When it hurts to leave home

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Meaning, Manifestations, and Management of Homesickness

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Proefschrift

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Maria Adriana Louisa van Tilburg

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Promotor: Prof. dr. G. L. van Heck
Copromotor: Dr. A. J. J. M. Vingerhoets

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Voorwoord

Elke keer wordt me de vraag gesteld of ik zelf ooit last heb gehad van heimwee. Als mijn antwoord daarop 'nee' blijkt te zijn, roept dat steeds verrassing of teleurstelling op bij degene die mij de vraag stelt. Hoe komt iemand die zelf nog nooit last heeft gehad van heimwee ertoe om dit fenomeen te bestuderen? Dat heb ik helemaal te danken aan mijn promotoren, die mij als student warm maakte voor wetenschappelijk onderzoek. Gedreven door hoe erbarmelijk weinig er bekend was over heimwee en de alledaagsheid van het fenomeen begonnen we met goede moed aan een verkennend onderzoek. Op dat moment hadden we in onze stoutste dromen niet verwacht wat een commotie dit onderzoek zou veroorzaken. Na een oproep in diverse huis-aan-huis blaadjes en de Libelle kregen we een stortvloed aan telefoontjes en brieven binnen. Eén voor één waren dit noodkreten van mensen die aan ernstige heimwee lijdde en verstoken bleven van enige informatie, laat staan enig begrip voor hun probleem. Er was geen boek, tijdschrift, of radio/tv-programma wat aandacht schonk aan heimwee. Het leek alsof het niet bestond; de heimweelijder was geheel op zichzelf aangewezen. De vele reacties duidde ons erop hoe belangrijk het was om onderzoek te doen naar heimwee. Daarom kreeg het eerste verkennende onderzoek een vervolg en nog één en nog één. Totdat het uitgroeide tot dit proefschrift. Steeds waren velen heimweelijders bereid om deel te nemen aan ons onderzoek. Zij hebben mij laten zien en voelen wat heimwee is en hoe ons onderzoek hun kan helpen. Zonder deze heimweelijders en alle anderen die de tijd en moeite hebben genomen om deel te nemen aan onderzoek, zou dit proefschrift nooit tot stand zijn gekomen. Inmiddels heeft de pers lucht gekregen van de nieuwswaarde van heimwee. Toch moet er nog hard aan de weg getimmerd worden om de velen vooroordelen over heimwee uit de weg te ruimen. Niet alleen onder het algemene publiek maar ook in de wetenschap waar heimwee helaas nogal eens gezien wordt als een 'mediamiek' onderwerp dat niet de aandacht van de serieuze wetenschap verdient. Ik hoop dat alle personen met heimwee ook in de toekomst paraat blijven om via onderzoek en media duidelijk te maken dat heimwee absoluut geen aanstelleritis is van mama's-kindjes.

Het schrijven van dit proefschrift heb ik ervaren als een leerzaam en plezierig karwei. Daarbij heb ik veel praktische steun gehad. In de eerste plaats van mijn promotoren die me altijd met raad en daad hebben bijgestaan. Guus en Ad, bedankt dat geen vraag of verzoek te gek was, ondanks jullie drukke schema's. Van jullie heb ik niet alleen het wetenschappelijk reilen en

zeilen geleerd, ik ben er ook door begeesterd. Zonder jullie was dit karwei nooit geklaard. Alhoewel de weg naar deze dag af en toe hobbelig was, zal ik er met weemoed aan terugdenken. Mijn dank gaat ook uit naar een derde persoon die een wezenlijke bijdrage heeft geleverd aan dit proefschrift. Niet alleen besloten we onze krachten te bundelen om een paar mooie onderzoeken van de grond te krijgen. Ook onze discussies over heimwee en haar scherpe blik vanuit de klinische hoek, hebben mij een genuanceerder beeld gegeven over dit onderwerp. Liesbeth Eurelings-Bontekoe, van de Rijksuniversiteit Leiden, wil ik op deze manier laten weten hoeveel ik aan onze ontmoetingen heb gehad. Hopelijk heb ik de kans met je te blijven werken in de toekomst. Verder wil ik alle personen bedanken met wie ik over dit onderwerp heb kunnen discussieren. Met name alle auteurs die mee hebben gewerkt aan het boek 'Psychological Aspects of Geographical Moves: Homesickness and Acculturation Stress'. Special thanks to Chris Thurber and Terence Hannigan. En ook alle leden van Onderzoeksarea II 'Critical live events and mental health', van het Research Institute Psychology and Health. Speciaal wil ik hiervan Maggie Stroebe bedanken die altijd bereid was om met mij over haar vakgebied te praten en haar ideeën over de relatie tussen rouw en heimwee toe te lichten. Als laatste wil ik Rinus Verkooijen bedanken voor de hulp bij de lay-out van dit boek.

