified child and his or her caregiver completed assessments one month before camp (baseline), one month after camp (two-months since baseline follow-up), and four months after camp (five-months since baseline follow-up). All camper and control families completed evaluations within the same timeframe to control for extraneous factors (e.g., the beginning of school) that could alter children's self-perception. The first follow-up evaluation was scheduled for one month after camp to assess sustained yet short-term changes in self-perception. The second follow-up evaluation was scheduled for four months after camp to assess lasting changes in self-perception. Consent, assent, and survey administration followed procedures outlined in Study 1. Families in the control group received a \$25.00 gift card for completing their baseline survey, a \$35.00 gift card for completing their two-

month follow-up survey, and a \$45.00 gift card for completing their five-month follow-up survey. Families in the camper group and control group received a \$15.00 bonus if they completed all three assessments.

**Measures.** At all three assessment points, child participants completed the SPPC. A description of the SPPC is provided in the Methods section for Study 1, and the full measure can be found in Appendix A. Among the subset of participants included in Study 2, each subscale of the SPPC demonstrated acceptable internal consistency across timepoints: social competence ( $\alpha = .70-.82$ ), behavioral conduct ( $\alpha = .62-.85$ ), and global self-worth ( $\alpha = .62-.72$ ). As such, in the current study, all items from the original measure were retained for subsequent analyses.

**Intervention.** Children assigned to the camper condition participated in Camp HOPE Tennessee, a weeklong overnight summer camp. In partnership with the Family Safety Center of Memphis and Shelby County, Camp HOPE Tennessee incorporated all components from the Camp HOPE America curriculum (described above in the background section). Additionally, the Camp HOPE Tennessee staff from the University of Memphis modified some of the camp activities (e.g., adding 30 minutes of mindfulness each day; including emotion charades in theatre activities) and counselor trainings (e.g., teaching counselors the principles of trauma-informed care). These modifications were intended to enhance the therapeutic value of the camp. At Camp HOPE Tennessee, daily activities included ropes and challenge courses, arts and crafts, field games, theatre-based activities, camp songs, nightly campfires, journaling, relaxation time in the cabins, mindfulness activities, pool time, team-building activities, and family-style meals (i.e., cabins eat together). Generally consistent with camp programming, activities were designed to promote creative thinking, decision-making, problem-solving, teamwork, self-esteem, agency, self-management, trust, organization, and goal setting. To promote a sense of safety and security,

camp rules and expectations were reviewed daily and included: kindness and respect towards all, staying with two other people at all times, and listening to adult staff during activities. Further, counselors were trained to establish close bonds with their campers, recognizing each camper's strength and giving each camper in their cabin individualized attention. The week of camp was followed by camp reunions throughout the year.

### ***Analytic Plan***

Using SPSS version 25.0, preliminary analyses assessed skewness, kurtosis, outliers, and multicollinearity to determine whether primary variables met key statistical assumptions (Tabachnick & Fidell, 2019). Additionally, missingness patterns were analyzed to ensure data were missing completely-at-random (MCAR) or at-random (MAR) and appropriate for multiple imputation.

All models were estimated in Mplus 8 (Muthen & Muthen, 1998-2017). The retention rate was 76.6% at two-month follow-up and 68.1% at five-month follow-up. When examining potential differences between participants who completed these follow-up assessments and those who did not, no significant differences (i.e.,  $p > .05$ ) in family income, caregiver IPV exposure, child sex, child race, child victimization exposure, or child self-perception were detected. Among participants who completed assessments, item-level missingness was 0.05% at baseline, 0.26% at two-month follow-up, and 0.21% at five-month follow-up. Item-level missingness was addressed by prorating scale scores to 80%. Multiple imputation was used to address scale-level missing data in the primary analyses. Scale-level missing data includes participants who did not complete their two-month follow-up ( $n = 11$ ) or five-month follow-up ( $n = 15$ ). It also includes participants who did not complete enough items to compute a total score using 80% proration ( $n = 4$  scale scores).



Three multigroup piecewise latent growth curve models (LGCM; Berlin, Parra, & Williams, 2014; Preacher, Wichman, MacCallum, & Briggs, 2008) were conducted to estimate changes in self-perception (Social Competence, Behavioral Conduct, and Global Self-Worth) from baseline to two-month follow-up and five-month follow-up. LGCM are structural equation models that estimate change in a dependent variable that is measured at multiple time points (i.e., baseline, 2-month follow-up, 5-month follow-up), thus measuring within-individual changes across time. In the current study, the multiple group piecewise LGCMs were conditional on condition (i.e., camper vs. control), facilitating between-group comparisons on each parameter. Each of the three models yielded three parameters: 1) the intercept, representing differences in baseline self-perception scores between camper and control groups; 2) slope one, representing differences in rate of change from baseline to two-month follow up; and 3) slope two, representing differences in rate of change from two-month follow-up to five-month follow-up. To investigate group differences (i.e., between camper and control participants) at two-month follow-up and five-month follow-up, these aforementioned models were reparametrized such that the intercept reflected estimated values at either two-month or five-month follow-up evaluation. The treatment effect estimated the difference between the camper and control groups at the second or third follow up. In all models, residual variances were set to zero for identification purposes, resulting in zero degrees of freedom. Fully saturated models such as these perfectly reproduce the covariance matrix and as such render the goodness of fit statistics non-informative (e.g. yield a chi square = 0, CFI = 1, and RMSEA = 0).

## **Results**

### ***Data Screening***

Data screening revealed no problems with skewness or kurtosis (i.e., no values above an absolute value of 2) for continuous variables. The Shapiro-Wilk test for normality was significant for all continuous variables, suggesting potential problems with normality. However, examination of the normal probability (Q-Q) plots indicated that deviations from normality were minor. Therefore, variables were not transformed. Examination of minimum and maximum values for all variables did not reveal any implausible values, and no outliers were identified (i.e., when standardized values for each data point were created, no values were greater than an absolute value of 3.29). Little's MCAR test was not significant, suggesting that data were missing completely at random and appropriate for multiple imputation.

### ***Descriptive Analyses***

Regarding victimization exposure, caregivers in the camper group reported an average baseline CTS score of 96.39 (SD = 134.37), with 83% of these caregivers endorsing at least one instance of IPV exposure in the last year. Caregivers in the control group reported an average baseline CTS score of 150.22 (SD = 162.14), with 87% of control group caregivers experiencing at least one instance of IPV exposure in the last year. Children in the camper condition reported an average baseline JVQR score of 2.87 (SD = 2.28), with 91% of camper children experiencing at least one form of victimization in the last year. The control group reported an average score of 3.26 (SD = 1.72) on the JVQR, with 92% experiencing at least one form of victimization in the last year. For additional descriptive information, see Table 3. Of note, there were no significant differences between camper and control group participants' report of baseline victimization exposure, demographic information (i.e., age, sex, race, income, socioeconomic status), or self-perception.

### ***Primary Analyses***

Intervention research often requires making decisions about whether participants are retained in their originally assigned condition (i.e., intent-to-treat analyses), re-assigned to the condition they actually received (i.e., as-treated analyses), or excluded from analyses if they do not remain in their originally assigned condition (i.e., completer analyses). Decisions about how to group participants into treatment conditions can have implications on the results, particularly in small samples. In the primary analyses, participants were retained in their originally assigned condition (i.e., intent-to-treat analysis, or ITT). Thus, these analyses compare scores between participants assigned to the camper group versus control group before their baseline assessment, regardless of whether those families attended camp. This approach upholds the randomization procedure and avoids potential biases that arise from re-assigning participants to conditions, or removing participants, based on their treatment attendance (Gupta, 2011). It also preserves the sample size thereby preserving statistical power. Finally, ITT analysis minimizes type I error and yields a conservative estimate of treatment effect (Gupta, 2011). Thus, ITT is often recommended as the primary participant-grouping approach (Gupta, 2011).

Researchers must also make meaningful decisions regarding how missing data is handled in their analyses. As mentioned above, the primary analyses for this study use multiple imputation to address missing scale-level data. Multiple imputation has been shown to reduce the potential for bias more effectively than traditional approaches for handling missing data (Enders, 2010). Finally, the primary analyses do not include covariates, given that randomization is intended to wash out between-condition differences, which theoretically eliminates the need to include potentially confounding variables. Consistent with this notion, preliminary analyses for the current dataset yielded no between-condition baseline differences on demographic variables

(i.e., age, sex, race, income, socioeconomic status), self-perception variables, or victimization variables.

**Global self-worth.** Comparing the rate of change in global self-worth (GSW) between groups from baseline to two-month follow-up (Slope 1), control group participants demonstrated improvements in GSW (Est. = .17, SE = 0.09), while campers demonstrated declines in GSW (Est. = -.07; SE = 0.11). Within-group effect size from baseline to two-month follow-up was medium for the control group ( $g = 0.54$ ) and for the camper group ( $g = 0.46$ ). Camper and control groups were not significantly different on Slope 1 (Diff. = -0.23; SE = 0.14;  $p = .095$ ;  $g = 0.49$ ). Although the rate of change from baseline to two-month follow-up was not significantly different, examining the intercept at two-month follow-up revealed that GSW scores for camper ( $M = 18.61$ ; SE = 1.02) and control ( $M = 21.26$ ; SE = 0.65) participants differed significantly at two-month follow-up (Diff. = -2.65; SE = 1.22;  $p = .029$ ;  $g = 0.63$ ), with control group participants endorsing higher levels of perceived GSW. Slope 2 revealed that control participants' GSW scores declined from two-month to five-month follow-up (Est. = -.14; SE = 0.08), while campers' GSW scores increased (Est. = 0.09; SE = 0.08). The within-group effect size reflecting change from two-month follow-up to five-month follow-up was medium for the control group ( $g = 0.46$ ) and small for the camper group ( $g = 0.25$ ). Slope 2 was significantly different between campers and control participants (Diff. = 0.23; SE = 0.11;  $p = .041$ ;  $g = -0.60$ ). At the final evaluation point (i.e., five-month follow-up), there were no longer significant between-group differences in GSW scores (Diff. = 0.51; SE = 1.40;  $p = .718$ ;  $g = 0.11$ ). See Table 4 and Figure 1, Panel A.

In sum, current findings do not support the hypothesis that children in the camper condition would demonstrate higher levels of GSW at two-month follow-up and five-month

follow-up, compared to children in the control condition. In fact, the current findings contradict this hypothesis at the two-month follow-up, with children in the control condition endorsing a more positive self-perception than children in the camper condition. At the final evaluation, there were no significant differences between the camper and control groups. While this finding does not contradict the hypotheses, it also does not support the hypothesis that camp would enhance children's self-perception.

**Behavioral conduct.** Regarding Behavioral Conduct (BC) scores, rates of change were not significantly different between the two groups for Slope 1 (Diff. = -0.02; SE = 0.11;  $p = .890$ ;  $g = 0.04$ ) or Slope 2 (Diff. = 0.02; SE = 0.11;  $p = 0.857$ ;  $g = 0.05$ ). Finally, comparison of intercept scores at two-month (Diff. = -0.30; SE = 1.47;  $p = .839$ ;  $g = 0.06$ ) and five-month follow-up (Diff. = 0.15; SE = 1.64;  $p = 0.927$ ;  $g = 0.03$ ) suggests that camper participants and control participants did not endorse significantly different scores at any time points. All within-group effect sizes were small (i.e.,  $g < 0.15$ ). See Table 4. These findings are inconsistent with the hypothesis that camp would enhance campers' behavioral conduct, as children in the camper condition did not endorse higher behavioral conduct scores than children in the control condition.

**Social competence.** For the Social Competence (SC) subscale, comparison of camper and control groups revealed nonsignificant differences at two-month follow-up (Diff. = -0.91; SE = 1.31;  $p = .489$ ;  $g = 0.20$ ), and five-month follow-up (Diff. = -0.87; SE = 1.66;  $p = .599$ ;  $g = 0.15$ ). Additionally, the camper group and control group did not demonstrate significantly different rates of change in SC scores for Slope 1 (Diff. = 0.02; SE = 0.16;  $p = .883$ ;  $g = 0.04$ ). Both groups demonstrated gains in social competence, with small within-groups effect size for both the camper group ( $g = 0.34$ ) and control group ( $g = 0.33$ ). Finally, there were not significant between-group differences on Slope 2 (Diff. = 0.00; SE = 0.13;  $p = .989$ ;  $g = 0.00$ ), for which

each slope was 0.00. This finding indicates that children in the camper group and control group both demonstrated very little change in SC between their two- and five-month follow-up evaluations. See Table 4. In sum, findings from the SC models do not support the hypothesis that camp would enhance campers' self-perception, as children in the camper condition reported similar levels of SC as children in the control condition at two- and five-month follow-up.

### *Secondary Analyses*

Secondary analyses were run to examine the impact of treatment non-completers (i.e., participants who were assigned to the camper condition but did not attend camp) on results. In these "as-treated" secondary analyses, participants were grouped according to whether they attended camp. Therefore, participants assigned to the camper group who did not attend camp ( $n = 5$ ) were re-assigned to the control group. This grouping system allows for comparison of children who attended camp and children who did not attend camp. Consistent with the primary analyses, multiple imputation was used to address missing scale-level data and covariates were not included.

Contrary to findings from the primary analyses, these secondary as-treated analyses revealed no significant differences between camper and control group children on GSW scores. Specifically, there were no between-group differences at baseline, two-month follow-up, or five-month follow-up. Additionally, these groups did not demonstrate significantly different rates of change in GSW between assessment points for either Slope 1 or Slope 2. Finally, between- and within-group effect sizes were relatively smaller (i.e.,  $g < 0.55$  and  $< 0.33$ , respectively), compared to the primary analyses. See Table 4 and Figure 1, Panel B. Consistent with findings from the primary analyses, these secondary analyses using the as-treated grouping system did not

reveal any significant differences between camper and control group participants on any of the slopes or intercepts for BC or SC. See Table 4.

In sum, when the five children randomized to the camper condition who did not attend camp were re-assigned to the control condition, the two groups did not differ on GSW. This is inconsistent with findings from the primary analyses, in which these five children were retained in the camper condition. Findings from the secondary analyses again do not support the hypothesis that camp would enhance children's self-perception. Rather, these findings indicate that children who attended Camp HOPE report self-perception scores similar to those reported by children who did not attend Camp HOPE. The fact that these five children changed the results in a meaningful way suggests that they reported significant declines in GSW from baseline to two-month follow-up and that there may be something unique about these families. It also highlights the importance of decisions about participant classification. If conclusions were drawn solely on the basis of the intent to treat analyses, findings would suggest that Camp HOPE negatively impacts children's GSW. The fact that children driving this significant difference between camper and control participants did not actually attend camp raises meaningful questions about whether Camp HOPE actually does have a negative impact on children's GSW.

## **Discussion**

Contrary to the hypothesis that Camp HOPE would enhance children's self-perception, results suggest that camp attendance did not significantly affect children's perceptions of their own behavioral conduct or social competence. Furthermore, results from the ITT analyses indicate that camp negatively impacted children's perception of their own self-worth. Of note, this finding was not significant in the as-treated analyses. Additionally, this negative impact was temporary, such that camper children reported notable improvements in self-perception at five-

month follow-up, at which point their self-worth scores aligned with children in the control condition. The finding that Camp HOPE had a temporary, negative impact on children's self-perception is inconsistent with research demonstrating that various types of intervention (e.g., skills groups, education groups, school-based cognitive behavioral therapy) can enhance self-perception and competencies among children exposed to violence (e.g., Johnston et al., 2003; Howell et al., 2017; Noether et al., 2007; Sullivan et al., 2002; Yule et al., 2019). It is also inconsistent with findings that camp-based interventions can enhance children's self-esteem (e.g., Readdick & Schaller, 2005; Thurber et al., 2007; Kiernan et al., 2004) and perceived self-competence (Seal & Seal, 2011).

While many studies have documented improved self-perception in response to intervention engagement, the current findings are consistent with some literature indicating null findings or iatrogenic effects of camp interventions on certain domains of self-perception (e.g., Sullivan et al., 2002; Thurber et al., 2007). Furthermore, most studies examining the impact of camp have implemented a pre-post design that evaluates changes within 3-14 days of the end of camp (Moola et al., 2014), rather than examining follow-up scores at a month or more past the conclusion of camp. This trend is concerning, considering that Moola and colleagues (2014) concluded that "the psychosocial benefits...associated with camp participation are not maintained over time and display temporal sensitivity." Consistent with this assertion, Török and colleagues (2006) found that self-esteem and self-efficacy improved at post-camp but declined at two-month follow-up. Similarly, one of the largest studies demonstrating the positive impact of camp on self-perception collected data on the last day of camp, where statistically significant growth emerged in many self-perception domains (Thurber et al., 2007). However, at the six-month follow-up evaluation, some of the gains were maintained, while other components of



children's competencies and identity either declined to pre-camp levels or below pre-camp levels (Thurber et al., 2007).

Literature suggests the effects of camp are time-sensitive, so it is possible that the current study would have yielded different results if children had completed post-camp evaluations closer to the conclusion of the camp week (i.e., within the days following camp). Indeed, it is possible that one-month post-camp represented a difficult time for campers, who recently experienced the end of camp and a transition back to a home environment characterized by adversity. At camp, these children established close relationships with caring adults and were offered opportunities for growth and development that are not normally accessible in their day-to-day lives. Leaving behind a safe, resource-rich environment and returning home to environments with a higher potential for violence and adversity may represent a stark contrast that engendered feelings of depression and lower self-worth. Indeed, the loss of resources and opportunities from the camp environment may have been internalized, resulting in children feeling personally responsible for this loss.

Finally, the Camp HOPE intervention is novel. To our knowledge, this is the first study to evaluate the impact of camp intervention on self-perception among children exposed to family violence. Many camp interventions that have been evaluated in the existing literature target populations with shared mental health or physical health difficulties, or non-clinical populations. Thus, it is possible that a camp intervention is not appropriate for children exposed to family violence. Although these children have a shared experience, this shared experience is not explicitly addressed through the intervention. Furthermore, as mentioned above, the contrast between the camp environment and the home environment may be more pronounced among this population, where the home environment is more likely to be characterized by adversity.

In sum, findings from the current study suggest that Camp HOPE has no impact on children's self-perception of their behavioral conduct or social competence. When children who did not attend camp were retained in their originally assigned camper condition, results indicate that Camp HOPE had a temporary negative impact on children's GSW. However, when children who did not attend camp were placed in the control group, results demonstrate that Camp HOPE had no effect on children's GSW.

### *Limitations*

Findings from the current study must be considered in the context of study limitations. As mentioned above, the temporal instability of camp-related changes raises questions about the current findings. Evaluating self-perception immediately after camp and at more frequent time points between one-month and five-month follow-up would offer a more complete understanding of how camp may impact children's self-perception. Additional measurement-related limitations include reliance on self-report data, which may introduce biases, and using a measure whose validity has been questioned for use with Black/African-American youth. Using measures that are well-validated for the current study population, as well as including additional sources of data (e.g., parent-report), would strengthen findings.

In addition to these measurement-related limitations, the sample size for the current study was quite small and fairly homogenous. As such, results should be interpreted with caution. Small sample sizes introduce greater potential for bias, given that each individual participant has a greater impact on the findings. Additionally, the current sample was comprised entirely of service-seeking families and children aged 7-12. Furthermore, most participants were Black/African-American children whose family income falls below the federal poverty line.

Thus, results from the current study may not generalize to non-service-seeking families, different racial groups, different socioeconomic groups, or different age groups.

### **Additional Analyses**

As a reminder, primary analyses included no covariates, addressed missing data using multiple imputation, grouped participants by the condition to which they were originally randomized, and included participants from 2019 only. Initial secondary analyses, presented above, altered only the participant grouping approach, placing participants into conditions based on whether or not they actually received the intervention. Additional secondary analyses can be found in Appendix C. These analyses examined the impact of covariates, alternative strategies for addressing missing data, additional participant grouping decisions, and including participants from camp year 2018.

## **Study 3**

### **Methods**

#### ***Participants***

Participants for the familial case study were three siblings from the Jones family (first and last names changed to protect privacy): Nicole (female; age 10 at baseline), Anthony (male; age 8 at baseline), and Jessica (female; age 7 at baseline). The family participated in the Camp HOPE Tennessee program in 2017. The Jones family demographics reflect the larger camp sample. The Jones siblings live with their mother and three other siblings who were outside of the age range for camp. They live intermittently with their mother's violent partner, and their mother endorsed IPV exposure at two of the three assessment timepoints. Ms. Jones reported a history of psychological and physical abuse and emotional neglect during her own childhood. Each of the Jones children endorsed exposure to direct (e.g., emotional abuse, bullying, physical

assault) and indirect (e.g., witnessing IPV and community violence) forms of violence at various assessment timepoints. All members of the Jones family self-identified as Black/African-American. Their annual household income from all sources was estimated to be \$10,000-\$15,000; thus, they were living well below the federal poverty line. Based on information garnered from the author's own interactions with the children, conversations with their caregiver, and feedback from the children's camp counselors, the Jones siblings represent three unique personalities. Nicole was noticeably shy, compared to other children her age, and she experienced bullying while at camp. Anthony was energetic and playful but displayed externalizing behavior problems throughout the week of camp, and he received negative attention from both peers and counselors. Jessica was cooperative, engaged, and well-liked, demonstrating behavior that was closest to that of the average camper.

