

“You Can Try or You Can Just Give Up”: The Impact of Perceived Control and Coping Style on Childhood Homesickness

Christopher A. Thurber and John R. Weisz
University of California, Los Angeles

Research on children's coping with homesickness during relatively uncontrollable separations has suggested that secondary control coping (i.e., adjusting oneself to fit objective conditions) is often preferred over primary control coping (i.e., modifying objective conditions to fit oneself). Related research suggests that negative affect is associated with (a) relinquishing control or using primary control to cope with uncontrollable stressors and (b) perceiving low control over stressors. The convergence of these factors was examined for the stressor of homesickness. Among 1,032 boys and girls spending 2 weeks at residential summer camps, the most frequent and effective way of coping with homesickness was to exert secondary control by engaging in a distracting physical activity. Contrary to speculation, the use of secondary control coping rose in adolescence. Congruent with empirical predictions, the most homesick children perceived low control over homesickness and separation, and coped by relinquishing control.

How young people cope with homesickness deserves careful study for at least two reasons. First, homesickness is experienced by millions of children who spend time away from home and primary caregivers (see McCann, 1941, for an early review). Self-reported homesickness incidence rates during a stay away from home vary between 71% and 96% (Fisher, 1989; Thurber, 1995, 1996b), with about 7% of children experiencing high levels of homesickness associated with severe depressive and anxious symptoms (Thurber, 1996b). Homesickness has been documented in children at boarding schools (e.g., Fisher, Elder, & Peacock, 1990), residential summer camps (Thurber, 1995), and hospitals (e.g., Mitchell, 1967), as well as in refugee children living with host families (Eisenbruch, 1990). In these environments, severe homesickness (cognitions focused on reuniting with caregivers, depressed and anxious affect, and behavior problems) is deleterious. There is evidence that homesick children present with nontraumatic physical ailments significantly more than their nonhomesick peers (Fisher, Frazer, &

Murray, 1986). Homesick boys and girls complain about somatic problems and exhibit more internalizing and externalizing behavior problems than their nonhomesick peers (Thurber, 1995, 1996b). One study found that homesick first-year college students were three times more likely to drop out of school than their nonhomesick peers (Burt, 1993). Other data have pointed to concentration and academic problems in homesick students (Fisher & Hood, 1987; Fisher, Murray, & Frazer, 1985). Several studies have not sought to measure homesickness per se but are nevertheless suggestive. For example, maladjustment to separation has been documented in psychiatric hospitals (e.g., Kim, Hahn, Kish, Rosenberg, & Harris, 1991) and pediatric extended care units (e.g., Saylor et al., 1987) and is generally associated with slower recovery.

Second, understanding how children cope with homesickness will be helpful in guiding interventions by complementing the broad etiologic theories that have been developed for depression and anxiety, both of which are common in homesick children. Among the most relevant theories that may shape interventions are those concerned with learned helplessness (Abramson, Seligman, & Teasdale, 1978) and control beliefs (Heckhausen & Schulz, 1995; Weisz, 1990).

Learned helplessness theory predicts that children who develop a belief that they cannot influence or adjust to their circumstance of separation from home will become depressed and make fewer attempts to change that circumstance. Control beliefs theory predicts that negative affect is most likely in children who perceive personal incompetence in the separation environment (e.g., poor social skills at a summer camp) and who perceive contingency uncertainty (e.g., uncertainty about whether friendly behavior will garner friends; Weisz, Sweeney, Proffitt, & Carr, 1993). Note that both theories hinge on control, the perception of which “reflects the fundamental human need for competence” (Skinner, 1995, p. 8; see also White, 1959). This is particularly relevant to coping, because children's choice of how to respond to a stressor hinges partly on their perception of the stressor's controllability.

Christopher A. Thurber and John R. Weisz, Department of Psychology, University of California, Los Angeles.

This research was supported in part by grants from Sigma Xi, the Scientific Research Society, the Colin Brown Fund, a University of California, Los Angeles, Departmental Research Award, and National Research Service Award MH10920-01 from the National Institutes of Health.

We thank Marian D. Sigman for her enthusiasm and insightful comments about the design and documentation of this research; Allison Wohlfiel for her assistance in coding interviews and questionnaires; Caryn and Gene Clark, Tom Giggi, Judy Snell, Audrey Vorperian, and the parents of all the campers for their enormous support of this research; the cabin leaders and camp staffs for their affable diligence; and the campers themselves for their inspiration, time, and honesty.

Correspondence concerning this article should be addressed to Christopher A. Thurber, Department of Psychology, University of California, 405 Hilgard Avenue, Los Angeles, California 90095-1563. Electronic mail may be sent via Internet to cthurber@u.washington.edu.

Control is also relevant to a study of children's coping with homesickness because the discomfort of separation and the demands of a novel environment can leave some children perceiving a reduced sense of control (Cooper, 1990). In turn, children's low perceived control may result in negative affect (Weisz, Weiss, Wasserman, & Rintoul, 1987; Weisz et al., 1989) and vice versa (Skinner, 1995). Not surprisingly, low perceived control has been associated with maladjustment to transitions (see Fisher & Cooper, 1990, for reviews). For these reasons, control beliefs theory (Weisz, 1990) and, in particular, the two-process model of control (Rothbaum, Weisz, & Snyder, 1982), offer a useful framework for studying the complexities of children's coping with homesickness.

The two-process model of control distinguishes between *primary control*—modifying objective conditions to fit oneself—and *secondary control*—adjusting oneself to fit objective conditions. *Relinquished control* coping—giving up or simply emoting—is not a process of exerting control but is a third way to categorize coping. In operationalizing these concepts, it is helpful to distinguish between coping methods and coping goals (Weisz, McCabe, & Dennig, 1994). Simply stated, *methods* are ways of acting or thinking; *goals* are the ends toward which coping methods are directed. On a macroscopic level, methods are codable as either observable or unobservable behavior (cf. Compas, 1987). On a microscopic level, diverse methods can be assigned various content codes (Band & Weisz, 1988). However, the concepts of primary and secondary control apply only to coping goals because only goals have an object of control: either one's self (secondary control) or the objective conditions (primary control). (See Heckhausen & Schulz, 1995, for further analysis of this point.)

Different sorts of control coping have different outcomes. Typically, relinquished control coping goals are associated with poor adjustment in children (Weisz et al., 1994). A few studies of children's coping have suggested that using secondary control or emotion-focused coping is the most adaptive choice when stressors are largely uncontrollable (Compas, Malcarne, & Fondacaro, 1988; Radovanovic, 1993; Weisz et al., 1994). Related studies of Type A behavior in children have suggested that efforts to control uncontrollable tasks can have deleterious cardiovascular consequences (Matthews, 1979). Indeed, it is tempting to conclude that optimal outcome is always achieved by using primary control coping for controllable stressors and secondary control coping for uncontrollable stressors. Theory and common sense suggest that attempts to change an unchangeable circumstance are the definition of futility and often lead to helplessness and depression.