Het schrijven van een proefschrift is echter niet alleen een wetenschappelijke reis. Het neemt vier jaar van je leven in beslag en ook in andere opzichten hebben velen mij in deze periode bijgestaan. In de eerste plaats natuurlijk mijn steun en toeverlaat en allerbeste vriendje, Bob van Kempen. Zonder jou zou ik niet zijn waar ik nu ben en wie ik nu ben. 'Per Aspera Ad Astra'; die droom is niet alleen uitgekomen, hij duurt nog steeds voort. Een stuwende kracht van deze tot werkelijkheid geworden droom zijn ook Jac en Lientje. Hun wil ik hierbij bedanken voor het invullen van een leegte in mijn leven en het geven van alle liefde en raad die ik in een eerdere periode zo gemist heb. Daarnaast wil ik niet de velen vrienden en vriendinnen, familieleden, en collega's vergeten met wie ik leed en plezier heb gedeeld in deze vier jaar; Lara, Antonique, Joop, Mariska, Rien, Anouschka, Thijs, Marc, Paul en alle anderen die ik hier helaas niet allemaal kan opnoemen. De volgende personen wil ik speciaal bedanken omdat zij de meeste ups en downs rondom mijn proefschrift hebben opgevangen. In de eerste plaats Gerty, voor alle discussies rondom het aio-schap, het proefschrift, het leven en alle andere onzin. En voor alles wat je nog op het laatste moment voor mij hebt gedaan, terwijl ik in Amerika zat te 'stressen'. Mogen we nog velen malen (virtuele) thee drinken. Op de tweede plaats Ivan omdat je het zo'n lange tijd bij me hebt uitgehouden. Altijd geduldig luisterend naar mijn opborrelende gedachtenspinsels. Je was een ideale kamergenoot. En natuur-

lijk Dineke, eerst student-assistent en nu ook vriendin. Bedankt voor je niet aflatende inzet en je goed geluimde lach. Tenslotte, sta ik in het krijt bij mijn paranimfen Bas en Margot. Het was een hele rust dat ik alle regeldingen rondom de promotiedag aan jullie kon overlaten, terwijl ik duimen zat te draaien in Amerika.

Contents

1 Introduction

Nowadays, many people leave home, family, friends, and even land of birth behind in pursuit of knowledge (e.g., students), better jobs and salaries, peace (e.g., asylum seekers) etc., or just a good time off (e.g., holidays). Whatever the reason, generally people expect a 'better' life in their new environment, compared to their old one. Unfortunately, many of them develop grief-like reactions to leaving home, also called *homesickness*. Homesickness is generally not expected and certainly not wanted by those who leave their home. It might turn the move into a total 'disaster'. Home and the urge to return home obsess homesick people, who become depressed and withdrawn. There is nothing that seems to interest them anymore, besides reminiscing and ruminating about home. The new environment is looked upon as a horrible place in which nothing is as good as at home. Prevalence rates of 16% (spontaneous report) to as many as 82% (prompted report) have been found among those who have left their homes (e.g., Fisher, 1989). In a study among Dutch adults (Thijs, 1992) it was found that only 7.3% never experienced homesickness in their whole lives. These figures may vary across studies, due to methodological differences and/or population characteristics. Nevertheless the data indicate that homesickness is a very common phenomenon. Prevalence rates seem to be unrelated to age and gender (e.g., Fisher, 1989), but there are results suggesting that they might vary across cultures (Carden & Feicht, 1991).