### ***Procedures/Measures***

The Jones family was recruited via FSC staff referral. Subsequently, Camp HOPE staff screened the family for eligibility, informed them about the nature and purpose of the camp evaluation, and enrolled them in the evaluation study. The Jones siblings participated in the weeklong overnight camp, and the family completed all three assessments. The Jones family completed a baseline assessment in June 2017, attended camp in July 2017, completed a two-month follow-up assessment in August 2017, and completed a five-month follow-up assessment in early December 2017.

At each assessment, Ms. Jones provided demographic information, as well as information about her exposure to IPV victimization, measured by the Revised Conflicts Tactics Scale (CTS2). After the initial assessment, which asks about IPV victimization in the previous year, Ms. Jones was asked to report on IPV victimization exposure since her most recent assessment

date. Each of the children reported on their victimization exposure using the Juvenile Victimization Questionnaire – 2<sup>nd</sup> Revision Reduced Item Version, Youth Past-Year Form (JVQR2-RIV) and their current self-perception using the Self-Perception Profile for Children (SPPC). At the first assessment, victimization exposure was assessed in the past year. At subsequent assessments, victimization exposure was assessed since the most recent assessment date.

In addition to these three measures, which are described in detail in Study 1, the current study also assessed children’s attachment to their primary caregiver using the Attachment-Maternal scale (Hamby et al., 2015). This measure is comprised of 6 items (e.g., “You seek out your mother (figure) when you’re upset.”), with response options ranging from 1 (“Not True”) to 4 (“Mostly True”). The total score ranges from 6 to 24, with higher scores reflecting better maternal attachment.

To supplement findings from children’s self-report, the current study also considered caregiver and counselor ratings of the siblings’ prosocial skills and emotional/behavioral difficulties, as measured by the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997). Counselors completed the SDQ on the final day of camp, reporting on campers in their cabin. Caregivers completed the SDQ at baseline, two-month follow-up, and five-month follow-up. The SDQ is a 25-item measure used to assess children’s positive and negative behaviors. Items reflect five domains of functioning: emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and prosocial behaviors. Counselors and caregivers were asked to rate the accuracy of each statement (e.g., “Your child often fights with other children or bullies them”) on a 3-point scale ranging from 0 (not true) to 2 (certainly true). Each subscale ranges from 0-10. A Total Difficulties score, ranging from 0-40, is calculated by summing scores from the

emotional symptoms, conduct problems, hyperactivity/inattention, and peer relationship problems subscales. The SDQ has demonstrated good internal consistency, with an alpha coefficient of .73 (Goodman, 2001). The measure has also demonstrated adequate construct and discriminant validity (Goodman, 2001). Full measure can be found in Appendix A.

To supplement the quantitative data collected from the Jones family, Ms. Jones completed a semi-structured interview that was audio recorded and transcribed. Ms. Jones answered the following questions: “Thinking back on the first year of camp, what changes did you notice in each of your children that attended?”; “Thinking back to July of 2017, how do you think camp might have impacted each of your children’s self-esteem? How do you think camp might have impacted each child’s social skills? And their behavior (i.e., ability to behave appropriately, cooperate, and avoid getting in trouble)?” Ms. Jones also answered the question, “Why do you think camp might have impacted each of your children differently?”

### ***Analytic Plan***

To our knowledge, Study 3 will be the first in-depth case examination of children participating in the Camp HOPE program, assessing change in self-perception across time. Using a case examination approach and archival data collected as part of the larger Camp HOPE evaluation, Study 3 will assess change in each of the Jones children’s scores on three facets of self-perception (i.e., Global Self-Worth, Social Competence, and Behavioral Conduct) across the three assessment points. Using plotted self-perception scores as a guide, Study 3 compiles information about the timing of camp, each child’s experiences at camp, and data about adversity exposure in between evaluation time points to understand fluctuations in each child’s self-perception. Studying three siblings from the same family and incorporating qualitative data from

their caregiver offers several unique advantages, allowing for a nuanced exploration of factors that might impact each child's self-perception in a different way.

The primary aim of this case study is to examine fluctuations in each child's self-perception in relation to the camp experience. This aim will be accomplished using data reflecting three siblings' self-perception scores across three assessment points. Study 3 will interpret this data and hypothesize about how the camp experience contributes to changes in self-perception. Additionally, this familial case study will consider how exposure to violence between assessment time points might be tied to fluctuations in each child's self-perception. Finally, researchers will consider how each child's personality and experiences at camp might have impacted the observed results, using qualitative data from the children's mother to inform suppositions. Of note, given the minimal amount of qualitative data provided from the single informant, no formal coding procedures were used for analyses. However, these nuanced observations are difficult to capture in quantitative evaluations that pool data across participants. By examining three siblings with unique traits, Study 3 will provide preliminary information about what individual and familial factors contribute to children benefiting from Camp HOPE.

### **Course of Treatment and Assessment of Progress**

At Ms. Jones's baseline assessment, she endorsed high levels of exposure to IPV in the last year, with a score of 321 on the CTS, which has a maximum score of 825. With a score of 321, Ms. Jones experienced approximately one incident of IPV per day, on average, over the past year. Ms. Jones was married to her violent partner, who she identified as her children's stepfather. She indicated that her children had witnessed violence between her and her violent partner in the last six months. Ms. Jones considered herself a single parent to her children and was the primary caregiver for three other children who were outside of the age range for

attending camp. All three of the Jones children seemed very close to their mother, and warm interactions between Ms. Jones and her three children were observed. On the measure of maternal attachment, which ranges in score from 6 to 24, Nicole's average score across all three timepoints was 23.00, Jessica's average score was 22.33, and Anthony's average score was 16.67. Ms. Jones reported that neither she, nor her children, had received mental health services in the past. Ms. Jones was not employed at the time of her initial assessment and reported a household income of \$10,000-\$15,000 per year. Ms. Jones reported receiving government assistance in the form of SNAP, WIC, SSI, TennCare, Assistance Lifeline, and free/reduced school lunch for her children.

One month after the Jones's baseline assessment, Nicole, Anthony, and Jessica attended Camp HOPE for approximately one week in July 2017. Each child attended camp for a total of 120 continuous hours, from the time that they arrived until their mother picked them up from the camp. Upon arrival to the camp drop-off site, each child was introduced to their cabinmates and cabin counselors. After all campers arrived, the children boarded a bus to the campsite. During the bus ride, counselors led activities and taught the campers camp songs. When the children arrived at camp, they were introduced to the rules of Camp HOPE, oriented to the campsite, and shown to their cabins. Each subsequent day, campers participated in meals with their cabin, team-building activities, outdoor activities, group discussions around the daily Camp HOPE curriculum, and campfire time. More information about each child's individual experiences and progress is provided below.

### ***Nicole***

At her baseline assessment, Nicole endorsed exposure to various forms of direct and indirect violence, with a total score of 5 on the JVQ. Specifically, Nicole indicated that, in the



last year, she had experienced physical assault and bullying and had witnessed physical IPV and physical assault with a weapon. Nicole's self-perception scores were consistent with the sample average for social competence (i.e., 17;  $M = 17.05$ ,  $n = 121$ ) and global self-worth (i.e., 19;  $M = 19.59$ ) but below the sample average for behavioral conduct (i.e., 17;  $M = 18.68$ ,  $n = 120$ ). At camp, Nicole was cooperative and received praise from counselors and camp staff for being generally calm and compliant. However, she experienced some interpersonal difficulty with peers. Her cabinmates teased her about her weight, and she frequently sought support from counselors and staff in managing these difficult peer interactions. Counselors provided support, encouraging Nicole to develop positive statements about herself and distance herself from these challenging peers. Counselors also intervened with Nicole's peers to remind them about the Camp HOPE expectation of kindness and respect for others and to encourage perspective taking. Difficulties with peers persisted, but Nicole continued to seek and follow advice from adults, and as the week progressed, she became friends with one of the girls in her cabin. Nicole, like most of the campers, was hesitant to engage in activities at first. With encouragement from adult staff, she participated in most activities during the week but sometimes chose to sit out. She often complained that she was not having fun.

At her post-camp evaluation, Nicole's social competence increased by two points to a score of 19, which was in line with the average post-camp score among other children who attended camp ( $n = 49$ ;  $M = 18.94$ ). Some of the ways that camp may have improved Nicole's social competence is through working with her counselors to navigate difficult social circumstances and establishing one close friendship. Nicole's post-camp behavioral competence score (i.e., 21) was four points higher than her baseline score and slightly higher than the camper sample average ( $n = 49$ ;  $M = 20.25$ ). Camp may have increased Nicole's behavioral conduct by

providing structure and clear expectations, providing praise for Nicole's cooperative behavior, offering Nicole a chance to be a leader for younger children, and offering Nicole choices about when to participate in activities and how to respond to difficult situations. Additionally, Nicole's exposure to the mindfulness regulation strategies and camp curriculum about how individuals' choices impact their lives and the lives of others may have helped her respond to situations more thoughtfully. Finally, Nicole's post-camp global self-worth score (i.e., 18) was one point lower than her baseline score and lower than the sample average ( $n = 49$ ;  $M = 20.43$ ). Although camp provided Nicole with many growth experiences, her overall sense of self-worth may have been negatively impacted by the bullying and peer rejection she experienced at camp. See Figure 2.

Between her baseline and post-camp evaluations, Nicole experienced direct (i.e., property victimization, bullying) and indirect (i.e., witnessing physical assault with a weapon) violence exposure, with a total score of 3 on the JVQ. It is difficult to interpret how Nicole's victimization exposure might have influenced her self-perception during this time. While these experiences can negatively influence children's self-perception, Nicole's self-perception seems to have been resilient to these potentially adverse effects. This finding may reflect the fact that victimization exposure is a normative experience for Nicole or that camp experiences and other protective factors buffered against some of the negative effects of victimization exposure. For instance, there were no changes to the Jones's financial or living situation between baseline and post-camp, with the exception that Ms. Jones reported going to a safe house/shelter once during this two-month period. Ms. Jones did not endorse exposure to IPV during this time period.

### ***Anthony***

At baseline, Anthony reported that he had experienced both direct and indirect violence exposure, with a JVQ score of two. Specifically, he endorsed experiencing physical assault and

witnessing physical IPV in the last year. His social competence score of 22 was higher than the sample average (n = 121; M = 17.05), and his global self-worth score of 21 was slightly higher than the sample average (n = 120; M = 19.59). Anthony's behavioral conduct score of 16 was lower than the sample average (n = 120; M = 18.68). At camp, Anthony was less inhibited than many of the other children. He was energetic and engaged almost immediately upon arrival at camp. He demonstrated impulsivity, difficulty sustaining attention, and hyperactivity throughout the week. For example, Anthony often blurted out answers or started an activity while instructions were still being given. Anthony quickly became friends with some of the children in his cabin, and he enjoyed being loud and silly with these peers. Anthony also often had conflict with his peers and with his closest friend at camp. Anthony demonstrated difficulty engaging in most activities, and counselors and staff frequently provided redirection, encouraging him to participate with his peers. Anthony sometimes chose to participate in activities and sometimes chose to sit out. While counselors and staff aimed to take a positive approach to discipline, Anthony's behavior was sometimes disruptive and warranted directly speaking to him about the problem behavior or enforcing a consequence. Anthony often became increasingly frustrated when adult staff provided redirection and utilized behavior management strategies; however, after being given time and space he was always able to rejoin the rest of the campers in the daily activities. Anthony often made negative comments about himself and other children, typically in a more humorous manner when participating in daily activities and in a more serious manner when feeling upset. While all of the Jones children indicated that they missed their mother, Anthony exhibited the most significant signs of homesickness, endorsing worry about his mother and a desire to go home at one point during the week of camp.

One month after camp, at his post-camp evaluation, Anthony's social competence score remained unchanged (i.e., 22) and was greater than the other children who attended camp ( $n = 49$ ;  $M = 18.94$ ). It is interesting that Anthony's social competence score did not change, given that he was very engaged with his peers at camp. However, it is likely that Anthony's pattern of peer interactions (i.e., having fun playing with peers; getting into frequent arguments with peers) was similar to his peer interactions in other contexts. Anthony's post-camp behavioral competence score (i.e., 18) was two points higher than his baseline score but remained lower than the camper sample average ( $n = 49$ ;  $M = 20.25$ ). Again, it is possible that the structure, clear expectations, and behavior management principles implemented in the camp setting helped Anthony's behavior. Additionally, opportunities for individual attention from counselors and adult staff allowed Anthony to reflect on what was happening when behavioral difficulties arose, make choices about how to respond, and practice regulating before re-engaging in activities. Finally, Anthony's post-camp global self-worth score (i.e., 19) represents a two-point decrease from his baseline score and was slightly lower than the camper sample average ( $n = 49$ ;  $M = 20.43$ ). Again, while camp may have offered Anthony the opportunity to develop skills and grow, he also encountered a significant amount of negative feedback from his peers, counselors, and staff. This type of feedback may have negatively impacted Anthony's overall sense of self-worth. See Figure 3.

Between his baseline and post-camp evaluations, Anthony reported experiencing direct violence (i.e., property victimization, physical assault), with a JVQ score of 2. Because Anthony's self-perception scores did not consistently or significantly decline, it is possible that these victimization experiences represent a normal part of Anthony's life and did not have a significant impact on Anthony's self-perception. It is also possible that these victimization

experiences were buffered by the camp experiences and other protective factors (e.g., relative stability within the family during this time).

### *Jessica*

Jessica reported exposure to direct violence at her baseline assessment, with a total JVQ score of 5. Specifically, Jessica indicated that she had experienced emotional abuse, bullying, and multiple forms of physical assault in the last year. Jessica's self-perception scores were lower than the sample average for social competence (i.e., 15;  $M = 17.05$ ), while her behavioral conduct (i.e., 18;  $M = 18.68$ ) and global self-worth (i.e., 19;  $M = 19.59$ ) scores were less than a point below the sample average. Jessica was quiet but engaged throughout the week of camp. She was very cooperative with staff, counselors, and peers. Despite being somewhat shy, she made friends with her cabinmates and played with them easily. Jessica and her friends at camp appeared genuinely excited to play together. Jessica was not likely to start a conversation, but when counselors or staff initiated interactions with her, she was always responsive and engaged. Although Jessica appeared somewhat shy about receiving attention, she seemed to enjoy the positive attention from adults at camp. Jessica was willing to engage in most activities quickly, with some encouragement from counselors. She always seemed willing to learn about topics that were new to her, and she particularly enjoyed exploring nature.

One month post-camp, Jessica's social competence score (i.e., 19) increased by four points from baseline. Jessica's post-camp social competence score was about the same as the other children who attended camp ( $n = 49$ ;  $M = 18.94$ ). Camp may have improved Jessica's social competence by providing a space for her to engage with her peers in activities designed to promote peer bonding and team building. Jessica's post-camp behavioral competence score (i.e., 19) was one point higher than her baseline score but remained below the sample average ( $n = 49$ ;

M = 20.25). This finding is interesting, given that Jessica was generally described as very well-behaved. It is possible that the positive attention she received at camp contributed to the improvement in behavioral conduct. However, because Jessica presented as cooperative and shy, most of the attention she received was aimed at her personal traits (e.g., curiosity, kindness) and intended to promote growth and engagement. Counselors and adult staff often overlooked opportunities to praise Jessica's behavior and conduct, which potentially undermined opportunities for improvement in Jessica's perception of her own behavioral conduct. At post-camp, Jessica's global self-worth score (i.e., 24) increased by five points from baseline and was more than three points higher than the sample average (n = 49; M = 20.43). Camp provided Jessica with a safe place to learn and grow, connecting with peers and engaging in a variety of activities that may have enhanced her self-concept. Additionally, Jessica consistently received praise for her positive character traits, which could have helped Jessica recognize her own strengths and increased her self-worth (e.g., kindness, willingness, curiosity). See Figure 4.

Jessica indicated that she had experienced both direct (i.e., bullying) and indirect (i.e., witnessing physical IPV and community violence) violence exposure between baseline and post-camp, with a total JVQ score of 3. Again, it is difficult to understand why Jessica's self-perception scores increased in the face of victimization exposure. During this time, Jessica, like her siblings, may have benefited from camp, family stability, and other protective factors/experiences that buffered against these violent episodes. It is also possible that Jessica's self-perception is not heavily influenced by victimization exposure because it is consistently present in her life.

***Counselor Report & Caregiver Report: Strengths & Difficulties Questionnaire***

Ms. Jones and the children's cabin counselors completed the Strengths and Difficulties Questionnaire (SDQ) for each of the Jones children. While the constructs captured in the SDQ (i.e., hyperactivity, conduct problems, emotional symptoms, peer problems, prosocial behavior) do not directly mirror the constructs represented on the self-perception measure, there is certainly overlap between the constructs. For instance, conduct problems and difficulties with hyperactivity, as reported by caregivers, are likely inversely related to children's self-perception of behavioral conduct. Similarly, peer problems are likely inversely related to children's self-perception of social competence. Finally, emotional symptoms are likely inversely related to children's global sense of self-worth. Therefore, SDQ scores from the Jones siblings' counselors and caregiver will be discussed in relation to SPPC scores.

**Counselor Report.** Nicole's counselor endorsed overall difficulties for Nicole (i.e., 9) that were close to the counselor reported sample average ( $M = 9.83$ ) and well below the highest possible score of 40. As a reminder, each subscale included in this overall difficulties score ranges from 0-10. Nicole's scores on these subscales were within one point of the sample average for emotional symptoms (i.e., 2) and peer problems (i.e., 2) but higher than the sample average on the hyperactivity scale (i.e., 5) and lower than the sample average on the conduct problems scale (i.e., 0). Nicole's prosocial behavior score was less than one point above the sample average (8;  $M = 7.12$ ) and close to the highest possible score of 10. Anthony's counselor endorsed total difficulties for Anthony (i.e., 19) that were much higher than the sample average on the last day of camp ( $M = 9.83$ ). Anthony's scores on all difficulties subscales were higher than the sample average, with a substantial elevation of hyperactivity representing the highest possible score on this subscale (10;  $M = 3.96$ ). Anthony's counselors rated him slightly lower than the sample average on prosocial behaviors (6;  $M = 7.12$ ). Jessica's counselor endorsed

below average overall difficulties for Jessica (1,  $M = 9.83$ ), as reflected in below average scores on all subscales that contribute to this score. Jessica's prosocial behavior score (i.e., 7) was close to the sample average of 7.12. Of note, counselors tend to endorse lower levels of difficulties, as compared to caregiver reports. See Table 5.

**Caregiver Report.** Ms. Jones reported on each of the children's functioning one month after camp. Ms. Jones's report suggests that Nicole's overall difficulties declined slightly from pre-camp (i.e., 17) to post-camp (i.e., 14) but remained elevated as compared to other females in her age range, with her score at the 92<sup>nd</sup> percentile. Ms. Jones's report of Nicole's post-camp total difficulties score was also higher than the average post-camp total difficulties score among campers in the current sample (per caregiver report;  $M = 10.92$ ). Per Ms. Jones's report, Nicole's emotional symptoms, conduct problems, and hyperactivity scores declined slightly from pre-camp to post-camp, while her peer problems score increased. Reductions in caregiver-reported hyperactivity and conduct problems are consistent with Nicole's self-reported increase in behavioral conduct. However, Ms. Jones' report is not consistent with Nicole's self-reported increase in social competence and reduction in global self-worth. It is possible that Nicole's significant difficulties with her peers at camp is reflected in her mother's report of Nicole's peer problems, whereas Nicole's self-report reflects increased skills in navigating social situations. Also, it is possible that Nicole's mother is overlooking emotional problems that Nicole is experiencing and that the discrepancy between the constructs of self-esteem and emotional problems is reflected in slightly discrepant reports of changes in these constructs over time. Regarding prosocial behavior, Ms. Jones's report on Nicole reveals a three-point increase from pre-camp to post-camp, with a score of eight that places Nicole in the 33<sup>rd</sup> percentile of her peers and consistent with the current sample average ( $M = 7.63$ ). See Table 6.



Ms. Jones did not complete a baseline evaluation of Anthony's scores, but she did complete a post-camp evaluation. Ms. Jones's rating of Anthony's post-camp total difficulties (i.e., 23) placed him in the 98<sup>th</sup> percentile, compared to his peers, and well above the sample average of 10.92. Ms. Jones reported that Anthony showed high levels of emotional symptoms (i.e., 5; 95<sup>th</sup> percentile), conduct problems (i.e., 7; 99<sup>th</sup> percentile), hyperactivity (i.e., 7; 90<sup>th</sup> percentile), and peer problems (i.e., 4; 95<sup>th</sup> percentile). All of Anthony's scores on the difficulties subscales were higher than the sample average scores. Elevations in Ms. Jones's report of Anthony's conduct problems and hyperactivity are consistent with Anthony's self-reported low behavior conduct score. Similarly, Ms. Jones's endorsement of elevated emotional symptoms for Anthony is consistent with Anthony's low self-reported global self-worth. However, Anthony reported above-average levels of social competence, which does not align well with Ms. Jones's report of elevated peer problems for Anthony. Given that counselor data and observations support the notion that Anthony demonstrated elevated peer problems, it is likely that this discrepancy reflects that Anthony has somewhat limited insight into his own social competence. Anthony's prosocial behavior score of 1, per Ms. Jones's report, placed him well below the sample average of 7.63 and in the 0<sup>th</sup> percentile of his normed peer group. See Table 6.