In reality, however, this neat correspondence between coping control and stressor control is complicated by several factors. First, even circumscribed stressors have controllable and uncontrollable elements; thus "mixed" primary-secondary coping, applied simultaneously and customized to fit the variegated elements of a single stressor, may be most adaptive (Weisz et al., 1994). A related form of adaptive customization may be sequentially "layered" coping, where one sort of coping is replaced by another sort if the first proves ineffective. Interestingly, research on children's everyday problem solving has argued that similar forms of adaptation are key components of intelligence (Berg & Calderone, 1994; Sansone & Berg, 1993) but appear

unrelated to academic achievement per se (Berg, 1989). A second complicating factor is the context in which the stressor occurs. There may be institutional constraints on primary control, as with summer camps. There may also be cultural preferences for primary versus secondary control (Seginer, Trommsdorff, & Essau, 1993; Weisz, Rothbaum, & Blackburn, 1984). Third, age, health, and cognitive sophistication may play key roles in explaining children's inclination to use primary versus secondary coping.

Because secondary control coping requires metacognitive sophistication (Harris, 1989; Weisz, 1983), children probably cope in this way with increasing frequency and selectivity as they grow older. A review by Compas, Banez, Malcarne, and Worsham (1991) summarized evidence that primary control coping emerges around ages 4–5 and increases until children are about 8 to 10 years old. By contrast, secondary control coping may emerge between ages 6–8 and increase through early adolescence (Band & Weisz, 1988; Compas et al., 1988; Curry & Russ, 1985; Harris & Guz, 1986). There is some evidence that this increase is specific to objectively uncontrollable stressors (Band & Weisz, 1990; Thurber, in press-a). The bulk of evidence suggests that the frequency of use of secondary control coping "might reach a temporary developmental plateau in adolescence" (Heckhausen & Schulz, 1995, p. 292).

In sum, these findings suggest that efficacious coping is mixed, layered, culturally acceptable, cognitively appropriate, and selectively applied. There are developmental trends in the ways children cope, but there may not be a simple relationship between the perceived controllability of a given stressor and type of control coping used. More likely, children's coping is based on an interaction among cognitive sophistication, perceived control, and level of emotional distress (Compas et al., 1991; Folkman, 1984), as well as any biological and environmental constraints on thoughts and behaviors (Heckhausen & Schulz, 1995).

The present study had five specific aims: (a) to describe how boys and girls cope with homesickness, (b) to explore the development of coping trends across age groups, (c) to measure children's perceptions of control during separation as well as the correlation between low perceived control and adjustment (i.e., levels of satisfaction and homesickness), (d) to examine the relationship between coping goals and adjustment, and (e) to examine the relationship, in an objectively uncontrollable separation circumstance, between perceived control of homesickness, coping goals, and adjustment. Specifically, if low perceived control leads to homesickness (c) and certain coping goals are associated with homesickness (d), can we find evidence of an interaction? Are children who perceive low control and whose coping is primary or relinquished control the most homesick?

Method

Participants

Participants were campers at two single-sex residential sports camps. Parent and child consent were obtained by mail several months prior to the start of camp. Of the 441 boys registered for the 1994 summer, 322 (73%) participated in this questionnaire study of coping; of the 940 girls registered for the 1994 summer, 727 (77%) participated. Because of

illness or incomplete questionnaires, 8 boys and 10 girls were ultimately eliminated from the sample. Thus, the final sample size was 315 boys and 717 girls. Ethnic minorities constituted 8% of the boys' sample and 9% of the girls' sample. An additional 3% of the boys' sample and 4% of the girls' sample were Caucasian children of international residence. All participants spoke English fluently.

Living quarters at the boys' camp were divided into five equal-sized age divisions, each in its own location in the 177-acre lakeside forest. Divisions were comprised of 6 cabins, each with room for 8 or 9 children and one or two cabin leaders. The girls' camp had three equal-sized age divisions, each in its own location, in a rural setting similar to the boys' camp but on a different lake. Each of the girls' divisions was comprised of 8 to 10 cabins, each with room for 6 to 12 girls and two cabin leaders. Boys and girls attended their respective camps either for 2 weeks (Session A or Session B) or for 4 weeks (Session C). Session C children all spent 8 hr away from camp with their caregivers on the 15th day, the change day between Session A and Session B. Otherwise, letters were the only contact with home. Campers were not allowed to return home except for severe medical, conduct, or emotional problems, all of which were rare.

The average age of participants was 12.6 years ($SD = 1.7$; range = 8–16); linear distance from home averaged 145 miles ($SD = 258$; range = 1–2,588); number of summers spent at any camp averaged 3.2 ($SD = 2.1$; range = 1–10); and number of summers spent at these particular camps averaged 2.7 ($SD = 1.6$; range = 1–8). There were no significant differences in the demographics of participants and nonparticipants, including on a unidimensional measure of socioeconomic status based on parents' occupations (Hollingshead, 1975). According to these indicators, the participants were representative of the children attending these camps.

Materials

Assessing coping. An original questionnaire, called the Ways of Coping with Homesickness (WOCH) was designed for this study. The format of the Woch was based on a screening questionnaire called KIDCOPE. Developed by Spirito, Stark, and Williams (1988), the 10-item KIDCOPE has gained popularity in pediatric settings because it is brief, yet it assesses the frequency and effectiveness of some typical coping styles: (a) distraction, (b) social withdrawal, (c) cognitive restructuring, (d) self-criticism, (e) blaming others, (f) problem solving, (g) emotional expression, (h) wishful thinking, (i) social support, and (j) resignation. Still, what the KIDCOPE gains in brevity, it loses in detail. Because of this, Spirito et al. have suggested using interview data to supplement KIDCOPE. Thus, the content of the Woch was based partly on the KIDCOPE and partly on an interview study on coping with homesickness (Thurber, in press-a). These results suggested that the most frequent ways children coped with homesickness were (a) engaging in physical activity to forget about homesickness, (b) renewing contact with home (e.g., through letter writing) to feel closer to home, (c) adjusting thoughts to perceive camp as short and pleasurable; (d) thinking about other things to forget about homesickness; (e) engaging in an activity that reminded one of home to focus on pleasant thoughts, and (f) changing feelings to be happy and have fun.

The 15-item Woch used an edited version of 8 of the 10 KIDCOPE items. The two KIDCOPE items on self-blame and blaming others were not included in the Woch because they were never mentioned in previous research on homesickness, and because they were judged to be more applicable to medical stressors than to homesickness. Of the remaining 7 items on the Woch, 6 were culled from the most popular interview responses in Thurber (in press-a). The last item was open-ended and asked children what other ways of coping they used to cope with homesickness. The Woch instructions asked boys and girls to think about all the things that they had thought or done to cope with homesickness

since arriving at camp. As on the KIDCOPE, children rated each of the 15 Woch items on two dimensions: frequency and effectiveness. For these two questions, "How often did you do this?" and "How much did it help?," children were asked to circle *not at all*, *some*, or *a lot*. Note that most items describe an integrated coping method and coping goal. Woch items are summarized in Table 1.