Although, the detrimental effects of homesickness on health have been reported in the scientific literature already in the 17th century (see Rosen, 1975), nowadays little is known about this phenomenon and its associated symptoms. Systematic research on homesickness has been sporadic, and mainly based on individual cases. From the 1960's onwards, the scientific interest in this phenomenon has been steadily increasing and the focus shifted from individual cases of severe homesickness to large scale studies among homesick(-prone) populations, like students, conscripts, and boarding school children. Recent studies on homesickness have mainly been directed at manifestations of homesickness and personality (e.g., rigidity; Eurelings-Bontekoe, Vingerhoets, & Fontijn, 1994) and/or environmental factors (e.g., presence of familiar persons and geographical distance from home; Gruijters, 1992) related to homesickness. Although some interesting relationships have been found and replicated, these studies suffer from several pitfalls. First, and most important is the lack of a generally accepted definition of homesickness, which separates it from related syndromes like nostalgia and separation anxiety. So, these studies might not be studying the same phenomenon at all. In addition, it is not clear whether homesickness is a singular syndro-

me, or multifaceted with subtypes which differ in etiology (e.g., Bergsma, 1963; Rümke, 1940). Second, most studies were done with homesick students and conscripts as subjects, greatly reducing the generalization to other populations. Furthermore, the greatest need for the homesick and those who are confronted with homesick people like caregivers, spouse, friends and family, is to know how to overcome the homesickness. For many people homesickness has become a chronic problem. And even if it is only transient, given the disabling quality it is a great advantage to know how to tackle this problem effectively. However, hardly any systematic research has been directed at coping strategies and interventions for the homesick. Recently, Thurber (see for an overview Thurber, 1997) investigated coping with homesickness among children.

Although there is still a lot of work to be done, the results of these first studies are of great value to parents, nurses, and any other care-giver confronted with homesick children. There is a need of such studies in adults as well, as homesickness affects people of all ages.

Summarizing the above, the following knowledge is lacking: (1) definition and (differential) diagnosis of homesickness; (2) information on the etiology of homesickness; (3) information on general symptoms (which can be generalized across various groups of homesick persons) and which of those features have diagnostic value, (4) information on the course and prognosis of homesickness, and (5) information on treatment/interventions. Although homesickness is generally a normal reaction to home, it is helpful to think of it in terms of a 'syndrome'. When opening a book on medical conditions, one would always find information on causes, symptoms, diagnosis, and treatments of each syndrome (see *Figure 1.1*). While this kind of knowledge about homesickness is of great (practical) value, it is typically not touched upon by modern research. Therefore, in this dissertation the focus will be on these topics. The reported studies included general samples of homesick adults. However, due to practical limitations participants in most studies were mainly female.

Several areas of interest divide the text. First an overview will be given of the literature on homesickness, which touches more extensively upon several of the topics discussed above. Chapters 3 to 5 focus upon 'Causes' and 'Diagnosis' (see Figure 1.1). Chapter 3 discusses differential diagnosis. Chapter 4 focuses upon the definition of homesickness in laymen. In chapter 5 and 6 it is investigated whether there are different types of homesickness which differ in etiology. The two blocks of Figure 1.1 'Symptoms' and 'Course' are touched upon in chapters 7 to 9. Chapter 7 and 8 are mainly replication studies in a general adult sample focusing on the symptoms found by Fishers among homesick university and boarding school children; varia-