Ms. Jones's report reveals a slight increase in Jessica's total difficulties score from pre-camp (i.e., 7) to post-camp (i.e., 8). This score places Jessica in the average range (68<sup>th</sup> percentile), compared to her normed peer group, and slightly below the current sample average of 10.92. Ms. Jones's report of Jessica's emotional symptoms, hyperactivity, and peer problems scores remained the same from pre-camp to post-camp, while her conduct problems score increased by one point. Of note, Ms. Jones's rating of Jessica's peer problems was the most elevated subscale for Jessica, with a score of 3 that places her in the 93<sup>rd</sup> percentile of her

normed peer group and slightly above the sample average of 2.51. Ms. Jones's report is somewhat inconsistent with Jessica's self-report, which revealed improvements across domains of self-perception. Given that Jessica's counselor report data and observations support the notion that Jessica demonstrated few difficulties and many strengths, Jessica's self-report of improved self-perception may reflect increased insight about how she compares to her peers. Finally, per Ms. Jones's report, Jessica's prosocial behavior score increased substantially from 5 at pre-camp to 9 at post-camp. This score places Jessica in the 56<sup>th</sup> percentile of her normed peer group and slightly above the current sample average of 7.63. See Table 6.

### ***Qualitative Caregiver Feedback***

In a brief interview with Ms. Jones in August 2019, she reflected on how Camp HOPE might have impacted her children. After attending camp, Ms. Jones stated that her children were "more outgoing" and talkative, which is consistent with improvements in social competence. She also noted that her children "want[ed] to explore more" and seemed "more excited." Similarly, she described her children as "hav[ing] a little more confidence," potentially reflecting increased global self-worth. Ms. Jones noted "a little bit of improvement" in behavior across her three children.

When Ms. Jones was asked why camp might have impacted her children, she discussed her children's emotional, mental, and physical connection with camp staff. She explained that "[The children] are always connected when they come back [from camp]. They're like, 'Mom oh I love my staff and they're so great!'" In addition to the strong connection Ms. Jones noted between her children and the camp counselors/staff, Ms. Jones also indicated that the camp experience as a whole, particularly the new and different activities, provide excitement. She stated, "The camp experience is just great. It has a great impact on them." Ms. Jones shared that

her children returned from camp eager to share stories about their experiences. It is possible that this opportunity for novel experiences expands the children's view of themselves and the world.

### **Complicating Factors**

It is important to consider how each child's developmental stage and gender may have impacted their experiences at Camp HOPE. For instance, Nicole's experience epitomizes many elements of the pre-adolescent female experience, including escalating relational aggression (Neal, 2007) and defiance (Van Petegem et al., 2015). Anthony's experience is consistent with many typical childhood experiences of boys, including high energy, playful interactions, and peer conflict that can peak and dissipate quickly (Collins, 1984; Noakes & Rinaldi, 2006). Finally, Jessica's unique experience is also best understood in the context of her age, as children in the early elementary school years tend to be more curious and agreeable and less cliquey (Brown & Dietz, 2009; Malik & Marwaha, 2018; Noakes & Rinaldi, 2006). These differences in age and gender are elaborated upon in subsequent paragraphs about each child's camp experience and individual personality.

Although all three children attended the same week of camp, the experience was different for each child. For instance, children spend a large amount of time with their cabins during the week of camp, and each child was in a different cabin with different counselors. All cabin counselors received the same training, but they implemented their knowledge and the curriculum in different ways. Cabinmates also play an important role in the camp experience, and each child was surrounded by a different peer group with different interactions and dynamics. For example, Nicole's cabin was characterized by visible cliques and bullying behavior, whereas Anthony's cabin was characterized by high energy and intermittent arguments between peers that were quickly resolved, and Jessica's cabin was characterized by generally compliant children with

varying levels of energy and requiring varying levels of redirection, who appeared to enjoy each other's company. Finally, adult support staff were intermittently available to provide support during the week of camp (e.g., leading activities, helping with behavior management, encouraging counselors), resulting in different interactions with each of the Jones children. These varied experiences across cabins, counselors, and staff all shaped each child's perspective on the camp.

In addition to these interpersonal differences, each child's experience was different because of their choices to participate or not participate in certain camp activities. As noted above, Nicole sometimes chose to sit out from activities, particularly those that required energy and movement (e.g., field games). She appeared more comfortable participating in activities like art and often engaged with adult staff as much as her peers during the activities. Anthony, on the other hand, had difficulty engaging in quiet and stationary activities (e.g., mindfulness) and sometimes missed activities due to behavioral concerns (e.g., becoming frustrated; sitting in time out). Anthony was most likely to engage in high energy activities, like pool time and field games. Jessica was the most likely child of this sibling set to participate in all of the activities. She sometimes needed encouragement from counselors to engage, but she appeared to enjoy all types of camp activities.

A final complicating factor related to the camp experience is that each child presented to camp with different strengths, weaknesses, and needs. For instance, Nicole was kind and patient, but she presented with some internalizing concerns and difficulty interacting with peers. Thus, Nicole may have benefited most from a kind and supportive peer environment and opportunities for positive affirmation, as well as personalized support for engaging in enjoyable activities and practice in having a more positive attitude. Anthony's presentation was antithetical to Nicole's.

His strengths were his energy and fun personality, but he presented with several externalizing concerns (e.g., noncompliant, argumentative), hyperactivity, impulsivity, and difficulty sustaining attention. Anthony may have benefited from a more rigid behavioral management system and individualized support to build regulation and attention skills. Jessica had many strengths, including kindness, curiosity, and attentiveness. She got along with her peers better than her siblings, and she easily participated in a wide variety of camp activities. However, Jessica also presented as somewhat shy and hesitant to engage in activities and interactions, often requiring support to engage. Jessica likely benefited most from the structure of Camp HOPE, where counselors and adult staff naturally provided this type of support and encouragement. The unique strengths, weaknesses, and needs of each child interact with the different camp experiences of each child to affect the impact of the camp intervention.

### **Access and Barriers to Care**

The Jones family faced several barriers to care, including intermittent difficulty with transportation, housing instability and limited financial resources. Additionally, the children's primary caregiver (mother) had limited time and resources, as she was caring for multiple children, working, and navigating divorce proceedings. Camp HOPE naturally overcomes some intervention barriers because it is free and does not require caregivers to transport their children to services multiple times. Additionally, the program offered transportation assistance to families for attending camp and reunion activities, and the camp also offered assistance with providing basic necessities for camp (e.g., swimsuit, change of clothes, sheets). Finally, because this intervention is camp-based, it reduces some of the stigma around mental health care and distrust in the formal mental health system. Despite the fact that Ms. Jones acknowledged some of the emotional and behavioral difficulties her children exhibited, neither she nor her children received

counseling or therapy in the year prior to their baseline assessment. Participating in Camp HOPE may have seemed like a safer, less stigmatizing option than formal intervention services.

In general, one of the biggest advantages of Camp HOPE is that it addresses so many barriers to care that families face when accessing traditional interventions. This may be particularly important among families impacted by violence in the home, as stressors commonly associated with family violence would likely exacerbate barriers to care (Hasselle et al., 2020; Sabri et al. 2015). For instance, these families are more likely to experience significant transitions, which can challenge consistency and routine and interfere with attendance at weekly therapy appointments. Because abusive partners often exhibit coercion and control, they may interfere with attendance at traditional counseling services (e.g., by limiting their partner's access to financial resources, by refusing to provide consent for their child to participate; Hasselle et al., 2020; Sabri et al., 2015). Other barriers that might be particularly salient in this population include caregivers' cognitive and emotional resources being depleted and mistrust in the healthcare system (Hasselle et al., 2020; Sabri et al., 2015). Camp HOPE directly addresses and reduces these barriers.

### **Follow-Up (How/How Long)**

The Jones family completed a third evaluation five months after camp as a way to assess the long-term impact of participating in Camp HOPE. At this follow-up evaluation, Nicole's self-reported social competence score continued to increase, by four points, to 23. Her follow-up social competence score was six points higher than her baseline score and over four points higher than the average camper score at follow-up ( $n = 40$ ;  $M = 18.85$ ). It is possible that Nicole learned social skills at camp that she continued to use in her daily life, leading her to feel more prepared to navigate various social situations. Nicole was exposed to a variety of social situations at camp

in which she could have developed social skills, including group activities of various sizes and comprised of different ages and genders, conversations with adults, and navigating interpersonal conflict. While she demonstrated some growth in social competence at two-month follow-up, continued improvement at five-month follow-up may reflect opportunities to practice these social skills after returning to school and interacting with peers more regularly. Additionally, Ms. Jones reported that her children seemed to be more outgoing and talkative after camp. Nicole's behavioral conduct score declined by five points between her post-camp and follow-up evaluations. Nicole's final score of 16 was one point lower than her baseline behavioral conduct score and was lower than the camper sample average ( $n = 40$ ;  $M = 19.70$ ). The fact that Nicole's behavioral conduct score was lower than the sample average is surprising, given that she was generally easy to redirect. It is possible that Nicole felt more confident about her behavioral conduct at her post-camp evaluation, because she was given choices about whether or not to participate in activities at camp. In a school setting, however, Nicole's reluctance to participate and engage may have been more problematic and deemed defiant. Nicole's follow-up global self-worth score increased by five points, to 23. This score was four points higher than her baseline score and nearly two points higher than the sample average ( $n = 40$ ;  $M = 21.10$ ). It is possible that the camp experience offered opportunities for Nicole to expand her sense of self and improved her self-worth by participating in new activities, engaging in new relationships, and having adult caregivers acknowledge her positive character traits. This enhanced sense of self may have been maintained over time, manifesting in her life and interactions in a way that is self-sustaining. Ms. Jones also noted that her children seemed more confident after attending camp. See Figure 2.

According to Ms. Jones's report on the Strengths and Difficulties Questionnaire (SDQ), Nicole's emotional and behavioral difficulties increased by four points between post-camp and follow-up. Nicole's final difficulties score of 18.00 was one point higher than her baseline score and falls in the 97<sup>th</sup> percentile, compared to her peers. From Ms. Jones's perspective, Nicole experienced notably greater difficulties compared to the sample average at follow-up ( $M = 12.32$ ). Nicole's emotional symptoms, conduct problems, and hyperactivity scores all increased from post-camp to follow-up. Her prosocial behavior score decreased from 8 at post-camp to 5 at follow up, which is identical to her baseline score. Nicole's final prosocial behavior score places her in the 6<sup>th</sup> percentile compared to her normed peer group and notably lower than the sample average of 7.41. Given Nicole's self-reported improvements in social, behavioral, and global self-perception, her mother's report of increased emotional and behavioral difficulties for Nicole is unexpected. It is possible that these discrepancies between Nicole's report and her mother's report represent Nicole's transition to adolescence, when it is normative for children to push boundaries and create distance between themselves and their caregivers. These developmentally appropriate changes can cause frustration for caregivers and make it difficult to accurately attune to their children's experiences. See Table 6.

At five-month follow-up, Anthony's social competence score (i.e., 22) was identical to his post-camp and baseline scores. This final score was above the sample average ( $n = 40$ ;  $M = 18.85$ ). Anthony's behavioral conduct score (i.e., 14) decreased by four points from post-camp to follow up. His final score of 14 was lower than his baseline score and the sample average ( $n = 40$ ;  $M = 19.70$ ). Anthony's decline in behavioral conduct scores is likely attributable to the fact that his hyperactivity and disruptive behavior would attract even more negative attention in a school setting than in the camp setting, given that school provides even fewer outlets for



Anthony's energy. Anthony's global self-worth score (i.e., 22) increased by three points from post-camp to follow-up and was higher than his baseline score. This final score of 22 was very slightly above the sample average follow-up score ( $n = 40$ ;  $M = 21.10$ ). Like Nicole, it is possible that Anthony's improvements in global self-worth might have been fostered by opportunities for engagement in new activities and relationships at camp, as well as having mentors recognize and acknowledge Anthony's positive traits. See Figure 3.

Ms. Jones's report of Anthony's emotions and behaviors revealed a total difficulties score that was one point higher than his post-camp score, for a total of 24.00. This placed Anthony in the 98<sup>th</sup> percentile compared to his normed peer group and notably higher than the sample average ( $M = 12.32$ ). Anthony's emotional symptoms score decreased by two points, and his peer problems score decreased by one point. These reductions are consistent with improvements in self-reported global self-worth and sustained social competence. Ms. Jones reported that Anthony's conduct problem score increased by one point and his hyperactivity score increased by three points. These increases are consistent with Anthony's self-reported decrease in behavioral conduct. Anthony's prosocial behavior score remained the same from post-camp to follow-up, with a final score of 1 that places him in the 0<sup>th</sup> percentile compared to his normed peer group and significantly below the sample average of 7.41. See Table 6.

Five months after camp, Jessica's social competence score continued to increase, by two points, to 21. This social support score was six points higher than her baseline score and above the sample average ( $n = 40$ ;  $M = 18.85$ ). Jessica's behavioral conduct score increased by five points between post-camp and follow-up, to 24. Her final score of 24 was six points higher than her baseline score and notably higher than the sample average ( $n = 40$ ;  $M = 19.70$ ). Finally, Jessica's follow-up global self-worth score of 23 was one point lower than her post-camp score

but four points higher than her baseline score. This final score of 23 was higher than the sample average ( $n = 40$ ;  $M = 21.10$ ). All three of Jessica's follow-up self-perception scores were higher than the average scores across campers. As stated above, Jessica was likely more receptive than her siblings to the opportunities camp offered. She engaged in more activities, established peer relationships more easily, and had more positive experiences at camp overall. Thus, Jessica may have emerged from camp with more skill growth than her siblings, reflected in more social skills, increased ability to behave and cooperate in a range of situations, and enhanced sense of self-worth. See Figure 4.

According to Ms. Jones's report, Jessica's total difficulties score decreased by five points between post-camp and follow-up, with a final score of three that is notably lower than her normed peer group average (i.e., 28<sup>th</sup> percentile) and the current sample average ( $M = 12.32$ ). Ms. Jones noted reductions in emotional symptoms, hyperactivity, and peer problems. In general, Ms. Jones's report of improvements in emotional and behavioral difficulties for Jessica is consistent with Jessica's self-perception scores. Jessica's prosocial behavior score decreased by one point, to a score of 8.00 that places her in the 37<sup>th</sup> percentile of her peers but slightly above the current sample average ( $M = 7.41$ ). See Table 6.

### **Limitations**

Study findings must be considered in light of several limitations. As noted above, external complicating factors (i.e., victimization exposure, family transition, new classroom) that may have influenced children's self-perception cannot be controlled for in the current study design. Indeed, a case study design precludes firm conclusions about whether changes in self-perception are attributable to the camp experience. Furthermore, because the current study did not collect qualitative data from the children, it is more difficult to make inferences about how

the camp experiences may have impacted each child's self-perception. Finally, the current study relied heavily on a measure of self-perception that is not well-validated among youth identifying as African-American/Black. Such a limitation raises questions about whether the current study is truly examining three unique and meaningful facets of self-perception.

There are also noteworthy limitations for caregiver- and counselor-reported data, which are influenced by their own experiences and perspectives. Ms. Jones endorsed more difficulties for her children than their counselors did, and her scores were often on the extreme end (i.e., falling above the 90<sup>th</sup> percentile or below the 10<sup>th</sup> percentile). While Ms. Jones's perspective is valuable, it is impacted by her own life experiences. For instance, significant life stressors may have consumed many of her resources, causing her to perceive negative behaviors from her children as less tolerable and more problematic. Additionally, Ms. Jones's qualitative feedback was collected two years after the first year of camp, and the passage of time may have negatively influenced her ability to accurately recall how camp affected her children.

Counselor reports are also influenced by their experiences, including personal stressors and previous experience working with children. Counselors in the current study completed questions at the end of the weeklong camp. Thus, their reports are likely influenced by fatigue, their most recent and salient memories of the Jones children, and their salient reference group (i.e., likely the other children in their cabin). Additionally, counselor reports are based on observations of children in a very unique setting and limited time span that may not translate to other environments in the children's daily lives.

Finally, the current study evaluated children participating in the pilot year of Camp HOPE Tennessee. During this pilot year, there were many unforeseen challenges and barriers to implementing components of the Camp HOPE model. While the leadership team typically

navigated these challenges effectively, the pilot year was less smooth and organized compared to subsequent years. As such, different findings may have emerged if data were collected in 2018 or 2019, when staff were more organized and efficient, programming ran more smoothly, and Camp HOPE curriculum was delivered more effectively.

### **Treatment Implications**

Camp HOPE represents a novel intervention for children exposed to family violence, addressing many barriers to intervention engagement that traditional interventions pose. Importantly, three children at different ages with unique personalities and interests were able to participate in this intervention. While they did not all participate in all components of camp, each child experienced new opportunities for learning and growth. Findings suggest that Camp HOPE is feasible with a range of children. Findings from the current study indicate, however, that camp may impact individual children in different ways. It is important to note that the following suppositions about the impact of camp are speculative and should be interpreted with caution, given that data collection points were separated by months of time and that self-perception could be influenced by many external factors.

All three children in this study endorsed small to medium improvements in perceived behavioral conduct, which supports the notion that camp creates opportunities for many types of children to learn how to manage their behavior in various situations. It is likely that the evidence-based behavior management strategies (e.g., active ignoring, labeled praise, immediate reinforcement) employed at camp offered opportunities for growth in this area. However, improvements in behavioral conduct were not sustained for Anthony and Nicole at the five-month follow-up. This finding suggests that behavior management strategies implemented by counselors and self-regulation skills learned in the camp environment may not translate to the

school and home settings. This highlights the importance of consistent expectations and behavior management strategies across care providers. The Camp HOPE intervention, therefore, may increase its long-term impact by offering parenting skills training to caregivers and providing trauma-informed behavior management training to school systems. Additionally, Camp HOPE may increase its impact by placing more emphasis on teaching children self-regulation strategies, encouraging practice of these strategies, and establishing strategies for maintaining emotion regulation skills practice after camp. A focus on providing youth with transferable skills that can be used in multiple settings may lead to more long-term camp benefits.

Regarding children's perceptions of social competence, Nicole and Jessica demonstrated improvements across time, whereas Anthony maintained very high levels of self-reported social competence across time. This finding implies that camp provides opportunities for learning how to navigate social situations with peers. Indeed, camp is a unique environment where children must learn to form cooperative relationships with their peers, who they live with for the entire week. Furthermore, camp provides opportunities to participate in team-building activities and get immediate support from adults when navigating peer interactions. Trends in social competence scores for each of the Jones siblings sustained over time, and the fact that Jessica and Nicole continued to report growth in social competence suggests that social skills acquired during camp may translate into children's home and school environments. Because the final follow-up occurred after the children had been in school for several months, continued growth in social competence suggests that Nicole and Jessica may have been able to apply social skills learned through camp experiences when interacting with peers and adults in the school setting, which also requires cooperation with peers, engagement in group activities, and interaction with adults. Campers may require different types of support for social growth, including encouragement for

shy or withdrawn children to engage, for hyperactive or eager children to take turns, for passive children to stand up for themselves, and for aggressive children to practice empathy. Findings from this case study indicate that all children can learn social skills from the camp experience.

Finally, camp appeared to have a short-term negative impact on global self-worth for the two Jones children who presented with significant internalizing and externalizing difficulties (i.e., Nicole and Anthony), two common presentations among children exposed to interpersonal trauma (D'Andrea et al., 2012). On the other hand, camp appeared to have a short-term positive impact on global self-worth for Jessica, who presented with no notable internalizing or externalizing challenges. While camp offered many opportunities for personal growth and expansion of self-concept, it also provided many challenging situations, including separation from the home environment/primary caregiver, negative peer interactions, high expectations for cooperative behavior in a range of activities, and activities that push children out of their comfort zones. Furthermore, living with new people and facing entirely new situations could be particularly challenging for youth with a trauma history. Without the coping skills to effectively navigate these potentially difficult situations, children with emotional and behavioral difficulties may be more likely to experience camp-related challenges and remember the negative experiences from camp. These children may also be at risk for internalizing negative experiences from camp or internalizing the loss of camp as somehow reflective of their own self-worth. Indeed, children exposed to interpersonal trauma are more vulnerable to feelings of guilt and shame and are more vulnerable to insecure styles of attachment (D'Andrea et al., 2012). Despite having the same potential trauma history, children presenting without significant internalizing or externalizing difficulties may be more likely to experience successful peer interactions, enjoyable engagement in a variety of activities, and positive feedback from adults during camp.

Therefore, these children become more likely to experience positive growth in the aftermath of camp.

Of note, at follow-up, Nicole's global self-worth improved notably, Anthony's global self-worth was slightly higher than baseline, and Jessica's global self-worth decreased slightly. Thus, the negative impact of Camp HOPE on global self-worth dissipated quickly, while the positive impact sustained for Jessica. Camp HOPE offers many opportunities for all campers to develop a more positive sense of self by identifying their strengths and unique traits. Camp HOPE might reduce the short-term negative impact on children's global self-worth by offering additional support for children presenting with notable internalizing or externalizing difficulties, distinguishing negative experiences (e.g., bullying, getting in trouble) from overall self-worth, and directly processing the end of camp and separation from counselors.