Classification of items into those with primary control goals, secondary control goals, and no goals (i.e., relinquished control) was directly based on the classification of interview data in Thurber (in press-a), for which the interrater reliability was nearly perfect ($\kappa = .94$, $z = 50.6$, $p < .01$). At first glance, some of Woch items may seem to have both primary and secondary control goals, but bear in mind that all coping has emotional regulation as an ultimate goal. Thus, classification must be based on the immediate goals of the coping method in question. For example, Item 9 in Table 1, "I went to see someone who could talk with me and help me feel better, like a leader or one of my friends," is classified as primary control coping because the immediate goal is largely to change the objective circumstance of solitary separation by seeking to establish closeness with another person. Therefore, Item 9 is an example of primary control—specifically, primary social support. By contrast, Item 5, "I thought about the people who care about me, and what they might say to make me feel less homesick," is classified as secondary control coping because the goal is to change oneself to fit the objective condition of separation. In contrast to Item 9, the child who copes in this way is not going out into the environment and actively attempting to draw people near, thereby reducing the objective condition of separation to feel better. Rather, this child who imagines loved ones' advice is using an entirely cognitive form of coping. Thus, Item 5 is an example of secondary control—specifically, secondary social support (see Thurber & Weisz, 1993, or Band & Weisz, 1988, for further discussions of this distinction).

The Woch was administered to the boys on the last day of their 14-day stay at camp. At the girls' camp, the Woch was administered at different times during the 2nd week of their stays. Scheduling constraints, such as out-of-camp trips, which the boys did not take, prevented uniform administration. Thus, Session A girls completed the Woch on the 12th day of their stay; Session B girls on the 9th day, and Session C girls on the 7th day. (Subsequent multivariate comparisons of self-reported homesickness, ratings of overall stay quality, as well as coping frequency and efficacy revealed no differences among the three groups of girls, once the effects of age and years of experience at this camp were covaried out.)

To measure test-retest reliability, girls and boys who remained at camp for a second 14-day session completed the Woch a second time: girls on the 9th day and boys on the 14th day of this second session. Evolution of coping methods and goals over time was expected, as children gained experience with separation in their new environment. Nevertheless, for the 117 children (66 boys and 51 girls) who completed it a second time, the Woch proved to have reasonable 11- to 14-day test-retest reliability. Frequency endorsements on the 14 closed-ended Woch coping items had an average test-retest correlation of .47; effectiveness endorsements had an average test-retest correlation of .50.

Five questions—three about control and two about affect—were added to the back side of the 1-page Woch questionnaire. These are discussed in the next two sections.

Assessing control. The Woch included three questions on perceived control. The three questions indexed general perceived control, control over homesickness, and retrospective decision control. They were: "In general, how much control do you have over how things go for you?," "How much control do you have over how homesick you get at camp?," and "In general, how much control did you have over coming to camp this summer?" Each question was rated on an 11-point Likert scale with anchors of 0 (*no control at all*), 5 (*some control*), and 10 (*a whole lot of control*). Related research (e.g., Thurber, 1996,

Table 1
Key to Items on the Way of Coping With Homesickness Questionnaire

Item	Classification
1. I tried to feel better by thinking about the good side of things, like about all the fun things to do at camp.	• Unobservable method • Secondary goal
2. I just changed how I felt, and tried to be happy and have fun.	• Unobservable method • Secondary goal
3. I reminded myself that my stay at camp was not that long after all and that I would be home pretty soon.	• Unobservable method • Secondary goal
4. I tried to forget about being homesick by just <i>not</i> thinking about my home, my parents, and other things I missed.	• Unobservable method • Secondary goal
5. I thought about the people who care about me, and what they might say to make me feel less homesick.	• Unobservable method • Secondary goal
6. I wished that things were different, like that I had never felt homesick at all, or that things here were more like at home.	• Unobservable method • Secondary goal
7. I did something fun to forget about being homesick, like go to an activity, play a game, or read a book—not just sit around.	• Observable method • Secondary goal
8. I did something to feel closer at home, like hang out with kids from home, write a letter to my parents, or look at a picture of my family or my pets.	• Observable method • Secondary goal
9. I went to see someone who could talk with me and help me feel better, like a leader or one of my friends.	• Observable method • Primary goal
10. I did something to try to get back home, like run away, or write to my parents and tell them to come get me.	• Observable method • Primary goal
11. I did something angry or mean to try to get sent home, like get in a fight, or destroy some camp property on purpose.	• Observable method • Primary goal
12. I spent time by myself.	• Observable method • No explicit goal
13. I just let my feelings out, maybe by crying or yelling.	• Observable method • No explicit goal
14. I didn't do anything. Nothing would have helped.	• No explicit method • No explicit goal

Note. Item numbers above correspond to those in Figure 1.

in press-b) demonstrated that these questions have high 2-week test-retest reliability, as well as construct and concurrent validity with lengthy published measures of perceived control, such as the Perceived Control Scale (PCS; Weisz, Proffitt, & Sweeney, 1991).

Assessing adjustment. The WOCH included two questions about adjustment. The positive-affect item was, "On a scale from zero to ten, where zero is the worst and ten is the best, my time at camp was:", with anchors of 0 = *terrible*, 5 = *so-so*, and 10 = *excellent*. The negative-affect item was, "During my stay, this is how homesick I was:", with anchors of 0 = *not at all homesick*, 5 = *sort of homesick*, and 10 = *very homesick*. Related research (Thurber, 1995, 1996, in press-b) demonstrated that these questions have high 2-week test-retest reliability, as well as construct and concurrent validity with lengthy measures of homesickness and negative affect, such as the Rate Your Day—Revised (Thurber, 1996), the Children's Depression Inventory (Kovacs, 1980), and the revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1978).

Procedure

During their staff training weeks, the 30 male cabin leaders at the boys' camp and the 48 female cabin leaders at the girls' camp voluntarily

participated in training on the measure and procedure. The 78 leaders were quite experienced, ranging in age from 16 to 25 years ($M = 19$ years), and having worked with children for between 2 and 10 summers at their respective camps ($M = 4.2$ summers). The cabin leaders were told that the purpose of the study was to understand children's adjustment to summer camp. They were naive to specific hypotheses.