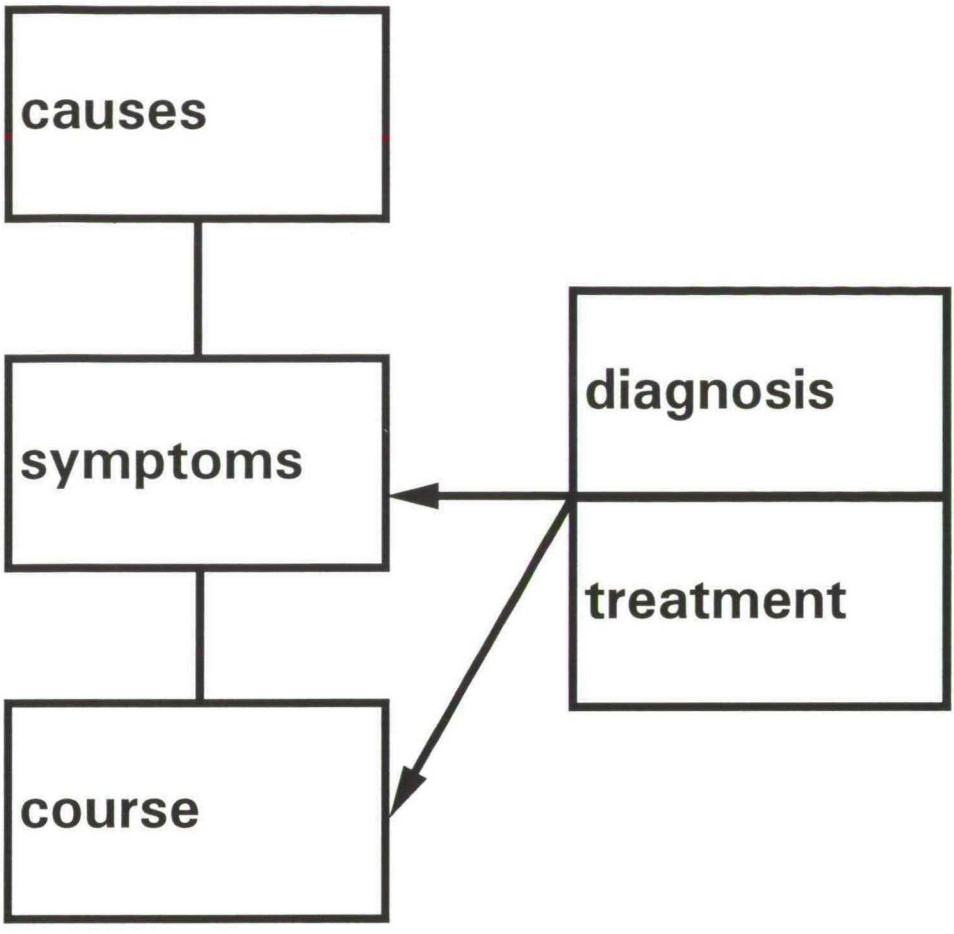

Figure 1.1

bles on onset and course of homesickness were included as well. Chapter 9 describes a longitudinal multiple case study on the course of homesickness during holiday trips. The block 'Treatment' of Figure 1.1 is touched upon in Chapters 10 and 11. These studies are not directed at specific treatments, but rather at (the effectiveness of) coping with homesickness. The results will be of great value to those developing interventions or treatments for the homesick. Finally, in the last chapter the outcomes of the various studies in this dissertation are discussed and directions for future research are given.

Chapters 2 to 11 are based on the following articles:

Chapter 2 Van Tilburg, M. A. L., Vingerhoets, A. J. J. M., & Van Heck, G.L. (1996). Homesickness: A review of the literature. *Psychological Medicine, 26*, 899-912.

Chapter 3 Van Tilburg, M. A. L. (1997). The psychological context of homesickness. In: M. A. L. Van Tilburg & A. J. J. M. Vingerhoets (Eds.), *Psychological aspects of geographical moves: Homesickness and acculturation stress* (pp. 39-54). Tilburg: Tilburg, University Press.

Chapter 4 Van Tilburg, M. A. L., Eurelings-Bontekoe, E. H. M., Landman, C. A. M., Verschuur, M., & Vingerhoets, A. J. J. M. (1998). Conceptual analysis of homesickness: A study on personal meanings. Submitted for publication.

Chapter 5 Van Tilburg, M.A.L., Eurelings-Bontekoe, E.H.M., Vingerhoets, A. J. J. M., & Van Heck, G. L. (1998). An exploratory investigation into types of homesickness. Submitted for publication.

Chapter 6 Van Tilburg, M. A. L., Vingerhoets, A. J. J. M., & Van Heck, G. L., & Eurelings-Bontekoe, E.H.M. (1998). Types of homesickness: A first validation study. Unpublished manuscript.

Chapter 7 Van Tilburg, M. A. L., Vingerhoets, A. J. J. M., & Van Heck, G. L. (1995). The psychological context of homesickness. Paper presented at the 13th World Congress of the International College of Psychosomatic Medicine, September 1995 Jerusalem, Israel.

Chapter 8 Van Tilburg, M. A. L., Vingerhoets, A. J. J. M., Van Heck, G. L., & Kirschbaum, C. (1997). Homesickness, mood, and self-reported health. Accepted for publication in *Sress Medicine*.

Chapter 9 Van Tilburg, M. A. L., Vingerhoets, A. J. J. M., Van Heck, G. L., & Kirschbaum, C. (1996). Mood changes in homesick persons during a holiday trip: A multiple case study. *Psychotherapy and Psychosomatics, 65*, 91-96.

Chapter 10 Van Tilburg, M. A. L., Vingerhoets, A. J. J. M., & Van Heck, G. L. (1997). Coping with homesickness: The construction of the Adult Homesickness Coping Questionnaire. *Personality and Individual Differences, 22*, 901-907.

Chapter 11 Van Tilburg, M. A. L., Vingerhoets, A. J. J. M., & Van Heck, G. L. (1998). Determinants of homesickness chronicity: Coping and personality. Submitted for publication.