It is important to note that findings from the current study represent a single family's experience and therefore cannot be assumed to generalize to other children. While Camp HOPE appears to be feasible and foster some forms of positive growth among children exposed to family violence, it is important to consider how this intervention may have a different impact on children with unique demographic characteristics, personality traits, and experiences.

### **Research and Clinical Recommendations**

This case study illustrates that Camp HOPE has the potential to help foster improved self-perception among children exposed to family violence. This intervention represents a strategy for connecting with children who may not receive formal mental health services. While formal mental health services are often stigmatized or present practical barriers to care (e.g., time, transportation, money), camp offers an alternative intervention format that may be less stigmatizing and more accessible. Thus, it is recommended that interventions aiming to support

families who are not engaged in formal mental health services continue to explore alternative formats that enhance accessibility while simultaneously working to maximize the positive impact of the intervention (e.g., alleviating symptoms, promoting positive growth). Additionally, it is recommended that Camp HOPE continue to provide a large number of adult staff, including cabin counselors, administrative staff, and support staff with a background in psychological services. This large provider to camper ratio offers many opportunities for individual support for unique children with unique needs. It is also recommended that Camp HOPE offer trauma-informed behavior management training to all adult staff.

Camp HOPE Tennessee recruited male and female staff, most of whom identified as Black/African-American. Many counselors lived in the same areas as many of the campers. It is important that Camp HOPE staff continue to be representative of the community, such that campers more easily relate to the counselors and view them as role models with whom they can identify. Indeed, a key principle of Camp HOPE is that campers are encouraged to eventually be counselors, providing a clear path by which campers might follow in the footsteps of the counselors they see as role models. Future iterations of Camp HOPE must also continue responding to the needs of the community, creating culturally-sensitive curriculum and activities that children can relate to and engage with.

It is important that Camp HOPE continues to consider how to improve its effectiveness for children presenting with unique histories, strengths, and difficulties. While offering individualized support throughout the week of camp will be important, camp administrators should evaluate which types of support may be more useful for individual children. Furthermore, camp administrators should consider adding elements that might improve the effectiveness of the camp. For instance, Camp HOPE may represent an opportunity to connect families to more



intensive support services when necessary, such that administrators could provide referrals to caregivers of children demonstrating significant mental health difficulties. Additionally, because some of the campers have inevitably experienced loss and abandonment, Camp HOPE must strategize how to manage the termination of camp and associated separation of campers from their counselors.

Future research should supplement existing data points with qualitative interviews with children, counselors, and caregivers at each assessment point. This approach would provide more insight into how children see themselves and how the camp experience impacts self-perception. Quantitative data analyses (e.g., dismantling studies) may also be used to understand which components of camp are most effective at promoting positive self-perception, as well as which components of camp may negatively impact children's self-perception. Similarly, it would be useful to implement a quantitative design that examines which children are most likely to benefit from Camp HOPE, as well as which children may experience negative consequences as a result of participating in Camp HOPE. In addition to seeking nuanced quantitative information about the impact of Camp HOPE, it would be useful to evaluate families at more regular intervals (e.g., the first post-camp week) to better understand fluctuations in self-perception across time. Finally, future research should examine how camp might impact other indicators of psychological functioning, in addition to self-perception.

### **General Discussion**

Existing literature indicates that victimization exposure can negatively affect children's self-perception (e.g., Turner et al., 2017), that interventions for children exposed to violence can improve their self-perception (e.g., Yule et al., 2019), and that camp experiences can positively impact children's self-perception (e.g., Kiernan et al., 2004). However, little is known about how

distinct types of victimization are related to different facets of self-perception and whether camp-based interventions can enhance self-perception among children affected by family violence. The current series of studies adds to the existing literature by exploring associations between three different metrics of childhood violence exposure and three different facets of children's self-esteem. This approach facilitates an examination of how different types of violence exposure uniquely relate to distinct facets of self-perception. These studies also contribute to the extant literature by evaluating whether a camp-based intervention designed specifically for children exposed to family violence promotes positive change in self-perception. Examining intervention effects using both a randomized control design and a qualitative case study approach allows for broad conclusions about the camp's effectiveness coupled with nuanced exploration of how the camp experience might impact children in a variety of ways. Findings from the current project demonstrate that direct victimization exposure has the strongest negative affect on children's self-perception. The current findings also indicate that Camp HOPE may have a short-term negative influence on children's sense of global self-worth, but that individual children may benefit from Camp HOPE.

Study 1 revealed that, consistent with the first hypothesis and previous literature, children exposed to more forms of direct victimization reported a more negative self-perception. This finding remained significant even after accounting for other forms of adversity and relevant demographic variables, suggesting that this association is robust. Interestingly, indirect victimization exposure was not significantly associated with self-perception in bivariate correlations but was positively associated with social competence and global self-worth in models accounting for direct victimization experiences, caregiver IPV exposure, and demographic variables. This unexpected finding contradicts the first hypothesis and is

inconsistent with previous literature. Finally, caregiver IPV exposure was not associated with children's self-perception in bivariate correlations or regression models. This unexpected null finding is inconsistent with the first hypothesis and with existing literature. In sum, Study 1 highlights the unique and robust association between children's direct victimization experiences and perceptions of themselves. In line with the shattered assumptions theory, these findings support the notion that children who are repeatedly victimized may internalize negative beliefs about themselves, taking personal blame for their victimization experiences.

Contrary to the second hypothesis, Study 2 demonstrates that Camp HOPE did not positively impact children's self-perception. While campers and control group participants reported similar levels of perceived social competence and behavioral conduct at each assessment, camp appeared to have a temporary negative impact on children's sense of self-worth. This finding emerged in the intent-to-treat analyses and the completer analyses, while results from the as-treated analyses were null. While campers endorsed lower levels of global self-worth at the first follow-up evaluation, compared to children in the control group, between-group differences were not present at the final evaluation. It is possible that the temporary reduction in global self-worth reflects children's response to the loss of camp, including opportunities for personal growth and relationships with adults and peers in a safe and stable environment.

While findings from Study 2 revealed that Camp HOPE did not positively impact children's self-perception, the familial case study in Study 3 offered a different perspective on the impact of the camp intervention. This case study shows that Camp HOPE is a novel and feasible intervention that can be implemented with children representing different ages, genders, personalities, strengths, and difficulties. It also suggests that a host of individual, familial, and

environmental factors may account for why some children benefit from Camp HOPE and others do not. While results from Study 3 must be interpreted with caution, it appears that Camp HOPE may be beneficial for children presenting with fewer internalizing and externalizing difficulties. These children may be most likely to experience the full “dose” of camp and a positive camp experience by participating in the range of activities that offer opportunities for personal growth. After attending Camp HOPE, children presenting with notable internalizing and externalizing difficulties appear to experience an array of positive and negative short-term and long-term changes in self-perception.

This series of studies, to our knowledge, are the first to examine the association between victimization experiences and self-perception in such a nuanced way, by considering three distinct types of victimization and three unique facets of self-perception. It is also the first set of studies to assess how a camp-based intervention influences self-perception among children exposed to family violence and the first in-depth case examination of children participating in such an intervention. Findings advance the literature on children experiencing family violence by highlighting the unique, detrimental effects of direct violence exposure on children’s self-perception within this population. Findings from the first randomized control trial design of Camp HOPE indicate that the camp has a short-term negative impact on children’s sense of global self-worth. A closer examination of changes in self-perception scores for individual children, however, shows that Camp HOPE may promote improvements in self-perception for some children. Future research may expand upon current findings by seeking to understand which children are most likely to benefit from Camp HOPE, which components of camp may promote positive or negative outcomes, and whether campers experience short-term benefits from the camp that may be reflected in an immediate post-camp evaluation.

## **Clinical and Policy Implications**

Several clinical and policy implications emerge from this series of studies. Children's exposure to direct victimization had a robust negative association with children's self-perception. This finding highlights the importance of victimization prevention initiatives for children, particularly children who are at-risk for experiencing cumulative victimization. Because exposure to one type of victimization is associated with significantly higher risk for exposure to other types of victimization (Finkelhor et al., 2009), identifying children who have been victimized and working with them to enhance their safety may be an important prevention measure. In addition to victimization prevention, it is critical to make effective intervention strategies accessible for children exposed to family violence, especially those who also report direct victimization exposure. Strategies for enhancing accessibility include offering transportation, free services, meals and incentives for participation, basic necessities required for intervention participation, and interventions that occur outside of formal health systems.

Because self-perception is such an important psychosocial resource and middle childhood is a critical period for the development of self-concept, it is important that interventions for children exposed to victimization experiences aim to preserve and enhance self-perception. Interventions may directly address negative beliefs about the self (e.g., using cognitive restructuring) and promote a more positive sense of self (e.g., by identifying values, interests, and strengths). Strategies for promoting a more positive sense of social competence may involve helping children explicitly identify positive peer relationships, times they have effectively navigated social situations, and types of friendships they hope to establish/maintain. This may be paired with social skill development that is didactic (e.g., teaching children how to start conversation, identify common interests, resolve conflict, state their needs) and experiential, as

well as cognitive restructuring around salient cognitive distortions (e.g., “Everyone hates me.”). Similarly, strategies for promoting a more positive sense of behavioral competence may involve helping children identify how they want to behave in different situation and their existing strengths, including times they feel they effectively manage their behavior and strategies they currently use to manage their behavior. This should be paired with teaching strategies for self-regulation and opportunities to practice these strategies in multiple contexts. Recommendations for promoting a more positive sense of global self-worth mirror those for social and behavioral competence but have a broader focus. Interventions may ask children to identify their core values, strengths, and positive traits. They may then provide coaching and opportunities for children to act in accordance with their values, use their strengths, and build competency in areas where there is a misalignment between core values and strengths/competencies. It is important that these interventions include cognitive restructuring around negative self-talk (e.g., “I am no good.”), help children create a balanced perspective of themselves and others (e.g., “We all have strengths and weaknesses.”), and refocus on effort and child behavior rather than outcomes.

Camp HOPE aligns with these recommendations by offering a strengths-based intervention that addresses many barriers to accessibility posed by traditional interventions. Although the Camp HOPE intervention incorporated a variety of components that could have enhanced children’s self-perception, this intervention does not appear to enhance children’s self-perception and may even negatively impact it in the short-term. One key recommendation for future iterations of Camp HOPE is to assess post-camp changes in self-perception to better understand whether the intervention does enhance self-perception immediately after camp, but that these changes are not sustained over time. Such information would inform clinical recommendations, which may focus on enhancing the sustainability of camp effects. Given that

children who attended camp reported higher levels of self-perception at five-month follow-up, it would also be useful to assess self-perception at regular and long-term follow-up intervals. This information would elucidate when the potential effects of camp might manifest and dissipate. Despite current uncertainty about when and how camp impacts children, several recommendations may be useful for clinicians and policymakers aiming to support children affected by family violence.

Regarding recommendations that may enhance the therapeutic value of Camp HOPE, it is recommended that camp sustain a large number of adult staff and counselors, which facilitates opportunities to provide individual attention and support to children presenting with unique strengths and needs. It is also recommended that Camp HOPE retain a diverse leadership team representing unique skills and perspectives. A camp-based intervention requires individuals with charisma and passion to lead and engage children, individuals with strong organizational skills to ensure that activities are planned and run smoothly, and individuals with warmth and compassion who can connect with children on an individual level. For Camp HOPE, it was helpful to have a team of psychologists who could train counselors in evidence-based behavior management principles, incorporate evidence-based emotion regulation strategies into the camp experience, and manage crisis behaviors that arose during camp. Furthermore, as mentioned above, it is important for the Camp HOPE staff to represent diverse racial/ethnic and gender identities that mirror campers' identities. This approach helps to enhance the cultural sensitivity of the intervention and provide role models with whom campers can readily identify.

In addition to sustaining these practices, certain modifications may enhance the therapeutic benefits of Camp HOPE. For example, the camp may offer individual or group therapy sessions throughout the week to provide targeted support for children presenting with

significant emotional or behavioral difficulties. These added therapy sessions may include opportunities for cognitive restructuring around negative thoughts about the self, learning and practicing emotion regulation strategies and social skills, and fostering a positive sense of self through more personalized and in-depth activities for identity exploration and self-esteem building. Similarly, Camp HOPE may incorporate other strategies, outside of individual or group therapy, to support positive self-perception development among campers. The current intervention identifies positive character traits for each child, encourages children to reflect on their strengths, and offers opportunities for children to use their strengths through hands on activities. However, these positive character traits and strengths could be emphasized more consistently throughout the week and expanded upon. Additionally, it would be helpful to remind children about how their strengths and traits can be used in their daily life and when navigating difficult situations outside of camp. These lessons might be more impactful with the use of concrete learning materials (e.g., visual aids; customized “strengths” bracelets; role plays). In addition to targeting self-perception directly, camp might also improve children’s self-perception by incorporating more opportunities to develop self-regulation skills and social skills throughout the week of camp. For example, while Camp HOPE Tennessee taught children deep breathing strategies, learning might be enhanced if counselors cue children to use these strategies at transition points throughout the day when behavioral difficulties are more likely to arise.

Beyond altering components of the camp to increase its effectiveness, it is possible that changing structural elements of the camp could enhance its utility. Because camp appears to be differentially effective for different children, it may be beneficial to revise eligibility criteria to enhance the camp’s ability to promote more positive self-perception. For instance, excluding children with significant internalizing and externalizing problems might increase the



effectiveness of the camp, to the extent that children without such difficulties garner more of the benefits of the camp experience. Such a decision should not be made without more robust research support for this supposition. It is also possible that allowing children to select from a menu of activities about how to spend each day could enhance effectiveness by allowing opportunities for growth and empowerment without imposing activities on children that might engender feelings of discomfort and ineptitude. Finally, it is possible that children's self-perception was negatively impacted by the abrupt loss of the camp experience. Thus, it may be useful to alter structural elements that mitigate against this sudden ending. For example, if Camp HOPE was a half-day camp, the 120 hours of contact time could be stretched out across six weeks, rendering the transition to and from camp less abrupt. Additionally, Camp HOPE could add opportunities for children to connect to the camp experience in creative yet structured ways throughout the year. While Camp HOPE currently offers reunions throughout the year, counselors and campers are often unable to attend. Similarly, although campers can contact counselors who share their cell phone numbers after camp, counselors are not able to sustain regular contact with all of their campers over time. Thus, it may be helpful to connect children with the camp experience in ways that feel predictable and consistent throughout the year.

Assuming that the camp experience does promote improved self-perception, but that these effects dissipate before the one-month follow-up evaluation, it would be important to enhance sustainability. For instance, as mentioned above, more regular contact with the camp experience may be useful in both promoting and sustaining positive change. When campers reconnect with Camp HOPE throughout the year, these experiences might enhance sustainability if they more closely mirrored the camp experience (e.g., cabin team-building activities, reviewing Camp HOPE curriculum, revisiting positive character traits and goals). Furthermore, it

might be helpful to send home tangible reminders of lessons learned at camp, ask parents to reinforce these messages and lessons, and encourage parents to help children practice skills learned at camp.

Finally, offering additional services outside of camp and monthly reunions could enhance the effectiveness of camp and sustainability of the potential positive impact of Camp HOPE. For instance, after-school programming for children would offer opportunities for ongoing skill development and connection with positive mentors. Similarly, Camp HOPE could set up a sustained mentorship program that provides ongoing access to positive adult relationships outside the family. Additionally, Camp HOPE could offer a separate intervention for caregivers. In an individual or group format, this caregiver intervention might focus on teaching caregivers about what their children learn at camp and giving them strategies to reinforce these lessons at home. A separate caregiver component may offer emotional support, teach strategies to enhance family safety, provide psychoeducation about the impact of trauma on children and adults, and deliver effective parenting strategies. This approach is commonly implemented in therapeutic interventions with children, such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen et al., 2006), Project Support (Jouriles & McDonald, 2015), Attachment, Self-Regulation, & Competency (ARC; Kinniburgh et al., 2017), and Alternatives for Families (Kolko et al., 2011). Because many families presented with limited access to financial and therapeutic resources, it could be helpful for Camp HOPE to establish a formal referral system that connects families to available local supports, including free family or child therapy. Such an approach would position Camp HOPE as a gateway to more intensive services for families who might benefit from regular and sustained treatment. Finally, Camp HOPE could expand its impact by

connecting with school systems to create more trauma-informed schools that better support children exposed to violence.

While results from the current investigation are not promising in regard to the camp enhancing self-perception, they are preliminary and should be interpreted with caution. However, if modifications to the research approach and the intervention continue to show that Camp HOPE is either ineffective or harmful, it is crucial that camp developers consider an alternative intervention strategy. Camp HOPE requires many resources, including money from donations and sponsors and donated time from volunteers. Thus, these resources must be allocated elsewhere if research demonstrates that Camp HOPE is not a worthwhile use of such time and energy. Interventions that have been shown to promote self-perception and competences among children, and therefore may represent a more appropriate allocation of resources, include individualized advocacy and support services for families affected by violence, cognitive behavioral programs in elementary schools, mindfulness-based interventions for children, psychoeducational and skill-building groups for children, and formal therapy groups that directly address children's trauma exposure and its effects (Johnston, 2003; Noether et al., 2007; Sullivan et al., 2002; Whitson et al., 2012; Yule et al., 2019).

### **Limitations**

Findings and recommendations from the current study must be considered in light of several limitations. For instance, reliance on cross-sectional data in Study 1 precludes conclusions about the directionality and temporality of the relationship between victimization experiences and self-perception. All three studies relied primarily on self-report measures, particularly the SPPC, which has been questioned as an appropriate measure for use with children identifying as African-American/Black. Reliance on self-report measures also

introduces potential biases including children's ability to comprehend the questions, accurately reflect on their experiences, and the tendency to present themselves in a positive light. Furthermore, the measure of victimization in Study 1 was brief, resulting in a somewhat restricted assessment of victimization that does not capture the entirety of victimizations that children may have experienced. Finally, the current sample was fairly homogeneous, comprised of families living in a mid-sized city in the Southeastern United States who sought services from a family justice center. Most of the families identified as African-American/Black and lived below the federal poverty line. It is possible that, within different populations, associations between violence exposure and self-perception might be different, and Camp HOPE may be more or less effective. Generalizability of results in Study 3 are particularly questionable, given that the findings are drawn from three siblings from the same family.

Conclusions about the effectiveness of camp are further limited by the timing of evaluations in the current study. Although previous research suggests that camp-related benefits may not be temporally stable, the current study did not assess children's self-perception until one month after camp. Without information about children's self-perception at post-camp, questions about the immediate effects of Camp HOPE remain unanswered. Similarly, the time elapsed between evaluations leaves many unanswered questions about factors that may have impacted children's self-perception, including the transition to the home environment and school environment, transitions to new schools and classrooms, and changes in family composition and living situation. While accounting for these experiences in Study 2 may prove useful, the inability to account for these experiences is particularly problematic in Study 3, where the lack of a control group makes it more difficult to disentangle the effects of camp from the effects of other life experiences.

## **Future Directions**

A number of future research directions emerge based on these studies. Future research should prioritize establishing a more culturally appropriate, well-validated measure of self-concept among children identifying as African-American/Black. Given the importance of self-perception during middle childhood and the multifaceted nature of this construct, it is necessary to understand factors that impact self-perception among children. This cannot be accomplished without accurate measurement. Additionally, longitudinal studies that explore associations between self-perception and victimization exposure over time, while accounting for other important variables, would facilitate better understanding of how these constructs are interrelated. Recruiting a larger and more diverse sample would allow researchers to better assess the nuances of these associations and account for more variables, including individual factors, relational factors, and environmental factors that might impact self-perception. For example, a larger sample would allow researchers to examine the moderating effect of gender and age on the association between victimization and self-perception.

Future research aiming to evaluate the impact of Camp HOPE would benefit from measuring outcomes at more frequent time intervals. For instance, evaluating children immediately before and after camp would reduce the potential impact of extraneous factors on outcomes, which could more effectively isolate the impact of the intervention. Additionally, assessing outcomes at regular intervals across a longer period of time would allow researchers to examine whether concepts learned at camp take effect at a later point and sustain or dissipate over time. Furthermore, future research should examine other outcomes, besides self-perception, to understand whether Camp HOPE impacts other indicators of functioning. Outcomes of interest may include mental health symptoms (e.g., depression, anxiety, posttraumatic stress),

behavioral difficulties, quality of relationships, sense of self-efficacy/agency, future orientation, and school engagement.

Researchers should also evaluate how to better support children exposed to family violence. A larger sample size would allow researchers to explore which children are most likely to benefit from Camp HOPE and which children are most likely to experience negative consequences of the camp. Such information would offer evidence-based inclusion and exclusion criteria for camp participation. In addition to exploring who might be most likely to benefit from Camp HOPE, future research should examine which elements of Camp HOPE might promote positive or negative change, as well as which proposed modifications might enhance the therapeutic value of the camp. Such information can be obtained by randomly assigning families to different versions of the camp intervention (e.g., 6-week day camp versus weeklong overnight camp). Including a waitlist control group in addition to a control group that receives a different type of intervention will facilitate firmer conclusions about the impact of the camp on children. These quantitative analytic strategies would benefit from supplemental qualitative data. For instance, interviewing children and caregivers more immediately after camp would allow researchers to understand potential mechanisms of change from the perspective of the campers and areas of growth that may not be captured in pre-selected measures of child functioning. While the current study included some qualitative components, a more planful and systematic qualitative study, including formal qualitative analyses, would offer nuanced information about the camp experience.