Incoming campers were given an explanation of the procedures of the study during their orientation to camp on the evening of the day they arrived. One of us (Christopher A. Thurber) explained that, on certain evenings, campers would fill out a questionnaire in the privacy of their own bunk. At the time of questionnaire distribution, nonparticipants would receive blank paper and a pencil, with which they could do whatever they wanted during the 5 to 10 min when participants were answering questionnaires. Therefore, if they wished, nonparticipants could remain indistinguishable from participants. Completed questionnaires would be immediately collected by Christopher A. Thurber at the boys' camp and by a senior staff member at the girls' camp. It was explained that no answers would ever be shared with camp staff or parents unless there was a reason to be concerned about a child's safety. Finally, children were informed that they could stop participating at any time. To ensure understanding and completion of questionnaires, cabin leaders read questionnaires aloud in the youngest divisions. Children

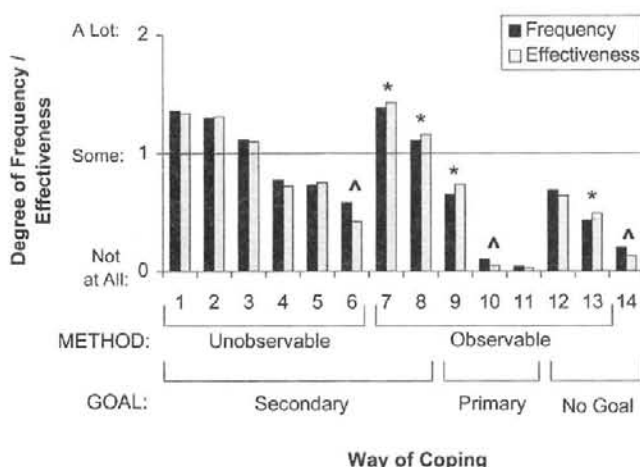


Figure 1. Mean frequency and effectiveness ratings for the 14 closed-ended items on the Ways of Coping with Homesickness Questionnaire. Items for which the effectiveness was statistically greater than the frequency are marked with an asterisk. Items for which the frequency was statistically greater than the effectiveness are marked with a caret. See text and Table 1 for further explanation.

read along and circled their responses. Monitoring of random cabins suggested that all procedures were carefully followed.

Results

The Results section is divided into five parts, corresponding to the five aims of the study.

How Boys and Girls Cope With Homesickness

Children's coping was mixed (involving both primary and secondary goals) and layered (involving more than one method). The modal child gave a *some* or *a lot* rating to 7 of the 14 closed-ended WOCH items. A mere 5 out of the 1,032 children sampled (0.5%) did not report using a combination of coping methods that had both primary control and secondary control goals. The mean frequency and effectiveness of the various ways that the entire sample ($N = 1,032$) reported coping with homesickness are depicted in Figure 1. Five of the 14 items had mean frequency and mean effectiveness ratings greater than the midpoint (*some*) on the 3-point scales. These items closely resembled the most frequent and effective method-goal combinations uncovered by interviews in Thurber (in press-a). The 5 WOCH items with the highest frequency endorsements by the entire sample were, in descending order: (a) doing something fun to forget about being homesick, (b) thinking positively to feel better, (c) simply changing feelings to be happy, (d) reframing time, and (e) renewing a connection with home (e.g., writing to parents) to feel closer to home.

Effects of gender and level of homesickness on the frequency of coping were analyzed with a 2×2 (Gender \times Level of Homesickness) multivariate analysis of covariance (MANCOVA), with the frequency of the 14 closed-ended WOCH items as dependent variables. Experience, as measured by the number of summers children had attended their camps, was not a sig-

nificant correlate of coping frequency. Therefore, only age was covaried in this analysis. Children who reported feeling less than *some* homesickness (< 5 on the WOCH homesickness question) were classified as having a *low* level of homesickness ($n = 778$). Those children who reported anything between *some* and *a lot* of homesickness (between 5 and 10 on the scale) were classified as having a *high* level of homesickness ($n = 254$). This amounted to comparing the most homesick quarter of the sample to the remaining three quarters combined. Multivariate results indicated there was a main effect level of homesickness, $F(14, 1014) = 10.7, p < .0001, \omega^2 = .13$, whereby the more homesick children reported coping more frequently than the less homesick children. With age again covaried, the partial correlation between homesickness intensity and mean coping frequency was .30 for boys and .33 for girls, $p < .0001$. MANCOVA showed a corresponding main effect of gender, $F(14, 1014) = 7.6, p < .0001, \omega^2 = .10$, whereby girls reported coping more frequently than boys. The multivariate interaction between homesickness and gender on coping frequency was insignificant.

For the entire sample of 1,032 children, mean intensity of self-reported homesickness decreased from age 8 to age 12 and then remained constant. For the 8.0–10.9-year-olds ($n = 190$), mean homesickness was 3.8 ($SD = 3.3$). For the 11.0–11.9-year-olds ($n = 154$), mean homesickness was 3.0 ($SD = 2.9$). For the 12.0–12.9-year-olds ($n = 230$), mean homesickness was 2.1 ($SD = 2.6$). For the 13.0–13.9-year-olds ($n = 218$), mean homesickness was 2.1 ($SD = 2.3$). Finally, for the 14.0–16.9-year-olds ($n = 240$), mean homesickness was 2.1 ($SD = 2.4$).

Developmental Trends in Coping

Gender effects across age groups. To test further for gender differences in coping frequency, a second MANCOVA was performed, with age and homesickness intensity as covariates. As before, girls reported, on average, more frequent coping than boys, $F(14, 1015) = 8.4, p < .0001, \omega^2 = .10$. Univariate tests indicated that the largest effects of gender on coping frequency were for the primary control social support item (Item 9 in Table 1) and the aggression item (Item 11) on the WOCH. Congruent with previous research, girls reported seeking social support more often than boys, $F(1, 1028) = 28.6, p < .0001, \omega^2 = .03$, and boys reported acting out as a ploy to get sent home more often than the girls, $F(1, 1028) = 28.9, p < .0001, \omega^2 = .03$. The frequency of these two ways of coping across five age groups is shown in Figure 2.