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Eurelings-Bontekoe, E. H. M., Vingerhoets, A. J. J. M., & Fontijn, T. (1994). Personality and behavioral antecedents of homesickness. *Personality and Individual Differences, 16*, 229-235.

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Gruijters, I. (1992). *Heimwee en situatiekenmerken* [Homesickness and situation characteristics]. Unpublished master's thesis, Tilburg University, Tilburg, The Netherlands.

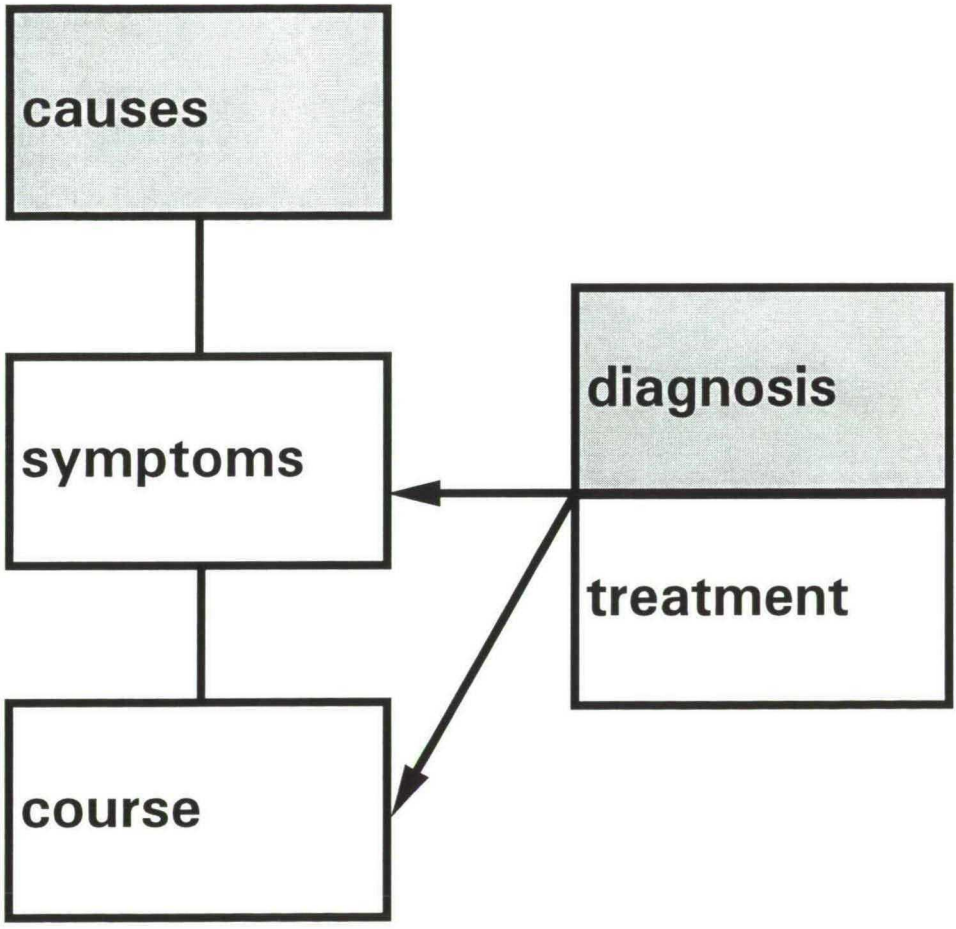
Rosen, G. (1975). Nostalgia: A 'forgotten' psychological disorder. *Psychological Medicine, 5*, 340-354.

Rümke, R.C. (1940). Over heimwee [On homesickness]. *Nederlands Tijdschrift voor de Geneeskunde, 84*, 3658-3665.

Thijs, H. (1992). *Heimwee en andere emoties* [Homesickness and other emotions]. Unpublished master's thesis. Tilburg University, Tilburg, The Netherlands.

Thurber, C. (1997). Children's coping with homesickness: Phenomenology and intervention. In: M. A. L. Van Tilburg & A. J. J. M. Vingerhoets (Eds.), *Psychological aspects of geographical moves: Homesickness and acculturation stress* (pp. 143-164). Tilburg: Tilburg University Press.