## **Conclusions**

This is the first study, to our knowledge, to examine the association between unique forms of victimization exposure and three facets of self-perception among children experiencing

family violence. Findings highlight the negative impact of direct victimization on children's self-concept. This is also the first study, to our knowledge, to evaluate the effect of Camp HOPE on self-perception among children exposed to family violence. Using a randomized control design, findings indicate that Camp HOPE does not promote positive self-perception among this population. However, more nuanced findings from the familial case study suggest that this intervention may be helpful for some children.

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Table 1.

*Study 1: Means, Standards Deviations, and Correlations of Proposed Model Variables*

	Child Age	Family Income	JVQ - Direct	JVQ - Indirect	CTS2 - Total	SPPC - Social	SPPC - Behavior	SPPC - Global
1	9.34 (1.45)	.09	-.21*	-.10	-.01	-.01	.12	-.09
2		\$20.3K (16.4K)	-.20	-.14	-.23*	-.06	.07	.07
3			2.00 (1.66)	.47***	-.14	-.40***	-.27*	-.34**
4				0.99 (0.95)	-.08	-.00	-.11	.03
5					149.18 (193.42)	.02	.02	.08
6						16.93 (4.81)	.36**	.54***
7							15.71 (3.64)	.50***
8								13.15 (3.00)

*Note.* Diagonal of table provides means (and standard deviations). JVQ = Juvenile Victimization Questionnaire; CTS2 = Revised Conflict Tactics Scale; SPPC = Self-Perception Profile for Children; \* $p < .05$ ; \*\* $p < .01$ , \*\*\* $p < .001$

Table 2.

*Study 1: Summary of Linear Regression Analyses Examining Associations between Children's Victimization Experiences and Self-Perception*

Variable	B	S.E.	<i>t</i> value	R <sup>2</sup> Mean (Range)	F Mean (Range)	<i>p</i> value Mean (Range)
<b>Social Competence</b>				.230 (.192-.265)	6.80 (5.42-8.20)	<.001 (.000-.001)
JVQ – Direct	-1.63	.33	-4.98***	-	-	-
JVQ – Indirect	1.22	.58	2.12*	-	-	-
CTS – Total	.00	.00	-.66	-	-	-
Family Income	.00	.00	-1.39	-	-	-
<b>Behavioral Conduct</b>				.117 (.089-.145)	1.97 (1.45-2.51)	.094 (.027-.205)
JVQ – Direct	-.71	.27	-2.62**	-	-	-
JVQ – Indirect	.06	.47	.12	-	-	-
CTS – Total	.00	.00	-.16	-	-	-
Child Age	-.49	.27	-1.83	-	-	-
Child Race	-.03	.04	-.68	-	-	-
Child Sex	-.23	.78	-.30	-	-	-
<b>Global Self-Worth</b>				.191 (.152-.242)	5.40 (4.09-7.25)	.001 (.000-.004)
JVQ – Direct	-.89	.22	-4.09***	-	-	-
JVQ – Indirect	.78	.37	2.09*	-	-	-
CTS – Total	.00	.00	.29	-	-	-
Child Age	-.35	.21	-1.66	-	-	-

*Note.* Beta and *t*-values are reported from the pooled dataset. R<sup>2</sup> and F statistics are reported as a range of the results from the imputed datasets; Child race represents a dichotomized variable (0 = African-American/Black; 1 = Not African-American/Black); Child sex: 0 = Female, 1 = Male; \* *p* < .05, \*\* *p* < .01, \*\*\* *p* < .001.

Table 3.  
*Study 2: Demographic and Clinical Characteristics*

	2019 Sample			2018-2019 Sample		
	Total (N = 47)	Camper (n = 23)	Control (n = 24)	Total (N = 65)	Camper (n = 34)	Control (n = 31)
Child Age (Years)	9.55 (1.63)	9.65 (1.53)	9.46 (1.74)	9.40 (1.49)	9.53 (1.33)	9.26 (1.65)
Child Race	78.7% African-American/Black	78.3% African-American/Black	79.2% African-American/Black	80.0% African-American/Black	76.5% African-American/Black	83.9% African-American/Black
Child Sex	53.2% Male; 46.8% Female	47.8% Male	58.3% Male	53.8% Male; 46.2% Female	47.1% Male	61.3% Male
Family Income	59.9% < \$20K	63.6% < 20K	56.4% < \$20K	59.7% < \$20K	57.5% < \$20K	62.0% < \$20K
Behavioral Conduct (T1)	18.43 (3.88)	18.26 (4.22)	18.58 (3.61)	18.75 (4.14)	18.41 (4.58)	19.13 (3.61)
Social Competence (T1)	16.01 (5.15)	15.57 (5.19)	16.43 (5.19)	16.39 (5.14)	16.12 (5.19)	16.69 (5.16)
Global Self-Worth (T1)	19.34 (3.72)	19.35 (3.56)	19.33 (3.94)	19.58 (4.04)	19.91 (4.06)	19.20 (4.05)
Behavioral Conduct (T2)	18.75 (4.87)	18.82 (5.19)	18.68 (4.70)	19.52 (4.50)	19.81 (4.80)	19.20 (4.22)
Social Competence (T2)	17.61 (4.08)	17.25 (3.60)	17.93 (4.53)	18.21 (3.93)	17.90 (3.63)	18.54 (4.27)
Global Self-Worth (T2)	20.03 (3.96)	18.53 (4.82)	21.37 (2.41)	20.42 (3.67)	19.67 (4.41)	21.24 (2.49)
Behavioral Conduct (T3)	18.81 (4.92)	19.80 (5.05)	17.81 (4.72)	19.14 (4.87)	19.77 (5.08)	18.37 (4.62)
Social Competence (T3)	17.79 (4.81)	17.50 (4.82)	18.09 (4.94)	18.22 (4.82)	17.87 (4.89)	18.65 (4.83)
Global Self-Worth (T3)	19.72 (4.15)	20.25 (3.66)	19.19 (4.65)	20.29 (4.35)	20.70 (4.27)	19.79 (4.52)

*Note.* T1 = Baseline assessment; T2 = Two-month follow-up assessment; T3 = Five-month follow-up assessment

Table 4.

*Study 2: Results from Primary and Secondary Analyses on Self-Perception, Using 2019 Dataset and Multiple Imputation, without Covariates*

	Intent-to-Treat Groupings (Primary Analysis)			As-Treated Groupings (Secondary Analysis)		
	Control Group (Est., SE)	Camper Group (Est., SE)	Difference (Est., SE, p-value, Hedge's g)	Control Group (Est., SE)	Camper Group (Est., SE)	Difference (Est., SE, p-value, Hedge's g)
<b>Global Self-Worth</b>						
Baseline Intercept	19.33 (0.79)	19.35 (0.73)	0.01 (1.07); p = .989; g = 0.01	19.33 (0.73)	19.35 (0.74)	0.02 (1.04); p = .985; g = 0.01
2-Month F/U Intercept	<b>21.26 (0.65)</b>	<b>18.61 (1.02)</b>	<b>-2.65 (1.22); p = .029; g = 0.63</b>	20.48 (0.77)	18.88 (1.03)	-1.61 (1.30); p = .216; g = 0.37
<i>Within-Groups Effect Size (g)</i>	0.54	0.17	-	0.28	0.12	-
5-Month F/U Intercept	19.28 (1.03)	19.79 (0.92)	0.51 (1.40); p = .718; g = 0.11	19.10 (0.90)	20.26 (0.94)	1.16 (1.30); p = .373; g = 0.25
<i>Within-Groups Effect Size (g)</i>	0.46	0.25	-	0.30	0.33	-
Slope 1	0.17 (0.09)	-0.07 (0.11)	-0.23 (0.14); p = .095; g = 0.49	0.10 (0.08)	-0.04 (0.14)	-0.14 (0.17); p = .418; g = 0.28
Slope 2	<b>-0.14 (0.08)</b>	<b>0.09 (0.08)</b>	<b>0.23 (0.11); p = .041; g = 0.60</b>	-0.10 (0.07)	0.11 (0.09)	0.20 (0.11); p = .072; g = 0.55
<b>Behavioral Conduct</b>						
Baseline Intercept	18.58 (0.72)	18.26 (0.86)	-0.32 (1.12); p = .774; g = .08	18.67 (0.67)	18.00 (1.00)	-0.67 (1.20); p = .579; g = 0.17
2-Month F/U Intercept	19.07 (0.98)	18.78 (1.09)	-0.30 (1.47); p = .839; g = 0.06	19.02 (0.89)	18.87 (1.30)	-0.15 (1.58); p = .923; g = 0.03
<i>Within-Groups Effect Size (g)</i>	0.11	0.11	-	0.08	0.18	-
5-Month F/U Intercept	18.38 (1.08)	18.53 (1.21)	0.151 (1.64); p = .927; g = 0.03	18.83 (0.96)	17.85 (1.42)	-0.98 (1.71); p = .567; g = 0.18
<i>Within-Groups Effect Size (g)</i>	0.14	0.04	-	0.04	0.18	-
Slope 1	0.07 (0.08)	0.05 (0.08)	-0.02 (-.11); p = .890; g = 0.04	0.05 (0.07)	0.08 (0.10)	0.03 (0.13); p = .798; g = 0.07
Slope 2	-0.03 (0.08)	-0.01 (0.07)	0.02 (0.11); p = .857; g = 0.05	0.00 (0.07)	-0.07 (0.10)	-0.07 (0.12); p = .527; g = 0.17
<b>Social Competence</b>						
Baseline Intercept	16.43 (1.04)	15.57 (1.06)	-0.87 (1.48); p = .558; g = 0.17	16.38 (0.88)	15.35 (1.33)	-1.03 (1.60); p = .520; g = 0.20
2-Month F/U Intercept	18.09 (0.94)	17.18 (0.92)	-0.91 (1.31); p = .489; g = 0.20	18.17 (0.81)	16.90 (1.11)	-1.27 (1.35); p = .347; g = 0.28
<i>Within-Groups Effect Size (g)</i>	0.34	0.33	-	0.38	0.30	-
5-Month F/U Intercept	17.96 (1.16)	17.09 (1.17)	-0.87 (1.66); p = .599; g = .15	17.69 (1.02)	17.41 (1.37)	-0.29 (1.73); p = .869; g = 0.05
<i>Within-Groups Effect Size (g)</i>	0.02	0.02	-	0.09	0.10	-
Slope 1	0.16 (0.11)	0.18 (0.11)	0.02 (0.16); p = .883; g = 0.04	0.17 (0.09)	0.18 (0.14)	0.01 (0.17); p = .971; g = 0.02
Slope 2	0.00 (0.08)	0.00 (0.10)	0.00 (0.13); p = .989; g = 0.00	-0.03 (0.08)	0.04 (0.12)	0.07 (0.14); p = .634; g = 0.15

*Note.* Bold text indicates significant findings.

Table 5.

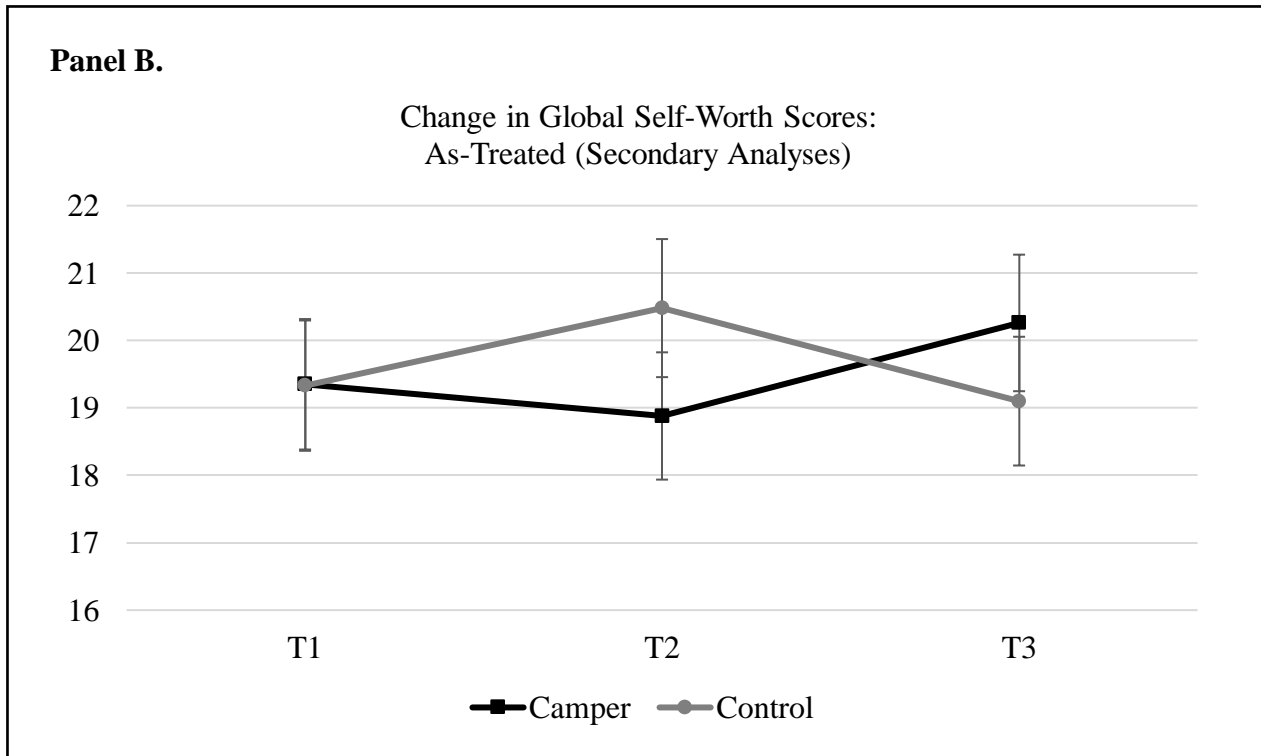
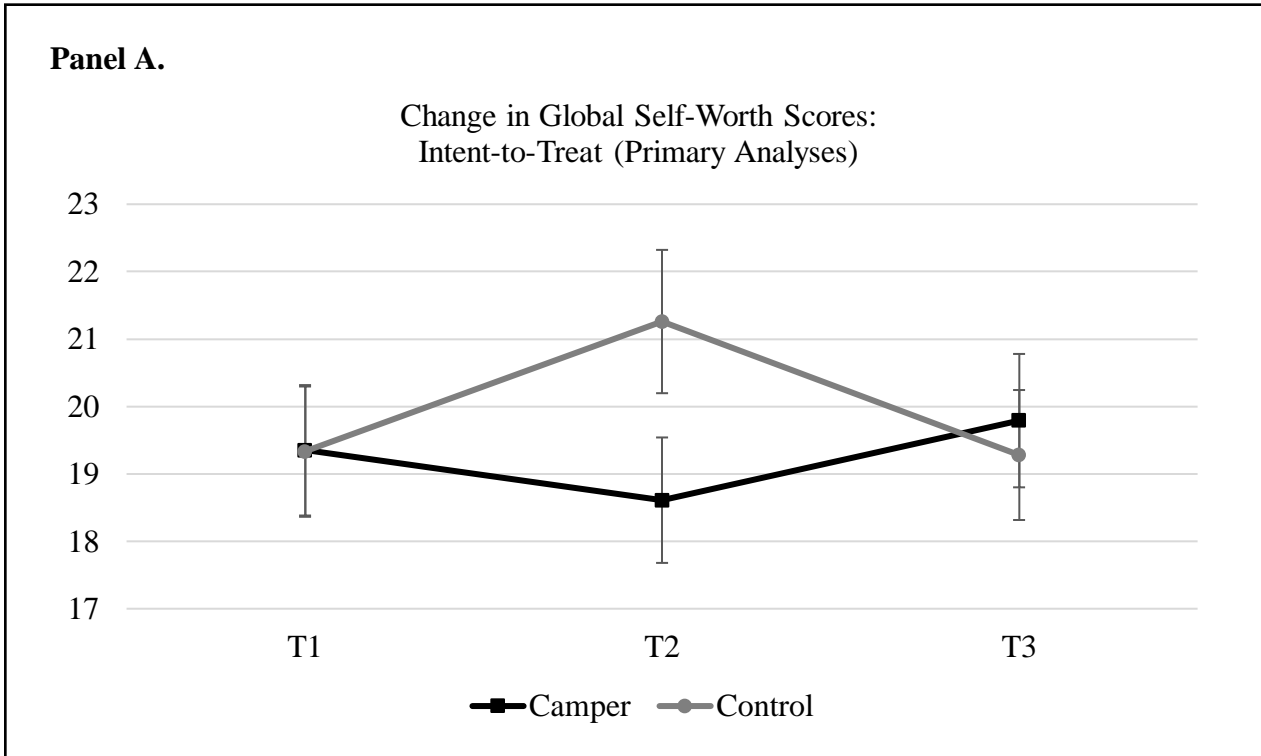
*Study 3: Strengths and Difficulties Questionnaire – Counselor Report at Post-Camp*

	Nicole	Anthony	Jessica	Sample Average
<b>Total Difficulties</b>	9	19	1	9.83
Emotional Symptoms	2	2	1	1.75
Conduct Problems	0	3	0	1.68
Hyperactivity	5	10	0	3.96
Peer Problems	2	4	0	2.43
<b>Prosocial Behavior</b>	8	6	7	7.12

Table 6.

*Study 3: Strengths and Difficulties Questionnaire – Caregiver Report*

	Baseline				2-Month Follow-Up				5-Month Follow-Up			
	Nicole	Anthony	Jessica	Sample Average	Nicole	Anthony	Jessica	Sample Average	Nicole	Anthony	Jessica	Sample Average
<b>Total Difficulties</b>	17	-	7	12.89	14	23	8	10.92	18	24	3	12.32
Emotional Symptoms	5	-	2	3.2	3	5	2	2.39	4	3	0	2.77
Conduct Problems	4	-	0	2.35	3	7	1	2.1	5	8	1	2.51
Hyper-activity	4	-	2	4.71	3	7	2	3.92	5	10	1	4.46
Peer Problems	4	-	3	2.64	5	4	3	2.51	4	3	1	2.56
<b>Prosocial Behavior</b>	5	-	5	7.95	8	1	9	7.63	5	1	8	7.41



*Figure 1 (Study 2).* Changes in Global Self-Worth scores among camper and control participants from baseline to five-month follow-up. Note: Error bars that do not overlap indicate significant differences.