Age effects by level of homesickness. Because homesickness and coping frequency were correlated, coping frequency across age groups was analyzed separately for children in the high- and low-homesickness groups. For the low-homesickness group, only primary control coping frequency followed a simple linear trend, decreasing slightly from age 8 through age 16, $r = -.11, p < .01$. MANOVA with tests for polynomial contrasts showed that secondary control coping frequency followed a quadratic trend, decreasing from age 8 through age 13, and then increasing for children ages 14–16, $t(776) = 2.89, p < .01$. Relinquished control coping also followed a quadratic trend, decreasing from

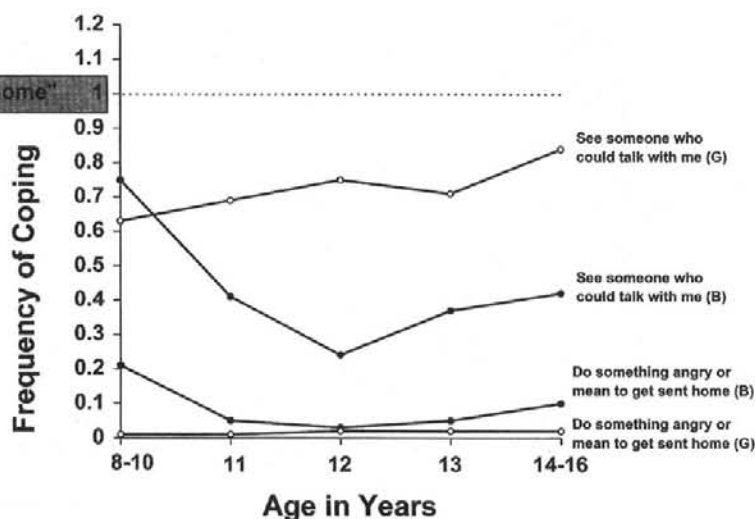


Figure 2. Developmental trends for boys (B) and girls (G) in the frequency of social support coping and aggressive coping.

age 8 through age 12, and then increasing for children ages 13–16, $t(776) = 3.51, p < .001$.

For the high-homesickness group, both primary and secondary control coping frequency followed simple linear trends, decreasing slightly from age 8 through age 16, $r = -.14, p < .05$, and $r = -.15, p < .05$, respectively. Relinquished control coping was fairly constant across age groups.

Homesickness effects. As reported above, the high-homesickness group coped more frequently overall than the low-homesickness group. There were no WOCH items for which the low-homesickness group reported more frequent coping than the high-homesickness group. To uncover the largest item contributions to this group difference, we used univariate analyses of covariance, controlled for age, to compare the high- and low-homesickness groups on their frequency endorsements for each of the 14 closed-ended WOCH items. Results suggested that, compared with the low-homesickness group, the children in the high-homesickness group coped significantly more frequently with every WOCH item except Items 1 (thinking about the good side of things), 2 (just trying to be happy), and 7 (doing an activity to forget about homesickness). Thus, regardless of their level of homesickness, all children cope with homesickness by looking on the bright side, maintaining a positive attitude, and keeping busy—all forms of secondary control.

The largest univariate effects of homesickness level on coping frequency were for Items 6 (wishful thinking) and 13 (simple emoting). Thus, the most homesick children reported wishing that things were different and letting their feelings out substantially more often than the less homesick children. For Item 6, $F(1, 1029) = 95.2, p < .0001, \omega^2 = .08$; for Item 13, $F(1, 1029) = 89.2, p < .0001, \omega^2 = .08$.

Perceived Control and Adjustment

Children's perception of control over homesickness ranged from 0 to 10, $M = 7.7 (SD = 2.5)$; for boys, $M = 7.7 (SD =$

2.9) and for girls, $M = 7.6 (SD = 2.3)$. There was no statistically significant difference between boys' and girls' perceptions of control over homesickness. A Wilcoxon rank sum test confirmed that girls self-reported a slightly higher level of homesickness on the day the WOCH was administered than boys; for girls, $M = 2.7 (SD = 2.6)$ and for boys, $M = 2.2 (SD = 3.2)$, with $W = 137,613 (p < .0001)$.

As expected, perceived control was correlated with self-reported affect. Table 2 summarizes the correlations among the five benchmark items on the WOCH that assessed perceived control and affect. Correlations for boys and girls are presented separately. The three indexes of control (over homesickness, over separation from home, and in general) were positively correlated with overall quality ratings of boys' and girls' stays at camp and negatively correlated with self-reported homesickness. Perceived control over homesickness had a particularly strong inverse relationship with homesickness intensity for both boys and girls. The magnitude of the correlation between perceived control over separation and homesickness was small for the girls.

Coping Goals and Adjustment

To analyze differences in adjustment among children who coped with homesickness in different ways, we classified the participants into one of four coping profiles, on the basis of their mean frequency endorsements on the WOCH. Participants whose mean frequency endorsement for primary control items was greater than their mean endorsements for secondary or relinquished control were classified as *primary dominant*. Participants whose mean frequency endorsement for secondary control items was greater than their mean endorsements for primary or relinquished control were classified as *secondary dominant*. Participants whose mean frequency endorsement for noncontrolling items (relinquished control, emoting, and social withdrawal) was greater than their mean endorsements for primary

Table 2
Intercorrelations Between Benchmarks of Perceived Control, Homesickness, and Positive Affect for Boys (B) and Girls (G)

Measure	1B/1G	2B/2G	3B/3G	4B/4G	5B/5G
1. Overall quality of stay at camp	—	-.46/-.39	.41/.31	.36/.31	.22/.32
2. Overall self-report of homesickness		—	-.35/-.23	-.49/-.40	-.13*/-.21
3. General sense of perceived control			—	.21/.41	.14*/.25
4. Perceived control over homesickness				—	.15**/.21
5. Perceived control over separation					—

* $p < .05$. ** $p < .01$. All other correlations are significant at $p < .0001$.

or secondary control were classified as *relinquished dominant*. Participants who did not have a dominant mean frequency endorsement for primary, secondary, or relinquished control WOCH items were classified as *nondominant*.

A series of one-way analyses of variance was used to test differences in adjustment among the four coping profiles. Results are summarized in Table 3. For the boys and girls, there were differences among the profile types in the WOCH benchmark indexes of positive and negative affect. As expected, the relinquished dominant profile rated their overall stays lower and their homesickness more intense than other profile types. Sheffé post hoc multiple range tests were used to tests for differences of $p < .05$ among the four profiles. These results are also presented in Table 3.

Interaction Among Perceived Control, Coping, and Adjustment

To explore the possibility that the most homesick children were those who perceived low control and who used primary control coping or relinquished control, the sample was first divided into three roughly equal groups, on the basis of their self-reported perceived control over homesickness. These three groups, and their corresponding levels of perceived control over homesickness on a scale from 0 to 10, were low control ($n = 284$; $M = 4.17$, $SD = 1.8$), moderate control ($n = 411$; $M = 8.2$, $SD = 1.8$); and high control ($n = 337$; $M = 10.0$, $SD = 0.0$). Next, within each level of control, participants were classified into one of the four coping goal profiles described earlier.

The continuous dependent variables of homesickness severity and overall stay rating were analyzed with a 3×4 (Level of Perceived Control Over Homesickness \times Dominant Goal Type) multivariate analysis of variance. For the entire sample, there was a significant multivariate main effect of perceived control,

$F(4, 2040) = 24.4$, $p < .0001$, $\omega^2 = .05$. Univariate tests showed this effect was significant for both rating of stay, $F(2, 1020) = 28.1$, $p < .0001$, $\omega^2 = .05$, and severity of homesickness, $F(2, 1020) = 37.8$, $p < .0001$, $\omega^2 = .07$.