PART I



2 Homesickness: A review of the literature

Miranda A.L. Van Tilburg, Ad J.J.M. Vingerhoets, and Guus L. Van Heck

Abstract

Homesickness has not received due attention from psychological researchers, in spite of the fact that it is of considerable interest to counsellors and caregivers of those who have migrated or moved temporarily or permanently (e.g., immigrants, refugees, students, soldiers). First, this review addresses the definition of homesickness, the possible different kinds of homesickness, its prevalence rate, and symptomatology. Second, an overview is given of the theories that account for psychological distress following leaving home. These theories link homesickness with separation-anxiety and loss, the interruption of lifestyle, reduced control, role change, and internal conflict. In addition, the review focuses on (i) studies that show that subjects reporting homesickness differ from non-homesick persons in terms of personality; (ii) the analyses of environmental characteristics that may play a crucial role in the onset and course of homesickness. Thirdly, Fisher's (1989) composite model of homesickness which summarizes key findings of the major studies on homesickness is discussed. Fourthly, methodological issues are addressed. Finally, suggestions for future research are presented and possibilities for interventions are proposed.

Introduction

Homesickness refers to the commonly experienced state of distress among those who have left their house and home and find themselves in a new and unfamiliar environment. It is generally represented as an intense longing for home accompanied by a depressive mood and a variety of somatic complaints. Leaving home, as in migration and residential move, is not only associated with distress, which may be labelled *homesickness*, but there is also evidence for far-reaching negative effects on health status. For example, there are data indicating that this event is associated with the onset of depression (Ekblad, 1993; Leff *et al.*, 1970; Schmitz, 1992; Weissman & Paykel 1973), deficiencies in the immune system (Schmitz, 1992), diabetes mellitus (Mooy, 1995), and leukaemia (Jacobs, 1980). Furthermore, change of residence is included in many life events inventories that are frequently used in stress research, including the Social Readjustment Rating Scale (Holmes & Rahe, 1967). Thus, there are strong indications that this stressor may have

dramatic consequences for vulnerable individuals. Moreover, it has been suggested that, from a clinical point of view, homesickness is an especially relevant issue in refugees. It may not only interfere with integration into new societies, but it may also lead to adjustment problems, when being back in the home country, because the situation there turns out to be less ideal than it was in the imagination.

Through history, homesickness has not only been of interest to poets and writers, also scientists have shown interest in this phenomenon although to a much lesser degree. Nevertheless, as far back as the seventeenth century, the importance of a systematic study of homesickness was recognized, particularly by Swiss investigators. For instance, Johannes Hofer concluded that homesickness was an illness of young people who were socially isolated in strange countries, whereas Scheuzer speculated that the cause of nostalgic feelings among Swiss soldiers in France was the deprivation of the refined Swiss air (Rosen, 1975). On the other hand, Detharding (cited in Bergsma, 1963) suggested that it was the depressing Swiss air which led to feelings of homesickness among French soldiers in Switzerland. In the seventeenth and eighteenth centuries homesickness, in these days often called nostalgia, was considered to be a disease of certain ethnic groups, predominantly the Swiss. Since early work on homesickness was focused, in particular, on hospitalized patients suffering from other diseases, organic pathology was stressed as an important cause of homesickness. This view was not eroded until the last decades of the nineteenth century, when developments in medicine led to a better understanding of the symptoms in the homesick. Subsequently, for no apparent reason, the interest in homesickness disappeared.

The doctoral dissertation *Heimweh und Verbrechen* (Homesickness and Crime) of Jaspers (1909), however, has given new impulses to the study of this phenomenon. From then on, homesickness was predominantly described among maids, child minders, and emigrants and was assumed to lead to criminal behaviour and fire-raising. A typical illustration is the case, described by Jaspers (1909), of a 16-year old maid who raised fire in four places in order to be sent home. In this period various psychoanalytical ideas, like regression and infantile bonding, emerged in the homesickness literature. Then, after World-War II the interest in the phenomenon disappeared almost completely; again, for no obvious reason.

The recent psychological literature on homesickness is rather slim and scattered. This is rather surprising, considering the commonality and intensity of the homesickness experience and the large numbers of people who nowadays (are forced to) travel because of work, study, and holidays, or due to the fact that they are prosecuted in their home countries. Homesickness has been studied among conscripts (Bergsma, 1963; Dijkstra & Hendrix, 1983; Eure-

lings-Bontekoe *et al.*, 1994), migrant populations and refugees (e.g., Eisenbruch, 1990; Hertz, 1988; Hojat & Herman, 1985; Larbig *et al.*, 1979; Schmitz, 1994), non-resident students, student nurses, and boarding school children (Brewin *et al.*, 1989; Carden & Feicht, 1991; Fisher, 1989; Fisher *et al.*, 1984, 1986; Fisher & Hood, 1987, 1988; Fisher, Murray & Frazer, 1985; Miller & Harwell, 1983; Porritt & Taylor, 1981), and institutionalized people (Taylor, 1986).