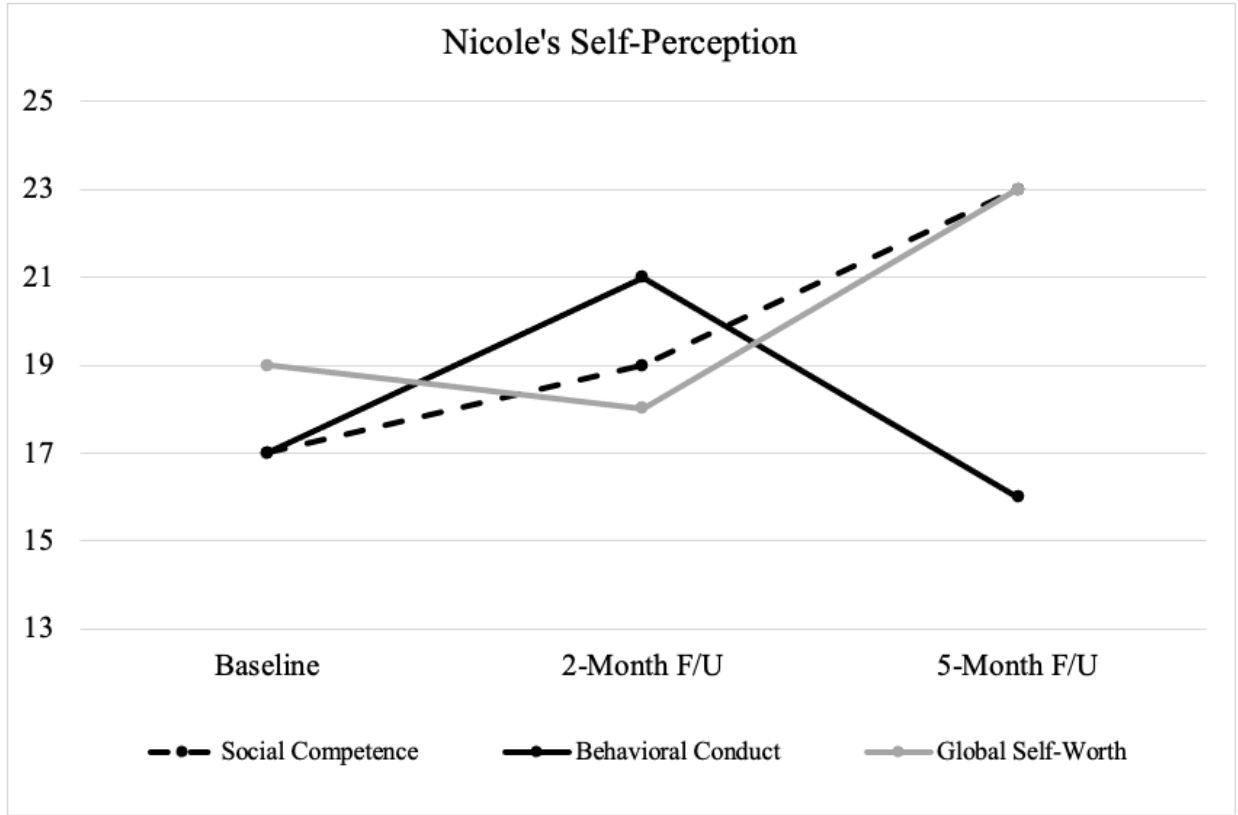


Figure 2 (Study 3). Changes in Nicole's Self-Perception from Baseline to Follow-Up



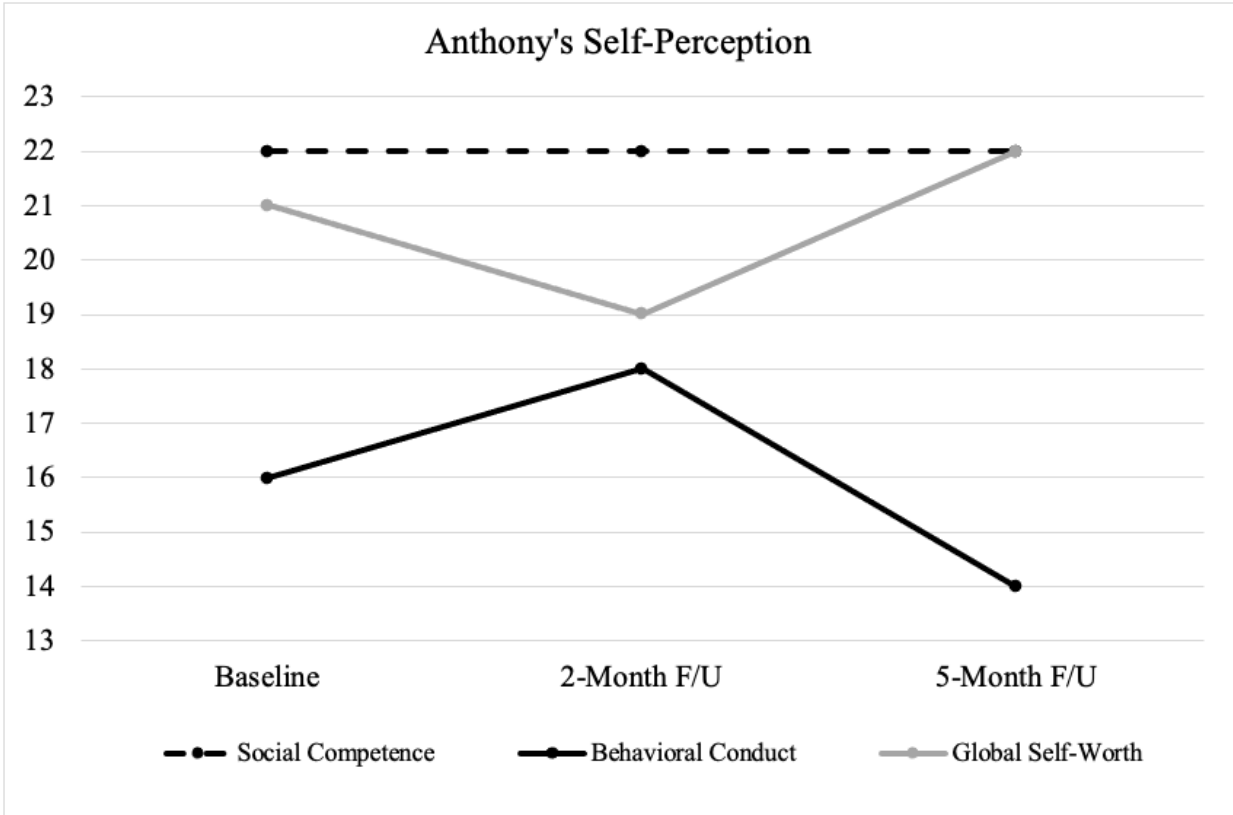


Figure 3 (Study 3). Changes in Anthony’s Self-Perception from Baseline to Follow-Up

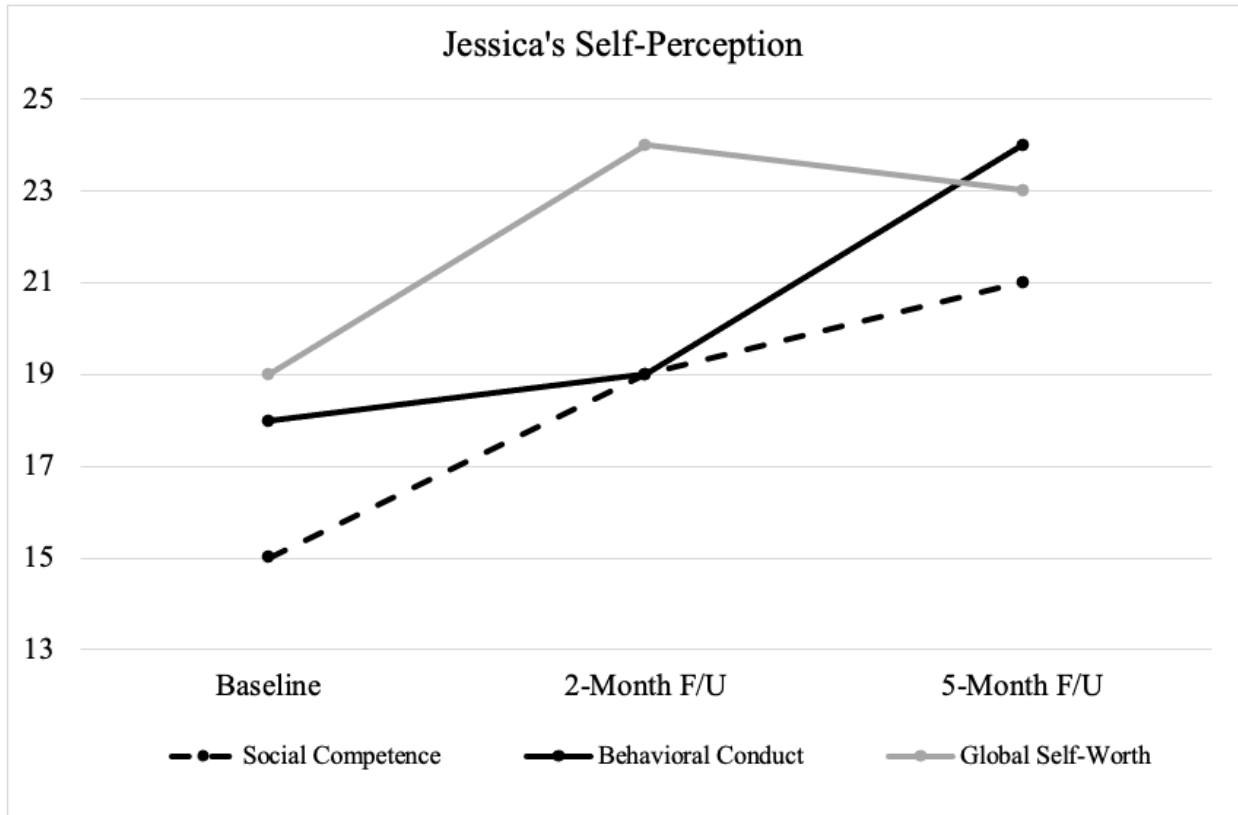


Figure 4 (Study 3). Changes in Nicole's Self-Perception from Baseline to Follow-Up

## Appendix A: Measures

### Revised Conflict Tactics Scale (CTS2)

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other or just have arguments or fight because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences.

**Instructions:** Please circle a number to show how many times your MOST RECENT VIOLENT PARTNER did each of these things **in the past year**. If your partner did not do one of these things in the past year, but it happened before that, circle “7.”

**How often did this happen?**

- 1 = Once in the past year
- 2 = Twice in the past year
- 3 = 3 to 5 times in the past year
- 4 = 6 to 10 times in the past year
- 5 = 11 to 20 times in the past year
- 6 = More than 20 times in the past year
- 7 = Not in the past year, but it did happen
- 0 = This Has Never happened

<i>How often did this happen?</i>	<b>1x in the past year</b>	<b>2x in the past year</b>	<b>3-5 times in the past year</b>	<b>6-10 times in the past year</b>	<b>11-20 times in the past year</b>	<b>More than 20 times in the past year</b>	<b>Not in the past year, but it did happen</b>	<b>This has never happened</b>
1. My partner showed care for me even though we disagreed.	1	2	3	4	5	6	7	0
2. My partner explained his or her side of the argument to me.	1	2	3	4	5	6	7	0
3. My partner swore or insulted me.	1	2	3	4	5	6	7	0
4. My partner threw something at me that could hurt.	1	2	3	4	5	6	7	0
5. My partner twisted my arm or hair.	1	2	3	4	5	6	7	0
6. I had a sprain, bruise, or small cut because of a fight with my partner.	1	2	3	4	5	6	7	0
7. My partner showed respect for my feelings about an issue.	1	2	3	4	5	6	7	0
8. My partner made me have sex without a condom.	1	2	3	4	5	6	7	0
9. My partner pushed or shoved me.	1	2	3	4	5	6	7	0

10. My partner used force (like hitting, holding down, or using a weapon) to make me have oral or anal sex.	1	2	3	4	5	6	7	0
11. My partner used a knife or gun on me.	1	2	3	4	5	6	7	0
12. I passed out from being hit on the head by my partner in a fight.	1	2	3	4	5	6	7	0
13. My partner called me fat or ugly.	1	2	3	4	5	6	7	0
14. My partner punched or hit me with something that could hurt.	1	2	3	4	5	6	7	0
15. My partner destroyed something belonging to me.	1	2	3	4	5	6	7	0
16. I went to a doctor because of a fight with my partner.	1	2	3	4	5	6	7	0
17. My partner choked me.	1	2	3	4	5	6	7	0
18. My partner shouted or yelled at me.	1	2	3	4	5	6	7	0
19. My partner slammed me against a wall.	1	2	3	4	5	6	7	0
20. My partner was sure we could work it out.	1	2	3	4	5	6	7	0
21. I needed to see a doctor because of a fight with my partner, but I didn't.	1	2	3	4	5	6	7	0
22. My partner beat me up.	1	2	3	4	5	6	7	0
23. My partner grabbed me.	1	2	3	4	5	6	7	0
24. My partner used force (like hitting, holding down or using a weapon) to make me have sex.	1	2	3	4	5	6	7	0
25. My partner stomped out of the room or house or yard during a disagreement.	1	2	3	4	5	6	7	0
26. My partner insisted on sex when I did not want to (but did not use physical force).	1	2	3	4	5	6	7	0
27. My partner slapped me.	1	2	3	4	5	6	7	0
28. I had a broken bone from a fight with a partner.	1	2	3	4	5	6	7	0
29. My partner used threats to make me have oral or anal sex.	1	2	3	4	5	6	7	0
30. My partner suggested a compromise to disagreement.	1	2	3	4	5	6	7	0
31. My partner burned or scalded me on purpose.	1	2	3	4	5	6	7	0

32. My partner insisted I have oral or anal sex (but did not use physical force).	1	2	3	4	5	6	7	0
33. My partner accused me of being a lousy lover.	1	2	3	4	5	6	7	0
34. My partner did something to spite me.	1	2	3	4	5	6	7	0
35. My partner threatened to hit or throw something at me.	1	2	3	4	5	6	7	0
36. I felt physical pain that still hurt the next day because of a fight with my partner.	1	2	3	4	5	6	7	0
37. My partner kicked me.	1	2	3	4	5	6	7	0
38. My partner used threats to make me have sex.	1	2	3	4	5	6	7	0
39. My partner agreed to try a solution I suggested.	1	2	3	4	5	6	7	0

## Strengths and Difficulties Questionnaire (SDQ)

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of this young person's behavior over the last six months or this school year.

	Not True	Somewhat True	Certainly True
1. Considerate of other people's feelings			
2. Restless, overactive, cannot stay still for long			
3. Often complains of headaches, stomach-aches or sickness			
4. Shares readily with other youth, for example books, games, food			
5. Often loses temper			
6. Would rather be alone than with other youth			
7. Generally well behaved, usually does what adults request			
8. Many worries or often seems worried			
9. Helpful if someone is hurt, upset or feeling ill			
10. Constantly fidgeting or squirming			
11. Has at least one good friend			
12. Often fights with other youth or bullies them			
13. Often unhappy, depressed or tearful			
14. Generally liked by other youth			
15. Easily distracted, concentration wanders			
16. Nervous in new situations, easily loses confidence			
17. Kind to younger children			
18. Often lies or cheats			
19. Picked on or bullied by other youth			
20. Often offers to help others (parents, teachers, children)			
21. Thinks things out before acting			
22. Steals from home, school or elsewhere			
23. Gets along better with adults than with other youth			
24. Many fears, easily scared			
25. Good attention span, sees work through to the end			

## Juvenile Victimization Questionnaire – 2<sup>nd</sup> Revision (JVQR2)

*Now we are going to ask you about some things that might have happened in the last year.*

1) In the last year, did anyone steal something from you and never give it back? Things like a backpack, money, watch, clothing, bike, stereo, or anything else?

- Yes
- No

2) Sometimes people are attacked with sticks, rocks, guns, knives, or other things that would hurt. In the last year, did anyone hit or attack you on purpose with an object or weapon? Somewhere like: at home, at school, at a store, in a car, on the street, or anywhere else?

- Yes
- No

3) In the last year, did anyone hit or attack you without using an object or weapon?

- Yes
- No

4) Next, we are going to ask about grown-ups who take care of you. This means parents, babysitters, adults who live with you, or others who watch you. Before we begin, I want to remind you that your answers will be kept totally private. If there is a particular question that you don't want to answer, that's O.K. but it is important that you be as honest as you can so that we can get a better idea of the kinds of things that kids your age sometimes face.

In the last year, did you get scared or feel really bad because grown-ups in your life called you names, said mean things to you, or said they didn't want you?

- Yes
- No

5) Sometimes groups of kids or gangs attack people. In the last year, did a group of kids or a gang hit, jump, or attack you?

- Yes
- No

6) In the last year, did any kid, even a brother or sister, hit you? Somewhere like: at home, at school, out playing, in a store, or anywhere else?

- Yes
- No

7) In the last year, did you get scared or feel really bad because kids were calling you names, saying mean things to you, or saying they didn't want you around?

- Yes
- No

8) In the last year, did a grown-up you know touch your private parts when they shouldn't have or make you touch their private parts?

Yes

No

9) In the last year, did a grown-up you did not know touch your private parts when they shouldn't have or make you touch their private parts?

Yes

No

10) In the last year, did you SEE a parent get pushed, slapped, hit, punched, or beat up by another parent, or their boyfriend or girlfriend?

Yes

No

11) In the last year, in real life, did you SEE anyone get attacked on purpose WITH a stick, rock, gun, knife, or other thing that would hurt? Somewhere like: at home, at school, at a store, in a car, on the street, or anywhere else?

Yes

No

12) In the last year, were you in any place in real life where you could see or hear people being shot, bombs going off, or street riots?

*If child asks what a riot is... "it is when a group of people gather on the sidewalk or in the street for a cause; they are usually loud and/or violent; the group might be holding signs, shouting things, or destroying things."*

Yes

No



### Self-Perception Profile for Children (S-PP-C)

We have some sentences here and, as you can see from the top of your sheet where it says “What I am like,” we are interested in what you are like, what kind of a person you are. This is a survey, *not* a test. There are no right or wrong answers. Since kids are very different from one another, you might put down answers that are different from other kids.

First, let me explain how these questions work. There is a sample question at the top, marked (a). It says “Some kids would rather play outdoors in their spare time **BUT** other kids would rather watch T.V.” This question talks about two kinds of kids, and we want to know which kids are most like *you*.

(1) So, what I want you to decide first is whether *you* are more like the kids on the left side who would rather play outdoors, or whether you are more like the kids on the right side who would rather watch T.V.

(2) Now the *second* thing I want you to think about, now that you have decided which kinds of kids are most like you, is to decide whether that is only *sort of true for you*, or *really true for you*. If it’s only sort of true, we will mark an X in the box under Sort of True for me; if it’s really true for you, then we will put an X in that box, under Really True for me.

(3) For each sentence, we will only check **one** box. Sometimes it will be on one side of the page, another time it will be on the other side of the page, but you can only check *one box* for each sentence. **YOU *DON’T* CHECK BOTH SIDES, JUST THE *ONE* SIDE MOST LIKE YOU.**

(4) OK, that one was just for practice. Now we have some more sentences that I will read out loud. For each one, you will tell me which kinds of kids are more like you, and how true each statement is for you.

#### What I Am Like

	Really True for me	Sort of True for me				Sort of True for me	Really True for me
<b>Sample Sentence</b>							
a.			Some kids would rather play outdoors in their spare time	<b>BUT</b>	Other kids would rather watch T.V.		
1.			Some kids feel that they are very good at their school work	<b>BUT</b>	Other kids worry about whether they can do the school work assigned to them		

2.			Some kids find it hard to make friends	<b>BUT</b>	Other kids find it pretty easy to make friends		
3.			Some kids do very well at all kinds of sports	<b>BUT</b>	Other kids don't feel that they are very good when it comes to sports		
4.			Some kids often do not like the way they behave	<b>BUT</b>	Other kids usually like the way they behave		
5.			Some kids are often unhappy with themselves	<b>BUT</b>	Other kids are pretty pleased with themselves		
6.			Some kids feel like they are just as smart as other kids their age	<b>BUT</b>	Other kids aren't so sure and wonder if they are as smart		
7.			Some kids know how to make classmates like them	<b>BUT</b>	Other kids don't know how to make classmates like them		
8.			Some kids wish they could be a lot better at sports	<b>BUT</b>	Other kids feel they are good enough at sports		
9.			Some kids usually do the right thing	<b>BUT</b>	Other kids often don't do the right thing		
10.			Some kids don't like the way they are leading their life	<b>BUT</b>	Other kids <i>do</i> like the way they are leading their life		
11.			Some kids are pretty slow in finishing their school work	<b>BUT</b>	Other kids can do their school work quickly		
12.			Some kids don't have the social skills to make friends	<b>BUT</b>	Other kids do have the social skills to make friends		
13.			Some kids think they could do well at just about any new sports activity they haven't tried before	<b>BUT</b>	Other kids are afraid they might not do well at sports they haven't ever tried		
14.			Some kids usually act the way they know they are supposed to	<b>BUT</b>	Other kids often don't act the way they are supposed to		
15.			Some kids are happy with themselves as a person	<b>BUT</b>	Other kids are often not happy with themselves		

16.		Some kids often forget what they learn	<b>BUT</b>	Other kids can remember things easily		
17.		Some kids understand how to get peers to accept them	<b>BUT</b>	Other kids don't understand how to get peers to accept them		
18.		Some kids feel that they are better than others their age at sports	<b>BUT</b>	Other kids don't feel they can play as well		
19.		Some kids usually get in trouble because of things they do	<b>BUT</b>	Other kids usually don't do things that get them in trouble		
20.		Some kids like the kind of person they are	<b>BUT</b>	Other kids often wish they were someone else		
21.		Some kids do very well at their classwork	<b>BUT</b>	Other kids don't do very well at their classwork		
22.		Some kids wish they knew how to make more friends	<b>BUT</b>	Other kids know how to make as many friends as they want		
23.		In games and sports some kids usually watch instead of play	<b>BUT</b>	Other kids usually play rather than just watch		
24.		Some kids do things they know they shouldn't do	<b>BUT</b>	Other kids hardly ever do things they know they shouldn't do		
25.		Some kids are very happy being the way they are	<b>BUT</b>	Other kids wish they were different		
26.		Some kids have trouble figuring out the answers in school	<b>BUT</b>	Other kids almost always can figure out the answers		
27.		Some kids know how to become popular	<b>BUT</b>	Other kids do not know how to become popular		
28.		Some kids don't do well at new outdoor games	<b>BUT</b>	Other kids are good at new games right away		
29.		Some kids behave themselves very well	<b>BUT</b>	Other kids often find it hard to behave themselves		
30.		Some kids are not very happy with the way they do a lot of things	<b>BUT</b>	Other kids think the way they do things is fine.		

### Attachment – Maternal

Answer the following questions about your mother (or mother figure). If she is deceased, answer these questions about when she was alive.

- If you never had a mother figure, check this box and skip to the next set of questions.

	<b>Mostly true about me</b>	<b>Somewhat true about me</b>	<b>A little true about me</b>	<b>Not true about me</b>
1. You seek out your mother (or mother figure) when you're upset.	4	3	2	1
2. You turn to your mother (or mother figure) when you're worried about something.	4	3	2	1
3. You turn to your mother (or mother figure) for comfort when you're not feeling well.	4	3	2	1
4. Your mother (or mother figure) encourages you to try new things that you'd like to do but are nervous about.	4	3	2	1
5. Your mother (or mother figure) encourages you to go after your goals and future plans.	4	3	2	1
6. Your mother (or mother figure) shows support for the things you do.	4	3	2	1

## Appendix B: Participant Flow

Figure B1.