There was also a significant multivariate main effect of coping profile, $F(6, 2040) = 5.2$, $p < .0001$, $\omega^2 = .02$. Univariate tests showed this effect was significant for rating of stay, $F(3, 1020) = 10.3$, $p < .0001$, $\omega^2 = .03$, but not for severity of homesickness.

Finally, there was a significant multivariate interaction between perceived control and coping profile, $F(12, 2040)$, $p < .0001$, $\omega^2 = .02$. Univariate tests showed that this interaction was significant for both rating of stay, $F(6, 1020) = 4.0$, $p < .001$, $\omega^2 = .02$, and severity of homesickness, $F(6, 1020) = 3.9$, $p < .0001$, $\omega^2 = .02$.

Figure 3 illustrates the interaction of control and coping goal profile for the dependent variable of homesickness. The numbers of children in the high and low control groups who fell into each of the four coping profiles are indicated in parentheses in this figure. These numbers illustrate that the modal child adaptively chose secondary control when he or she perceived low control over the stressor of homesickness. The most homesick children were those in the low control group whose coping profiles were relinquished control or nondominant.

Other Kinds of Coping

Some 25% of the sample mentioned some other way of coping. In most cases, answers to the open-ended coping question on the WOCH were alternately worded versions of the 14 closed-ended WOCH items. Among those children who mentioned alternate ways of coping, relaxing, sleeping, and forgetting about home were unique to boys; handling a transitional

Table 3
Differences in Adjustment Among Four Coping Goal Profiles

Measure	PriDom	SecDom	RelDom	NonDom	p	Sheffé
Overall rating of stay	8.4	8.6	7.5	8.3	.00001	3 < 1, 2, 4
Overall homesickness	2.7	2.5	3.6	2.0	.0025	3 > 2, 4

Note. $N = 1,032$. PriDom = primary dominant coping goal profile ($n = 46$); SecDom = secondary dominant coping goal profile ($n = 856$); RelDom = relinquished control goal profile ($n = 85$); NonDom = nondominant coping goal profile ($n = 45$).

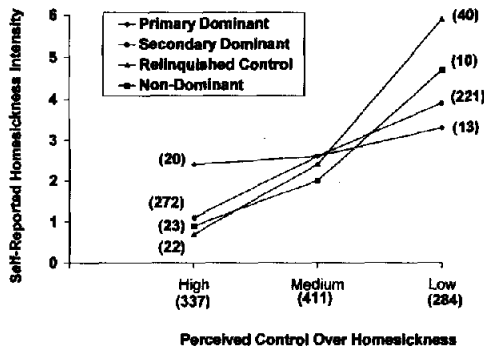


Figure 3. The interaction between perceived control over homesickness and dominant coping goal on self-reported homesickness intensity: boys and girls ($N = 1,032$). Numbers in parentheses are group sizes.

object, thinking alone, and looking at a family photo were unique to girls.

Discussion

The aims of this study were (a) to describe how boys and girls cope with homesickness, (b) to explore the development of coping across age groups, (c) to measure perceived control and its relation to adjustment, (d) to examine the relationship between coping goals and adjustment, and (e) to test the interaction between perceived control and dominant coping style on homesickness. Each aim is discussed in turn.

Descriptively, the results were consistent with previous research. Nearly every child's coping was mixed. Children combined primary and secondary control to cope with homesickness, even though their circumstance of separation was relatively uncontrollable. For example, two of the most common coping goals that boys and girls reported were increasing actual social support (primary control) and decreasing thoughts of home (secondary control). Overall, the most common way that boys and girls coped with homesickness was to do something fun to forget about their homesickness. In general, girls reported coping more frequently than boys. Consistent with previous research, the largest gender effect on coping frequency was for social support, which girls reported seeking more frequently than boys. Consistent with some research on problem solving (Berg, 1989), experience was not a significant covariate of coping frequency. However, homesickness intensity did correlate with overall coping frequency.

Frequency is perhaps a crude way to index coping. One can imagine some ways of coping with homesickness, such as returning home, that need only be used once. Nevertheless, boys' and girls' self-reports of the frequency of different kinds of coping are congruent with previous research. For example, engaging in a physical activity to forget about being homesick is supported by research demonstrating that distraction reduces depressive symptoms (e.g., Nolen-Hoeksema & Murrow, 1993). The fact that girls turned to social support more than boys has also been documented (Frydenberg & Lewis, 1991, 1993). The fact that severely homesick children coped more than less homesick children is indirectly supported by research demonstrating that anxious children persevere with strategic

coping more than nonanxious children do (Kendall & Chansky, 1991) and by research demonstrating that depressed adults engage in effortful and accurate cognitive processing more than nondepressed adults do (Yost & Weary, 1996).

The development of coping frequency across age groups was complex. For less homesick children, primary control coping frequency decreased as children got older. Perhaps older children understood the uncontrollable aspects of their separation better than younger children. The fact that older children were generally less homesick than younger children also probably contributed to a decrease in primary control across age groups. Yet this trend in homesickness intensity does not explain why, in the low-homesickness group, secondary control decreased from age 8 through age 13 and then increased through age 16. Several explanations may account for this quadratic trend. First, secondary control may have been replacing primary control as older children understood the constraints on their exerting primary control. Second, sociocultural constraints on what is considered appropriate coping may have changed across age groups. Adolescents may realize that running away is not a mature way to deal with their homesickness, even though they may be more capable of doing so than an 8-year-old. Thus, the U-shaped frequency curve of secondary control coping may reflect the shifting belief across age groups that one cannot exert primary control, then that one can exert primary control, and finally, that one should not exert primary control. If these changes do reflect the development of competency beliefs and sociocultural perceptions, it is important to note that age group trends in other contexts might be quite different. Nevertheless, the results of this study suggest that the reported plateau of secondary control coping frequency in adolescence may be an oversimplification.

In the high-homesickness group, there was more frequent coping across the board, with both primary and secondary control decreasing in frequency across age groups. Both of these findings seem easily explained by the fact that distressed children usually cope more often than happy children and by the fact that homesickness intensity decreased across age groups, even within the high-homesickness group. Although the influence of cognitive and social maturation on coping frequency for this high-homesickness group is unclear, there was no simple plateau of secondary control coping in adolescence. Additional research that addresses the combined influences of institutional constraints, cognitive sophistication, and sociocultural norms on all types of coping is clearly needed to better understand developmental trends in control coping.