In this article, the recent psychological literature on homesickness will be reviewed and integrated. First, definitions of the concept of homesickness will be provided. Then, the symptomatology will be described and prevalence rates will be given. In addition, psychological theories and recent research concerning homesickness will be discussed. Furthermore, methodological issues will be addressed. Finally, some recommendations for interventions and future research will be formulated.

What do we mean by homesickness?

Homesickness is a well-known phenomenon for most people. Fisher (1989), found considerable consensus on key features, such as (a) preoccupation with family, friends, home, and routines, and (b) attitudes to the new environment and its consequences, among both homesick and non-homesick first-year university students and school pupils. More individual differences were found at the level of symptoms, which "feature at subordinate levels in the definitions provided by subjects" (Fisher, 1989: 123). This is an important aspect, because it is necessary to know that the term 'homesickness', at least at the level of key features, is used consistently across affected and non-affected groups. In spite of the fact that there seems to be sizeable convergence in written definitions of homesickness, some idiosyncrasy also exists; not only with respect to symptoms, but also regarding the breath of the concept. For instance, other states like nostalgia (a yearning for bygone days) or missing deceased persons are sometimes viewed as manifestations of homesickness by lay persons (Thijs, 1992). But also professionals seem to have difficulty in defining the concept, as may be clear from Fisher's (1989: 28) statement that "there are no clinical experts who could provide diagnostic criteria".

Baier and Welch (1992) performed a conceptual analysis in order to distinguish homesickness from related concepts such as separation-anxiety and school phobia. On the basis of prototypical cases of homesickness the following six criteria were formulated: (a) homesickness happens in all age groups, under conditions of being away from home; (b) frequently homesickness is not acknowledged, nor are homesickness feelings processed intrapersonally;

(c) in adults and older children homesickness is sometimes experienced with embarrassment or denial; (d) homesickness reflects a persuasive feeling of sadness and thoughts about the place left; (e) children who are homesick are generally encouraged to suppress their feelings; and (f) somatic complaints may accompany the longing for home or family (Baier & Welch, 1992: 56). For clinical practice these criteria can offer some hold, but quite some questions remain. For example, one crucial question is whether distress and avoidance behaviour in unpleasant and involuntary situations (e.g., being in the army or in a hospital) should be considered as qualitatively similar to feelings of homesickness occurring during a holiday? In the latter case often there is no objective aversive situation, merely being away from home, even with the whole family, may suffice to evoke an intemperate desire to go home in some persons (Van Tilburg *et al.*, 1996; *see chapter 9 in this book*).

Homesickness can be conceived of as being related to adjustment disorder. According to the DSM-IV (1994) criteria, adjustment disorder is a maladaptive response to an identifiable psychosocial stressor occurring within three months and remitting within six months of the termination of the stressor. The reaction must be in excess of a normal and expectable reaction to the stressor(s) and/or it has to impair school or work performances and hinder social activities or interpersonal relationships. Six subtypes have been distinguished which characterize the predominant symptoms. Severe homesickness may be seen as a particular form of two of these subtypes, namely adjustment disorder with depressed mood or adjustment disorder with physical complaints, when two other conditions are fulfilled, namely being away from home (the stressor) and thinking a lot about home. But, if homesickness is not severe enough to hamper daily activities like work and social activities, then, according to DSM-IV criteria, homesickness has to be viewed as a normal reaction to being away from home. Homesickness can both be labelled as an acute adjustment disorder (remittance of symptoms within six months), in the case of persons whose homesickness feelings disappear or persons who return within six months, and as chronic adjustment disorder (persistence of symptoms for six months or longer) in cases of severe homesickness.

On the other hand, homesickness also shares some characteristic features with agoraphobia. Sufferers may be severely hampered in their professional and private life because it is impossible for them to spend one or more nights outside their home, even when accompanied by their family.

Furthermore, homesickness is often considered to be a reactive depression (e.g., Baier & Welch, 1992; Eurelings-Bontekoe *et al.*, 1994; Fisher, 1989). Characteristic of the homesick, as opposed to the depressed, are the ruminative and obsessive thoughts about home and the desire to return home.