*Timeline of Camp HOPE evaluation timepoints and intervention dates.*

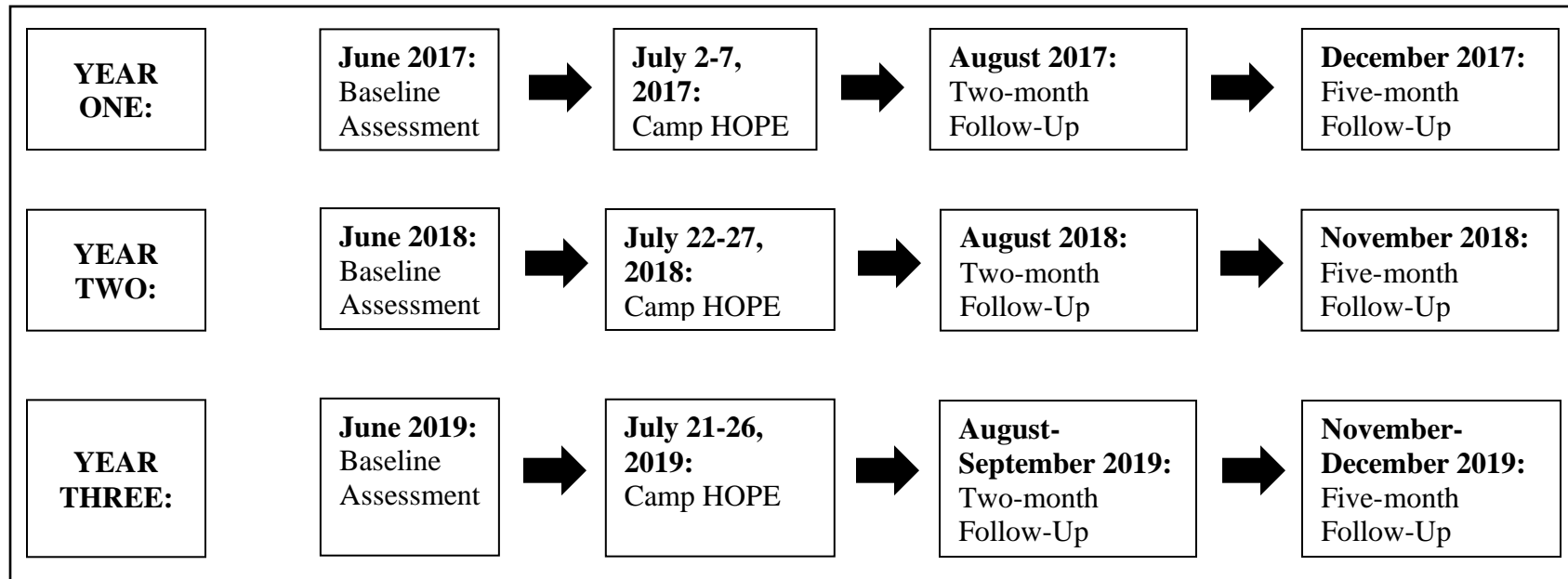
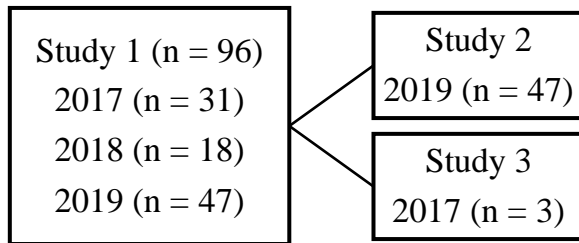


Figure B2.

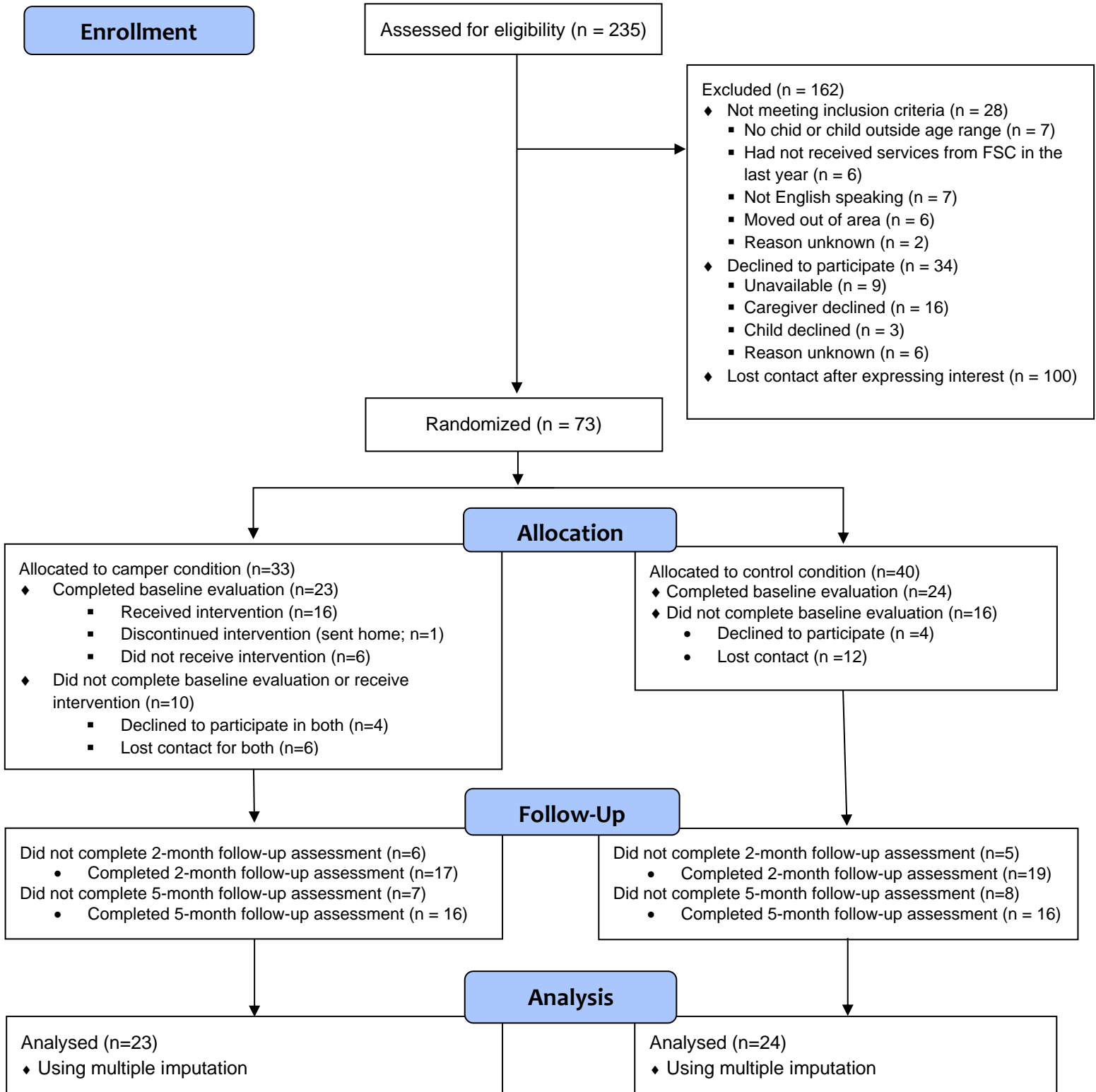
*Participant flow across studies.*



*Note:* Study 1 was a cross-sectional examination of the association between victimization exposure and children’s self-perception. Study 2 used longitudinal data to evaluate the impact of Camp HOPE on children’s self-perception. Study 3 was a familial case study that investigated three siblings’ self-perception scores across time, discussing potential explanations for observed changes in self-perception. In 2017-2018, participants were recruited via FSC staff referrals, FSC partner site referrals, contacting families from the FSC database, and speaking with families at FSC events. Therefore, most of the participants were recruited by FSC staff. In 2019, participants were recruited by calling families from the FSC database, approaching families in the waiting room at the FSC, and cross-referral from another study conducted as part of a partnership between University of Memphis and FSC. Thus, most participants were recruited by University of Memphis research staff.

Figure B3.

CONSORT flow diagram for participant recruitment in the intervention evaluation.



## **Appendix C: Additional Secondary Analyses**

In addition to the as-treated secondary analyses reported in the main text, a series of additional secondary analyses were run to examine the impact of multiple imputation, covariates, and treatment non-completers on results. First, analyses were re-run using listwise deletion instead of multiple imputation to address missing data. Second, covariates were included in the analyses. Finally, additional analyses were run to explore the difference between as-treated, intent-to-treat, and completer groupings. These additional secondary analyses were run for all three components of self-perception (GSW, BC, and SC). Consistent with findings from the primary and secondary analyses reported in text, camper and control groups did not evince significant differences in Behavioral Conduct or Social Competence in any of these secondary analyses, so only results for Global Self-Worth will be reported here.

### **Missing Data**

Although multiple imputation is a strong, scientifically grounded method of handling missing data (Enders, 2010), the use of listwise deletion and analysis of only observed data may be warranted when there is a large amount of missing data on the outcome variable and when data are missing completely at random (Jakobsen, Gluud, Wettersley, & Winkely, 2017). As such, primary analyses were run without imputing missing values for children's self-perception scores. Using listwise deletion resulted in a sample of 14 camper participants and 16 control group participants. Results were similar to results from the primary analyses, providing some support that the data were missing at random (an assumption of multiple imputation).

Consistent with findings from the primary analyses regarding Global Self-Worth (GSW), control group participants demonstrated improvements in perceived GSW between baseline and two-month follow-up (Est. = 0.23, SE = 0.10), while campers demonstrated declines in perceived



GSW during this timeframe (Est. = -0.18, SE = 0.12). Within-group effect size was large for the control group ( $g = 0.76$ ) and small-medium in the camper group ( $g = 0.39$ ). In these analyses using listwise deletion, the difference in rate of change from baseline to two-month follow-up (Slope 1) was significantly different between groups (Diff. = -0.42, SE = 0.15;  $p = .006$ ;  $g = 0.94$ ). Although the rate of change from baseline to two-month follow-up was significantly different, the difference between the camper ( $M = 18.57$ , SE = 1.33) and control ( $M = 21.25$ ; SE = 0.63) groups' two-month follow-up scores was not significant in the current analyses (Diff. = -2.68; SE = 1.47;  $p = .069$ ;  $g = 0.68$ ). This finding is inconsistent with results from the primary analyses. Consistent with findings from the primary analyses, Slope 2 was significantly different between campers and control participants (Diff. = .23; SE = 0.11;  $p = .046$ ;  $g = -0.69$ ), with campers' GSW scores increasing (Est. = 0.08; SE = 0.08) and control participants' GSW scores declining (Est. = -0.14; SE = 0.08) from two-month to five-month follow-up. The within-group effect sizes reflecting change from two-month to five-month follow up was medium in the control group ( $g = 0.57$ ) and small in the camper group ( $g = 0.28$ ). At the final evaluation point (i.e., five-month follow-up), there were not significant differences between camper ( $M = 19.79$ , SE = 0.95) and control ( $M = 19.19$ ; SE = 1.13) participants' GSW scores (Diff. = 0.23; SE = 0.11;  $p = .046$ ;  $g = 0.69$ ). See Table C1.

In sum, findings from these secondary analyses, using listwise deletion to address missing data, do not support the hypothesis that camp would improve children's self-perception. These findings are similar to those from the primary analyses. In the primary analyses, Slope 1 was not significantly different between groups, while the two-month follow-up intercept was significantly different between groups. In the current secondary analyses, Slope 1 was significantly different between groups, while the two-month follow-up intercept was not

significantly different between groups. Although the significance values emerge on different parameters, the two sets of results mirror one another and convey a similar story: camp negatively impacted children's GSW. However, this negative impact abated over time. Indeed, camper children's GSW scores improved between two- and five-month follow up in both primary and the current list wise deletion analyses, such that there were no between-group differences at five-month follow-up.

### **Confounding Variables**

Research demonstrates that potentially confounding variables (i.e., variables that have an association with group membership and with outcomes) can alter study results in meaningful ways (de Boer, Waterlander, Kuijper, Steenhuis, & Twisk, 2015). In accordance with recommendations from multiple research groups (e.g., Austin, Zwarenstein, Juurlink, & Stanbrook, 2010; de Boer et al., 2015), results from crude models presented as the primary analyses are supplemented with results from adjusted models, which are presented here as secondary analyses. Confounding variables (i.e., family income, child sex) were determined based on existing literature, prognostic value, and the presence of meaningful between-group differences and will be referred to as 'covariates.' In the current study, family income was negatively associated with camper and control participants' global self-worth scores and control participants' behavioral conduct scores at the two-month follow-up evaluation. Gender was significantly associated with behavioral conduct scores at five-month follow-up, such that boys endorsed lower levels of perceived behavioral conduct.

### ***Missing Outcome Data Imputed***

Results from analyses including covariates were similar to those from the primary analyses. Consistent with findings from the primary analyses, control group participants

demonstrated improvements in perceived GSW between baseline and two-month follow-up (Est. = 0.17; SE = 0.05), with a medium effect size ( $g = 0.59$ ), while campers demonstrated declines in perceived GSW during this timeframe (Est. = -0.07, SE = 0.10), with a small effect size ( $g = 0.18$ ). This difference in rate of change was not significantly different between groups (Diff. = -0.23, SE = 0.14;  $p = .085$ ;  $g = 0.62$ ). Although the rate of change from baseline to two-month follow-up was not significantly different between groups, the difference between the camper ( $M = 18.61$ , SE = 0.95) and control ( $M = 21.26$ ; SE = 0.57) groups' two-month follow-up scores was significant in the current analyses (Est. = -2.65, SE = 1.11;  $p = .017$ ;  $g = 0.69$ ). Slope 2 revealed that control participants' GSW scores declined from two-month to five-month follow-up (Est. = -0.14; SE = 0.07), with a medium effect size ( $g = 0.50$ ), while campers' GSW scores increased (Est. = 0.09; SE = 0.07), with a small effect size ( $g = 0.26$ ). Slope 2 was significantly different between campers and control participants (Est. = 0.23; SE = 0.10;  $p = .029$ ;  $g = 0.67$ ). At the final evaluation point (i.e., five-month follow-up), there were no longer significant between-group differences in GSW scores (Diff. = 0.51; SE = 1.34;  $p = .705$ ;  $g = 0.11$ ). See Table C1. Like the primary results, these results including covariates do not support the hypothesis that camp would enhance children's self-perception. Indeed, the finding that control group participants endorsed more positive self-perception at two-month follow-up contradicts this hypothesis.

### ***Missing Outcome Data Not Imputed***

Analyses including covariates were also run using listwise deletion to address missing data on the self-perception outcomes. These results are similar to those from the crude analyses (i.e., the primary analyses that omitted covariates). Consistent with findings from the crude analyses, control group participants demonstrated improvements in perceived GSW between

baseline and two-month follow-up (Est. = 0.23, SE = 0.09;  $g = 0.84$ ), while campers demonstrated declines in perceived GSW during this timeframe (Est. = -0.18, SE = 0.10;  $g = 0.43$ ). Like the findings from the crude analyses using listwise deletion, this rate of change was significantly different between groups (Diff. = -0.42; SE = 0.14;  $p = .003$ ;  $g = 1.09$ ). In contrast to the crude analyses using listwise deletion to address missing outcome data, but consistent with findings from the primary analyses and the secondary analyses including covariates and imputing outcome data, the difference between the camper ( $M = 18.57$ , SE = 1.16) and control ( $M = 21.25$ ; SE = .52) groups' two-month follow-up scores was significant (Diff. = -2.68; SE = 1.27;  $p = .035$ ;  $g = 0.78$ ). Slope 2 revealed that control participants' GSW scores declined from two-month to five-month follow-up (-0.14; SE = 0.08;  $g = 0.59$ ), while campers' GSW scores increased (Est. = 0.08; SE = 0.07;  $g = 0.30$ ). Consistent with findings from the primary analyses and secondary analyses that included covariates and imputed missing outcome data, Slope 2 was significantly different between campers and control participants (Diff. = 0.23; SE = 0.10;  $p = .029$ ;  $g = 0.73$ ). At the final evaluation point (i.e., five-month follow-up), there were no longer significant between-group differences in GSW scores. See Table C1.

In sum, including covariates did not meaningfully alter the results. Results from these secondary analyses, which included covariates and used either multiple imputation or listwise deletion to address missing data, do not support the hypothesis that camp would enhance children's self-perception. Consistent with the primary analyses, findings from these secondary analyses again suggest that camp negatively impacted children's self-perception, such that children in the camper condition reported lower GSW scores at two-month follow-up compared to children in the control condition. However, this negative impact does not appear to sustain across time, given nonsignificant between-group differences at five-month follow-up.

## Secondary Analyses by Condition

As stated in the main text, secondary analyses were run to examine the impact of decisions about how to classify participants who were not retained in their originally assigned condition. In the as-treated analyses, participants assigned to the camper group who did not attend camp were re-assigned to the control group. In addition to the as-treated analyses using multiple imputation and excluding covariates (presented in the main text), as-treated analyses were run using listwise deletion and including covariates.

### *As-Treated Analyses*

When as-treated analyses were re-run, using listwise deletion to exclude cases with missing data on the outcome variables (rather than imputing the missing Time 2 and Time 3 self-perception data), results again revealed nonsignificant differences between the camper and control groups. The difference between rate of change in GSW scores from Time 2 to Time 3 approached significance, with camper group children demonstrating greater gains in GSW (Est. = 0.23; SE = 0.12;  $p = .056$ ;  $g = 0.71$ ). All within-group effect sizes were small to medium, ranging from 0.38 to 0.47. See Table C2.

**As-treated analyses with covariates.** Analyses were also run using the as-treated grouping system and including covariates. When multiple imputation was used to address missing data on outcomes, none of the differences between camper and control children's self-perception intercepts or slopes were significant. Slope 2 approached significance (Est. = 0.20, SE = 0.11,  $p = .055$ ,  $g = 0.57$ ), suggesting that campers' GSW scores (Est. = 0.11, SE = 0.08;  $g = 0.36$ ) increased more than control group participants' GSW scores (Est. = -0.10, SE = 0.07;  $g = 0.32$ ) between two- and five-month follow-up.

When covariates were included and listwise deletion was used to address missing data on outcomes, both slopes were significantly different between groups. Control group participants demonstrated improvements in perceived GSW between baseline and two-month follow-up (Est. = 0.15, SE = 0.08;  $g = 0.43$ ), while campers demonstrated declines in perceived GSW during this timeframe (Est. = -0.19, SE = 0.14;  $g = 0.60$ ). This rate of change was significantly different between groups (Diff. = -0.34; SE = 0.16;  $p = .030$ ;  $g = 0.85$ ). Slope 2 revealed that control participants' GSW scores declined from two-month to five-month follow-up (Est. = -0.11; SE = 0.07;  $g = 0.40$ ), while campers' GSW scores increased (Est. = 0.12; SE = 0.08;  $g = 0.50$ ), revealing significant between-group differences (Diff. = 0.23; SE = 0.11;  $p = .030$ ;  $g = 0.76$ ). There were no between-group differences on the intercepts, indicating that camper and control group scores were not significantly different from one another at two-month follow-up or five-month follow-up. See Table C2.

### ***Completer Analyses***

While the as-treated analyses recategorized participants assigned to the camper group who did not attend camp, the “completer” analyses excluded these participants ( $n = 5$ ) from all analyses. This categorization yielded a total sample of 42 families, with 17 families in the camper condition and 24 families in the control condition. Results from the completer analyses were almost identical to results from the primary, intent-to-treat analyses. First, analyses were run using multiple imputation to address missing outcome data and excluding covariates. In these analyses, camper and control groups were not significantly different on Slope 1, but the intercept at two-month follow-up revealed that GSW scores for camper ( $M = 18.82$ , SE = 0.98) and control ( $M = 21.18$ ; SE = 0.60) participants differed significantly (Diff. = -2.36; SE = 1.15;  $p = .039$ ;  $g = 0.67$ ). Additionally, there was a medium within-groups effect size representing

difference in control group participants' scores from baseline to two-month follow-up ( $g = 0.53$ ). Slope 2 revealed that control participants' GSW scores declined from two-month to five-month follow-up (Est. =  $-0.13$ ; SE =  $0.08$ ;  $g = 0.46$ ), while campers' GSW scores increased (Est. =  $0.09$ ; SE =  $0.09$ ;  $g = 0.28$ ). This difference approached significance (Est. =  $0.23$ ; SE =  $0.12$ ;  $p = .058$ ;  $g = 0.56$ ). At the final evaluation point (i.e., five-month follow-up), there were no longer significant between-group differences in GSW scores (Est. =  $0.78$ ; SE =  $1.46$ ;  $p = .596$ ;  $g = 0.16$ ). See Table C3.