As expected, low perceived control was associated with more severe homesickness and lower overall ratings of satisfaction. Although girls reported slightly more intense homesickness, there were no differences between boys' and girls' perceptions of control. Within the group of children who perceived low control over homesickness, the relinquished dominant copers and nondominant copers (who did equal amounts of relinquished control coping, primary coping, and secondary coping) were the most homesick. Probably this relationship is transactional. Children who perceive low control give up and do not actively cope to alleviate homesickness, and children who are homesick are less capable of mobilizing their resources to actively cope; they subsequently perceive low control over homesickness. Within the group of children who perceived high control over

homesickness, those few with a primary dominant coping profile were the most homesick. This finding suggests that, in a relatively uncontrollable circumstance, such as this planned 2-week stay away from home and primary caregivers, an emphasis on changing the circumstance may exacerbate negative affect. Alternatively, perhaps it is those children who perceive high control over homesickness, yet are most homesick, who persist in efforts to alter objective conditions.

Regarding the interaction between perceived control and dominant coping style on adjustment, a limited amount of research suggests that maladjustment results from mismatching coping goals to the stressor in question (see Compas et al., 1988). For example, attempts to exert primary control over uncontrollable stressors is futile and may lead to depressed mood (Weisz et al., 1994). This study was not in a position to test this notion thoroughly. Doing so would have entailed asking children more specific questions about their perceived control over the circumstance of separation, such as "Could you return home if you really tried?" In this study, children were asked the global question, "How much control do you have over how homesick you get at camp?" This is as much a question about regulating emotions and cognitions as it is a question about changing objective circumstances. Nevertheless, results indicated that most children adaptively chose to cope in secondary controlling ways, regardless of their perceived control over homesickness. More important, the most homesick children were those who perceived low control and who coped by relinquishing control.

Future research could address whether homesickness and other forms of maladjustment are characterized by misunderstanding what the controllable and uncontrollable aspects of a stressor are. A thorough understanding of the stressor may be more adaptive than a general penchant toward primary or secondary control. Broad application of primary control may neglect the uncontrollable aspects of a stressor; broad application of secondary control may neglect the controllable aspects of a stressor. Such broad applications, although rare, may reflect an incomplete or biased appraisal of the stressor in question and make it difficult for children to adapt to the variegated nature of complex stressors.

If this reasoning explains some of the observed results in this study, then there may be potentially useful implications for intervention. Clearly, most children coped effectively with homesickness. Levels of homesickness were generally low, and most children perceived high control over it. However, early identification of distressed children may not mean finding those who have mismatched perceived control and coping goals. Instead, it may involve finding children who do not thoroughly understand that the stressor of homesickness has both circumstantial and affective components and that both of these components have controllable and uncontrollable aspects. Once these children are identified, a thorough explanation and modeling of mixed and layered coping may be an excellent defense against homesickness. Such an intervention would clearly enhance children's coping competence, which past research (see Skinner, 1995) has suggested is an aspect of control that is strongly linked with positive affect. Beyond education, however, future research on homesickness must address ways of turning children's thoughts into actions. Research has demonstrated the deleterious effects of perseverative thinking about coping strate-

gies (Kendall & Chansky, 1991) and ruminating about stressors (Nolen-Hoeksema, 1991).

Many children may share the sentiment of one boy who remarked in an interview that "you can try or you can just give up." Maybe the most homesick children do not understand how and why they should try. Or, perhaps their understanding is profound and preoccupying, causing them to perseverate in a state of homesickness. Still other children may experience homesickness compounded by anxiety about not knowing how to cope or why they have become so homesick. Our research suggests that the least homesick children have an implicit knowledge about using different combinations of primary and secondary control coping at different ages. Indeed, the development of coping skills probably involves learning how to perform a given skill, when to apply the skill appropriately, and how to combine it with other skills for maximum benefit. Investigating ways to accelerate this learning, prevent relinquished control, and motivate children to engage their coping skills should be primary goals of future research.

References

- Abramson, L. Y., Seligman, M. E. P., & Teasdale, J. D. (1978). Learned helplessness in humans: Critique and reformation. *Journal of Abnormal Psychology, 87*, 49-74.
- Band, E. B., & Weisz, J. R. (1988). How to feel better when it feels bad: Children's perspectives on coping with everyday stress. *Developmental Psychology, 24*, 247-253.
- Band, E. B., & Weisz, J. R. (1990). Developmental differences in primary and secondary control coping and adjustment to juvenile diabetes. *Journal of Child Clinical Psychology, 19*, 150-158.
- Berg, C. A. (1989). Knowledge of strategies for dealing with everyday problems from childhood through adolescence. *Developmental Psychology, 25*, 607-618.
- Berg, C. A., & Calderone, K. S. (1994). The role of problem interpretations in understanding the development of everyday problem solving. In R. J. Sternberg & R. K. Wagner (Eds.), *Mind in context: Interactionist perspectives on human intelligence* (pp. 105-132). Cambridge, England: Cambridge University Press.
- Burt, C. (1993). Concentration and academic ability following the transition to university: An investigation of the effects of homesickness. *Journal of Environmental Psychology, 13*, 333-342.
- Compas, B. E. (1987). Coping with stress during childhood and adolescence. *Psychological Bulletin, 101*, 393-403.
- Compas, B. E., Banez, G. A., Malcarne, V. L., & Worsham, N. (1991). Perceived control and coping with stress: A developmental perspective. *Journal of Social Issues, 47*, 23-34.
- Compas, B. E., Malcarne, V. L., & Fondacaro, K. M. (1988). Coping with stressful events in older children and young adolescents. *Journal of Consulting and Clinical Psychology, 56*, 405-411.
- Cooper, C. L. (1990). Coping strategies to minimize the stress of transitions. In S. Fisher & C. L. Cooper (Eds.), *On the move: The psychology of change and transition* (pp. 315-327). New York: Wiley.
- Curry, S. L., & Russ, S. W. (1985). Identifying coping strategies in children. *Journal of Clinical Child Psychology, 14*, 61-69.
- Eisenbruch, M. (1990). Cultural bereavement and homesickness. In S. Fisher & C. L. Cooper (Eds.), *On the move: The psychology of change and transition* (pp. 191-205). New York: Wiley.
- Fisher, S. (1989). *Homesickness, cognition, and health*. Brighton, England: Erlbaum.
- Fisher, S., & Cooper, C. L. (1990). *On the move: The psychology of change and transition*. New York: Wiley.