When completer analyses were re-run, excluding cases with missing data on the outcome variables, results mirrored those from the intent-to-treat analyses using listwise deletion. Specifically, control group participants demonstrated improvements in perceived GSW between baseline and two-month follow-up (Est. =  $0.23$ , SE =  $0.10$ ;  $g = 0.76$ ), while campers demonstrated declines in perceived GSW during this timeframe (Est. =  $-0.19$ , SE =  $0.16$ ;  $g = 0.47$ ). This difference in rate of change (Slope 1) was significantly different between groups (Diff. =  $-0.42$ , SE =  $0.19$ ;  $p = .024$ ;  $g = 0.92$ ). This finding suggests that campers' GSW scores were declining at a significantly greater rate, compared to control group children. Although the rate of change from baseline to two-month follow-up was significantly different, the difference between the camper ( $M = 18.80$ , SE =  $1.36$ ) and control ( $M = 21.25$ ; SE =  $0.63$ ) groups' two-month follow-up scores was not significant. Like the intent-to-treat analyses using listwise deletion, this finding is inconsistent with results from the analyses using imputed outcomes. Consistent with findings from the analyses using imputed data for the outcomes, Slope 2 was significantly different between camper and control participants (Est. =  $0.26$ ; SE =  $0.13$ ;  $p = .042$ ;  $g = 0.79$ ), with campers' GSW scores increasing (Est. =  $0.12$ ; SE =  $0.10$ ;  $g = 0.41$ ) and control participants' GSW scores declining ( $-0.14$ ; SE =  $0.08$ ;  $g = 0.55$ ) from two-month to five-month

follow-up. At the final evaluation point (i.e., five-month follow-up), there were not significant differences between camper ( $M = 20.40$ ,  $SE = 0.99$ ) and control ( $M = 19.19$ ;  $SE = 1.13$ ) participants' GSW scores ( $Est. = 1.21$ ;  $SE = 1.50$ ;  $p = .419$ ;  $g = 0.29$ ). See Table C3.

**Completer analyses with covariates.** Analyses were also run using the “completer” participant grouping system and including covariates. Results mirrored those from the intent-to-treat analyses including covariates and were similar to those from the completer analyses that did not include covariates. When multiple imputation was used to address missing data on outcome variables, rate of change between camper and control groups was not significantly different between baseline and two-month follow-up. However, the intercept at two-month follow-up revealed that GSW scores for control participants ( $M = 21.18$ ,  $SE = 0.52$ ) were significantly higher than for camper participants ( $M = 18.82$ ;  $SE = 0.85$ ;  $Est. = -2.36$ ,  $SE = 1.00$ ,  $p = .018$ ;  $g = 0.78$ ). Additionally, there was a medium within-groups effect size representing a difference in control group participants' scores from baseline to two-month follow-up ( $g = 0.58$ ). There were significant differences between groups on Slope 2, with control participants' GSW scores declining from two-month to five-month follow-up ( $-0.13$ ,  $SE = 0.07$ ,  $g = 0.50$ ) and campers' GSW scores increasing ( $Est. = 0.09$ ,  $SE = 0.08$ ,  $g = 0.30$ ;  $Diff. = 0.23$ ,  $SE = 0.11$ ,  $p = .041$ ;  $g = 0.64$ ). At the final evaluation point (i.e., five-month follow-up), there were no longer significant between-group differences in GSW scores ( $Diff. = 0.78$ ;  $SE = 1.40$ ;  $p = .579$ ;  $g = 0.17$ ). See Table C3.

When the completer analyses with covariates were re-run, excluding cases with missing data on the outcome variables, results mirrored those from the intent-to-treat analyses using listwise deletion and including covariates. Specifically, control group participants demonstrated improvements in perceived GSW between baseline and two-month follow-up ( $Est. = 0.23$ ,  $SE =$



0.10;  $g = 0.86$ ), while campers demonstrated declines in perceived GSW during this timeframe (Est. = -0.19, SE = 0.14;  $g = 0.60$ ). This difference in rate of change (Slope 1) was significantly different between groups (Est = -0.42, SE = 0.16;  $p = .010$ ;  $g = 0.98$ ). Similarly, the difference between the camper (M = 18.80, SE = 1.01) and control (M = 21.25; SE = .50) groups' two-month follow-up scores was significantly different (Diff. = -2.45, SE = 1.13,  $p = .030$ ;  $g = 0.94$ ). Consistent with findings from the analyses using imputed data for the outcomes, Slope 2 was significantly different between camper and control participants (Est. = 0.26; SE = 0.11;  $p = .020$ ;  $g = 0.85$ ), with campers' GSW scores increasing (Est. = 0.12; SE = 0.08;  $g = 0.50$ ) and control participants' GSW scores declining (Est. = -0.14; SE = 0.08;  $g = 0.60$ ) from two-month to five-month follow-up. At the final evaluation point (i.e., five-month follow-up), there were not significant differences between camper (M = 20.40, SE = 0.94) and control (M = 19.19; SE = 1.08) participants' GSW scores (Diff. = 1.21; SE = 1.43;  $p = .398$ ;  $g = 0.30$ ). See Table C3.

In sum, decisions about how to classify participants impacted study findings. Results from the intent-to-treat analyses and completer analyses yielded similar findings, suggesting that children who attended Camp HOPE showed declines in self-perception at the two-month follow-up (i.e., significant differences on Slope 1 or at two-month follow-up). These findings contradict the hypothesis that camp would enhance children's self-perception. However, results from most analyses using the as-treated grouping system revealed no significant differences between camper and control condition, indicating that camp did not significantly impact children's self-perception, in a positive or negative way. These findings do not provide support for the hypothesis that camp would enhance children's self-perception, but they do not directly contradict this hypothesis. The one exception to null findings among the as-treated analyses emerged when listwise deletion was used to address missing data and covariates were included.

In these analyses, rates of change were significantly different between groups, suggesting again that camp negatively affected children's self-perception and directly contradicting study hypotheses. This exception is consistent with other trends in findings from the current study, where analyses using listwise deletion and including covariates were most likely to yield significant results. These results suggest that Camp HOPE has a temporary, negative impact on children's global self-worth that abates over time.

### **Pooled (2018-2019) Data**

Data collection in 2017 (n = 31 families) and 2018 (n = 18 families) followed different procedures compared to the rigorous RCT design used in 2019. The initial year of data collection (2017) was considered a pilot year, during which the research team assessed the feasibility of various procedural elements (e.g., RCT design, recruitment and retention strategies, survey administration procedures). In 2018, participants were recruited into the study throughout the year and assigned to condition based on the timing of recruitment, the number of remaining available slots at camp, and the family's preferences and availability to attend camp. As such, the primary analyses do not include data collected from either of these two years of camp given that the data from 2017 and 2018 does not represent a true RCT design.

Despite limitations associated with combining datasets using different study procedures, several factors justified the decision to combine 2018 and 2019 datasets for a series of secondary analyses. First, the 2019 sample size did not meet the estimated minimum number of participants required for each condition, based on the a priori power analysis (see Methods). Additionally, comparison of datasets from 2018 and 2019 revealed no significant differences on study variables. Therefore, data collected from camper and control group participants in 2018 were combined with the 2019 data to increase power. Combining these datasets resulted in 34 camper

families and 31 control families (N = 65). Data from 2017 were not combined with other years because there were significant differences between conditions in the 2017 baseline data, there were significant differences between the 2017 and 2019 baseline data, and study procedures in 2017 were more inconsistent with procedures from 2019. Furthermore, including the data from 2018 alone yielded adequate power.

### ***Multiple Imputation***

The first set of analyses run using the pooled 2018-2019 dataset mirrors the primary analyses, using multiple imputation to address missing data, omitting covariates, and retaining participants in their originally assigned conditions (i.e., intent-to-treat). Results from these analyses were similar to those found using only the 2019 participants.

Consistent with the 2019 analyses, the pooled analyses revealed significant differences between conditions on Slope 2, such that campers' GSW improved (Est = 0.06; SE = 0.06;  $g = 0.17$ ) more than the control group GSW (Est. = -0.12; SE = 0.07;  $g = 0.41$ ) between two-month and five-month follow-up (Diff. = 0.18; SE = 0.09;  $p = .037$ ;  $g = 0.48$ ). However, analyses using the pooled dataset did not reveal significant differences between conditions on two-month follow-up GSW scores (Diff. = -1.69; SE = 0.94;  $p = .072$ ;  $g = 0.43$ ). This finding is inconsistent with findings from the 2019 analyses. Regarding the BC and SC subscales, none of the slopes or intercepts demonstrated significant differences between the camper and control groups in the pooled analyses. This is consistent with findings from the 2019 analyses. See Table C4.

In sum, results from the pooled 2018-2019 analyses are fairly consistent with findings from the 2019 dataset. No significant differences emerged between conditions for the BC and SC subscales. Additionally, results from the GSW analyses trend in the same direction as in the primary analyses, such that campers' GSW scores declined at two-month follow-up but

“bounced back” at five-month follow-up, whereas control group GSW scores improved at two-month follow-up but declined by five-month follow-up. This pattern of results does not support the hypothesis that Camp HOPE would enhance children’s self-perception. However, these results from the pooled analyses did not reveal significantly greater declines in GSW between baseline and two-month follow-up among the camper group. They also did not reveal significantly lower GSW scores at two-month follow-up among the camper group. Thus, findings from the pooled analyses do not contradict the hypothesis or reinforce the conclusion that Camp HOPE negatively impacted children’s self-perception.

### **Discussion**

Findings from the series of secondary analyses generally align with findings from the primary analyses, such that the data follow the same pattern across analyses. Specifically, the camper group demonstrates a decline in GSW scores at two-month follow-up that improves at five-month follow-up, whereas the control group demonstrates improved GSW at two-month follow-up that declines at five-month follow-up. In all analyses, the camper group reports lower GSW scores than the control group at two-month follow-up. However, this difference is significant only in certain iterations of the analyses. Similarly, the difference in rate of change in GSW scores between camper and control groups was significant in some variations of the analyses while these slope differences were nonsignificant in other variations of the analyses. Findings at the final evaluation point (i.e., five-month follow-up) consistently yielded nonsignificant differences between camper and control group GSW scores, in line with the primary analyses. Findings from all analyses are inconsistent with the hypothesis that camp would enhance children’s self-perception.

It is important to consider which factors impacted the presence or absence of significant findings. In the current study, significant findings were most likely to emerge in the intent-to-treat or completer analyses, with very few significant differences emerging between groups when using the as-treated grouping system. This finding highlights the potentially unique trends in GSW scores among the five children who were invited to attend camp, but ultimately did not attend. When these children were removed from the analyses altogether, in the completer analyses, significant between-group differences emerged at two-month follow-up, which mirrors results from the intent-to-treat analyses. The fact that the camper group evinced significantly lower GSW scores than the control group, even after removing these five potentially unique participants who did not attend camp, bolsters confidence in the conclusion that Camp HOPE negatively, albeit temporarily, impacted children's GSW.

When comparing analyses employing multiple imputation versus listwise deletion, a greater number of significant between-group differences in GSW emerged when participants with missing outcome data were removed from the analyses. This finding suggests that the potential biases and unnecessary noise that multiple imputation can introduce (e.g., Von Hippel, 2007) may have obscured significant differences between groups. Additionally, including relevant covariates resulted in a greater number of significant between-group differences in GSW. Covariates were not included in the primary analyses because there were no significant differences between camper and control group participants at baseline. However, it appears that controlling for demographic factors reduces noise thereby facilitating a clearer understanding of Camp HOPE's impact on children's GSW.

Table C1.

Results from secondary analyses on the Global Self-Worth subscale, run using the 2019 dataset and intent-to-treat groupings.

	Listwise Deletion, Covariates Excluded			Multiple Imputation, Covariates Included			Listwise Deletion, Covariates Included		
	Control Group (Est., SE)	Camper Group (Est., SE)	Difference (Est., SE, p-value, Hedge's G)	Control Group (Est., SE)	Camper Group (Est., SE)	Difference (Est., SE, p-value, Hedge's G)	Control Group (Est., SE)	Camper Group (Est., SE)	Difference (Est., SE, p-value, Hedge's G)
Baseline Intercept	18.75 (0.94)	20.29 (0.92)	1.54 (1.32); p = .244; g = 0.41	19.33 (0.74)	19.35 (0.72)	0.01 (1.03); p = .989; g = 0.00	18.75 (0.88)	20.29 (0.91)	1.54 (1.27); p = .230; g = 0.43
2-Month F/U Intercept	21.25 (0.63)	18.57 (1.33)	-2.68 (1.47); p = .069; g = 0.68	<b>21.26</b> <b>(0.57)</b>	<b>18.61</b> <b>(0.95)</b>	<b>-2.65</b> <b>(1.11);</b> <b>p = .017;</b> <b>g = 0.69</b>	<b>21.25</b> <b>(0.52)</b>	<b>18.57</b> <b>(1.16)</b>	<b>-2.68</b> <b>(1.27);</b> <b>p = .035;</b> <b>g = 0.78</b>
Within- Groups Effect Size (g)	0.76	0.39	-	.59	0.18	-	0.84	0.43	-
5-Month F/U Intercept	19.19 (1.08)	19.79 (0.91)	0.60 (1.42); p = .684; g = 0.15	19.28 (0.97)	19.79 (0.89)	0.51 (1.34); p = .705; g = 0.11	19.19 (1.08)	19.79 (0.91)	0.60 (1.42); p = .673; g = .15
Within- Groups Effect Size (g)	0.57	0.28	-	0.50	0.26	-	0.59	0.30	-
Slope 1	<b>0.23</b> <b>(0.10)</b>	<b>-0.18</b> <b>(0.12)</b>	<b>-0.42</b> <b>(0.15);</b> <b>p = .006;</b> <b>g = 0.94</b>	0.17 (0.05)	-0.07 (0.10)	-0.23 (0.14); p = .085; g = 0.62	<b>0.23</b> <b>(0.09)</b>	<b>-0.18</b> <b>(0.10)</b>	<b>-0.42</b> <b>(0.14);</b> <b>p = .003;</b> <b>g = 1.09</b>
Slope 2	<b>-0.14</b> <b>(0.08)</b>	<b>0.08</b> <b>(0.08)</b>	<b>0.23</b> <b>(0.11);</b> <b>p = .046;</b> <b>g = 0.69</b>	<b>-0.14</b> <b>(0.07)</b>	<b>0.09</b> <b>(0.07)</b>	<b>0.23</b> <b>(0.10);</b> <b>p = .029;</b> <b>g = 0.67</b>	<b>-0.14</b> <b>(0.08)</b>	<b>0.08</b> <b>(0.07)</b>	<b>0.23</b> <b>(0.10);</b> <b>p = .029;</b> <b>g = 0.73</b>

Note. Bold text indicates significant findings.

Table C2.

Results from as-treated secondary analyses on the Global Self-Worth subscale, run using the 2019 dataset.

	Listwise Deletion, Covariates Excluded			Multiple Imputation, Covariates Included			Listwise Deletion, Covariates Included		
	Control Group (Est., SE)	Camper Group (Est., SE)	Difference (Est., SE, p-value, Hedge's G)	Control Group (Est., SE)	Camper Group (Est., SE)	Difference (Est., SE, p-value, Hedge's G)	Control Group (Est., SE)	Camper Group (Est., SE)	Difference (Est., SE, p-value, Hedge's G)
Baseline Intercept	18.95 (0.93)	20.50 (0.73)	1.55 (1.18); p = .187; g = 0.41	19.33 (0.70)	19.35 (0.74)	0.02 (1.02); p = .985; g = 0.01	18.95 (0.91)	20.50 (0.68)	1.55 (1.14); p = .172; g = 0.42
2-Month F/U Intercept	20.60 (0.86)	18.80 (1.36)	-1.80 (1.61); p = .262; g = 0.44	20.48 (0.69)	18.88 (0.92)	-1.61 (1.16); p = .166; g = 0.42	20.60 (0.77)	18.80 (1.01)	-1.80 (1.27); p = .156; g = 0.52
Within-Groups Effect Size (g)	0.40	0.47	-	0.30	0.13	-	0.43	0.60	-
5-Month F/U Intercept	19.00 (0.99)	20.40 (0.99)	1.40 (1.40); p = .318; g = 0.34	19.10 (0.86)	20.26 (0.91)	1.16 (1.26); p = .356; g = 0.26	19.00 (0.96)	20.40 (0.94)	1.40 (1.35); p = .298; g = 0.35
Within-Groups Effect Size (g)	0.38	0.41	-	0.32	0.36	-	0.40	0.50	-
Slope 1	0.15 (0.09)	-0.19 (0.16)	-0.34 (0.18); p = .061; g = 0.75	0.10 (0.08)	-0.04 (0.14)	-0.14 (0.16); p = .399; g = 0.28	<b>0.15</b> <b>(0.08)</b>	<b>-0.19</b> <b>(0.14)</b>	<b>-0.34</b> <b>(0.16);</b> <b>p = .030;</b> <b>g = 0.85</b>
Slope 2	-0.11 (0.07)	0.12 (0.10)	0.23 (0.12); p = .056; g = 0.71	-0.10 (0.07)	0.11 (0.08)	0.20 (0.11); p = .055; g = 0.57	<b>-0.11</b> <b>(0.07)</b>	<b>0.12</b> <b>(0.08)</b>	<b>0.229</b> <b>(0.11);</b> <b>p = .030;</b> <b>g = 0.76</b>

Note. Bold text indicates significant findings.

Table C3.

Results from completer analyses on the Global Self-Worth subscale, run using the 2019 dataset.

	Multiple Imputation, Covariates Excluded			Listwise Deletion, Covariates Excluded			Multiple Imputation, Covariates Included			Listwise Deletion, Covariates Included		
	Control Group (Est., SE)	Camper Group (Est., SE)	Difference (Est., SE, p-value, Hedge's G)	Control Group (Est., SE)	Camper Group (Est., SE)	Difference (Est., SE, p-value, Hedge's G)	Control Group (Est., SE)	Camper Group (Est., SE)	Difference (Est., SE, p-value, Hedge's G)	Control Group (Est., SE)	Camper Group (Est., SE)	Difference (Est., SE, p-value, Hedge's G)
Baseline Intercept	19.33 (0.79)	19.35 (0.74)	0.02 (1.08); p = .986; g = 0.01	18.75 (0.94)	20.50 (0.73)	1.75 (1.19); p = .141; g = 0.51	19.33 (0.74)	19.35 (0.74)	0.02 (1.04); p = .985; g = 0.01	18.75 (0.87)	20.50 (0.68)	1.75 (1.10); p = .112; g = 0.56
2-Month F/U Intercept	<b>21.18 (0.60)</b>	<b>18.82 (0.98)</b>	<b>-2.36 (1.15); p = .039; g = 0.67</b>	21.25 (0.63)	18.80 (1.36)	-2.45 (1.49); p = .101; g = 0.72	<b>21.18 (0.52)</b>	<b>18.82 (0.85)</b>	<b>-2.36 (1.00); p = .018; g = 0.78</b>	<b>21.25 (0.50)</b>	<b>18.80 (1.01)</b>	<b>-2.45 (1.13); p = .030; g = 0.94</b>
Within-Groups Effect Size (g)	0.53	0.14	-	0.76	0.47	-	0.58	0.16	-	0.86	0.60	-
5-Month F/U Intercept	19.23 (1.04)	20.00 (1.03)	0.78 (1.46); p = .596; g = 0.16	19.19 (1.13)	20.40 (0.99)	1.21 (1.50); p = .419; g = 0.29	19.23 (0.98)	20.00 (1.00)	0.776 (1.40); p = .579; g = 0.17	19.19 (1.08)	20.40 (0.94)	1.21 (1.43); p = .398; g = 0.30
Within-Groups Effect Size (g)	0.46	0.28	-	0.55	0.41	-	0.50	0.30	-	0.60	0.50	-
Slope 1	0.16 (0.09)	-0.04 (0.13)	-0.20 (0.16); p = .201; g = 0.41	<b>0.23 (0.10)</b>	<b>-0.19 (0.16)</b>	<b>-0.42 (0.19); p = .024; g = 0.92</b>	0.16 (0.09)	-0.04 (0.12)	-0.20 (0.15); p = .184; g = 0.42	<b>0.23 (0.10)</b>	<b>-0.19 (0.14)</b>	<b>-0.42 (0.16); p = .010; g = 0.98</b>
Slope 2	-0.13 (0.08)	0.09 (0.09)	0.23 (0.12); p = .058; g = 0.56	<b>-0.14 (0.08)</b>	<b>0.12 (0.10)</b>	<b>0.26 (0.13); p = .042; g = 0.79</b>	<b>-0.13 (0.07)</b>	<b>0.09 (0.08)</b>	<b>0.23 (0.11); p = .041; g = 0.64</b>	<b>-0.14 (0.08)</b>	<b>0.12 (0.08)</b>	<b>0.26 (0.11); p = .020; g = 0.85</b>

Note. Bold text indicates significant findings.



Table C4.

Results from secondary analyses on the Global Self-Worth subscale, run using the pooled 2018-2019 dataset, excluding covariates, and grouping participants based on initial condition assignment (i.e., intent-to-treat).

<b>Multiple Imputation for Missing Outcome Data</b>			
	<i>Control Group</i> (Est., SE)	<i>Camper Group</i> (Est., SE)	<i>Difference (Est., SE,</i> <i>p-value, Hedge's G)</i>
Baseline Intercept	19.25 (0.72)	19.91 (0.69)	0.67 (1.00); p = .504; g = 0.16
2-Month F/U Intercept	21.16 (0.55)	19.47 (0.78)	-1.69 (0.94); p = .072; g = 0.43
<i>Within-Groups Effect Size (g)</i>	0.53	0.10	-
5-Month F/U Intercept	19.47 (0.87)	20.28 (0.83)	0.81 (1.20); p = .500; g = 0.17
<i>Within-Groups Effect Size (g)</i>	0.41	0.17	-
Slope 1	0.17 (0.09)	-0.05 (0.08)	-0.22 (0.12); p = .065; g = 0.45
Slope 2	<b>-0.12</b> <b>(0.07)</b>	<b>0.06</b> <b>(0.06)</b>	<b>0.18 (0.09);</b> <b>p = .037;</b> <b>g = 0.48</b>

Note. Bold text indicates significant findings.