- Fisher, S., Elder, L., & Peacock, G. (1990). Homesickness in a school in the Australian Bush. *Children's Environments Quarterly*, 7, 15–22.
- Fisher, S., Frazer, N., & Murray, K. (1986). Homesickness and health in boarding school children. *Journal of Environmental Psychology*, 6, 35–47.
- Fisher, S., & Hood, B. (1987). The stress of the transition to university: A longitudinal study of psychological disturbance, absent-mindedness and vulnerability to homesickness. *British Journal of Psychology*, 78, 425–441.
- Fisher, S., Murray, K., & Frazer, N. A. (1985). Homesickness, health, and efficiency in first year students. *Journal of Environmental Psychology*, 5, 181–195.
- Folkman, S. (1984). Personal control and stress and coping processes: A theoretical analysis. *Journal of Personality and Social Psychology*, 46, 839–852.
- Frydenberg, E., & Lewis, R. (1991). Adolescent coping: The different ways in which boys and girls cope. *Journal of Adolescence*, 14, 119–133.
- Frydenberg, E., & Lewis, R. (1993). Boys play sports and girls turn to others: Age, gender and ethnicity as determinants of coping. *Journal of Adolescence*, 16, 253–266.
- Harris, P. L. (1989). *Children and emotion*. Oxford, England: Basil Blackwell.
- Harris, P. L., & Guz, G. R. (1986). *Models of emotion: How boys report their emotional reactions upon entering an English boarding school*. Unpublished manuscript, University of Oxford, Department of Experimental Psychology.
- Heckhausen, J., & Schulz, R. (1995). A life-span theory of control. *Psychological Review*, 102, 284–304.
- Hollingshead, A. B. (1975). *Four factor index of social status*. Unpublished manuscript, Yale University, New Haven, CT.
- Kendall, P. C., & Chansky, T. E. (1991). Considering cognition in anxiety-disordered children. *Journal of Anxiety Disorders*, 5, 167–185.
- Kim, W. J., Hahn, S., Kish, J., Rosenberg, L., & Harris, J. (1991). Separation reaction of psychiatrically hospitalized children: A pilot study. *Child Psychiatry and Human Development*, 22, 53–65.
- Kovacs, M. (1980). Rating scales to assess depression in school aged children. *Acta Paedopsychiatrica*, 46, 305–315.
- Matthews, K. A. (1979). Efforts to control by children and adults with the Type A coronary-prone behavior pattern. *Child Development*, 50, 842–847.
- McCann, W. H. (1941). Nostalgia: A review of the literature. *Psychological Bulletin*, 38, 165–182.
- Mitchell, J. V. (1967). Recreational therapy program alleviates homesickness. *Hospital Topics*, 44, 97–98.
- Nolen-Hoeksema, S. (1991). Responses to depression and their effects on the duration of depressive episodes. *Journal of Abnormal Psychology*, 100, 569–582.
- Nolen-Hoeksema, S., & Murrow, J. (1993). Effects of rumination and distraction on naturally occurring depressed mood. *Cognition and Emotion*, 7, 561–570.
- Radovanovic, H. (1993). Parental conflict and children's coping styles in litigating separated families: Relationships with children's adjustment. *Journal of Abnormal Child Psychology*, 21, 697–713.
- Reynolds, C. R., & Richmond, B. O. (1978). What I think and feel: A revised measure of children's manifest anxiety. *Journal of Abnormal Child Psychology*, 6, 271–280.
- Rothbaum, F., Weisz, J. R., & Snyder, S. (1982). Changing the world and changing the self: A two-process model of perceived control. *Journal of Personality and Social Psychology*, 42, 5–37.
- Sansone, C., & Berg, C. A. (1993). Adapting to the environment across the life span: Different process or different inputs? *International Journal of Behavioral Development*, 16, 215–241.
- Saylor, C. F., Pallmyer, T. P., Finch, A. J., Eason, L., Trieber, F., & Folger, C. (1987). Predictors of psychological distress in hospitalized pediatric patients. *Journal of the American Academy of Child and Adolescent Psychiatry*, 26, 232–236.
- Seginer, R., Trommsdorff, G., & Essau, C. (1993). Adolescent control beliefs: Cross-cultural variations of primary and secondary orientations. *International Journal of Behavioral Development*, 16, 243–260.
- Skinner, E. A. (1995). *Perceived control, motivation, and coping*. Thousand Oaks, CA: Sage.
- Spirito, A., Stark, L. J., & Williams, C. (1988). Development of a brief checklist to assess coping in pediatric patients. *Journal of Pediatric Psychology*, 13, 555–574.
- Thurber, C. A. (1995). The experience and expression of homesickness in preadolescent and adolescent boys. *Child Development*, 66, 1162–1178.
- Thurber, C. A. (1996). *The phenomenology of homesickness in boys and girls: Longitudinal follow-up and extension*. Manuscript submitted for publication, University of California, Los Angeles.
- Thurber, C. A. (in press-a). Describing boys' coping with homesickness using a two-process model of control. *Anxiety, Stress, and Coping*.
- Thurber, C. A. (in press-b). Preliminary models of risk and protective factors for childhood homesickness. *Child Development*.
- Thurber, C. A., & Weisz, J. R. (1993). *Coding manual for coping with competitive loss and separation from home*. Unpublished manuscript, University of California, Los Angeles, Department of Psychology.
- Weisz, J. R. (1983). Can I control it? The pursuit of veridical answers across the life span. *Life Span Development and Behavior*, 5, 233–300.
- Weisz, J. R. (1990). Development of control-related beliefs, goals, and styles in childhood and adolescence: A clinical perspective. In K. W. Schaie, J. Rodin, & C. Scholler (Eds.), *Self-directedness and efficacy: Causes and effects throughout the life course* (pp. 103–145). New York: Erlbaum.
- Weisz, J. R., McCabe, M. A., & Dennig, M. D. (1994). Primary and secondary control among children undergoing medical procedures: Adjustment as a function of coping style. *Journal of Consulting and Clinical Psychology*, 62, 324–332.
- Weisz, J. R., Proffitt, V., & Sweeney, L. (1991). *The Perceived Control Scale for Children: Development and validation*. Unpublished manuscript, University of California, Los Angeles, Department of Psychology.
- Weisz, J. R., Rothbaum, F., & Blackburn, T. (1984). Standing out and standing in: The psychology of control in America and Japan. *American Psychologist*, 39, 955–969.
- Weisz, J. R., Stevens, J. S., Curry, J. F., Cohen, R., Craighead, W. E., Burlingame, W. V., Smith, A., Weiss, B., & Parmelee, D. X. (1989). Control-related cognitions and depression among inpatient children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 28, 358–363.
- Weisz, J. R., Sweeney, L., Proffitt, V., & Carr, T. (1993). Control-related beliefs and self-reported depressive symptoms in late childhood. *Journal of Abnormal Psychology*, 102, 411–418.
- Weisz, J. R., Weiss, B., Wasserman, A. A., & Rintoul, B. (1987). Control-related beliefs and depression among clinic-referred children and adolescents. *Journal of Abnormal Psychology*, 96, 58–63.
- White, R. W. (1959). Motivation reconsidered: The concept of competence. *Psychological Review*, 66, 297–333.
- Yost, J. H., & Weary, G. (1996). Depression and the correspondent inference bias: Evidence for more effortful cognitive processing. *Personality and Social Psychology Bulletin*, 22, 192–200.

Received January 2, 1996

Revision received June 5, 1996

Accepted July 23, 1996 ■