Most authors consider homesickness as a singular syndrome (e.g., Baier & Welch, 1992; Brewin *et al.*, 1989; Burt, 1993; Eurelings-Bontekoe *et al.*, 1994; Fisher, 1989; Lu, 1990). In contrast, the Dutch psychiatrist Rümke (1940) distinguished several kinds of homesickness, namely homesickness for the familiar environment or area, homesickness for persons in the familiar environment, pseudo-homesickness (which is a pattern of homesickness-like reactions resulting from personality disorders), and a fourth form in which unbearableness of the new situation is the predominant aspect.

Bergsma (1963) has made a distinction between normal and pathological homesickness. He considered homesickness feelings as normal phenomena, which can become pathological when they cannot be conquered. According to this author, pathological homesickness can be divided into the following forms: (a) primitive homesickness which is found among primitive and mentally retarded persons who are excessively connected to their surroundings, (b) infantile or symbiotic homesickness which occurs, when there is a primary connection with the mother figure in a mutually dependent-relationship, (c) neurotic homesickness reflecting an ambivalent and discordant relationship with parents, (d) hysterical homesickness which is based upon a neurotic and discordant relationship with a hysterical mother, with whom the homesick try to identify themselves, (e) mental-deficiency homesickness, due to some sort of mental deficiency, (f) liberty homesickness in which case the yearning for freedom is more predominant than the desire to go home, (g) *zeewee* (a Dutch term; literally translated: 'sea sickness') which occurs among seamen who live ashore, and (h) *hinausweh* (a German term meaning 'return sickness') which is a form of homesickness that occurs when one returns home.

It may be clear that Rümke (1940) and Bergsma (1963) both were inspired by Freudian theories which are no longer held by the majority of clinicians today. Nevertheless, it is interesting to examine whether homesickness, given current psychological knowledge, can be divided in subcategories with a specific aetiology and different expressions. If these classifications turn out to be valid, then this will have major implications for theory, research, and intervention of homesickness. Particularly because different causes and consequences for the separate forms are assumed.

Preliminary data of our own research group strongly suggest the existence of at least four independent types of homesickness (Vingerhoets *et al.*, 1995), namely homesick for persons, homesick for the environment, difficulties with adapting to the new environment, and difficulties with new routines. These types considerably overlap with Rümke's (1940) classification. Seen from a more practical and clinical perspective such a differentiation is of the utmost importance, assuming that each type may have a different aetiology and

demands a specific therapeutic approach. Therefore, adequate assessment procedures and research concerning the validity of these subtypes are badly needed.

Symptomatology of homesickness

Homesickness manifests itself by certain physical, cognitive, behaviourial, and emotional symptoms (Baier & Welch, 1992; Carden & Feicht, 1991; Dijkstra & Hendrix, 1983; Fisher, 1989)[1]. The most frequently reported physical problems are: gastric and intestinal complaints, sleep disturbances, appetite loss, headache, fatigue, and a "funny feeling" in the legs. In addition, all sorts of vague complaints and minor aches and pains have been reported.

At the cognitive level, especially missing home, obsessional thoughts about home, negative thoughts about the new environment, and absent-mindedness are reported. It is remarkable that at this level attention is not primarily directed at problems at home, but rather at idealizing the home environment (Fisher, 1989).

Behaviourial characteristics are apathy, listlessness, lack of initiative, and little interest in the new environment. For instance, talking about home all the time, not wanting to eat, crying, withdrawal, attention-seeking behaviour, acting out, and fighting have frequently been observed in school camps (Winland-Brown & Maheady, 1990).

Emotional manifestations of homesickness are mainly characterized by depressive mood. Moreover, feelings of insecurity, loss of control, nervousness, and loneliness are frequently reported. Therefore, homesickness is often considered to be a reactive depression, comparable with depression following grief (Dijkstra & Hendrix, 1983; Eurelings-Bontekoe *et al.*, 1994; Fisher, 1989; Hamdi, 1974; Porritt & Taylor, 1981; Taylor, 1986). Fried (1963; cited in Porritt & Taylor, 1981) spoke of it as "grieving for a lost home", although he recognized that the grieving can also be directed at lost relationships. Hamdi (1974) hypothesized a two-stage process of adaptation to a new living environment: "The process of giving up the previous way of

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1 In a recent study among 329 (pre-)adolescent boys Thurber found that homesickness was experienced as a combination of depression and anxiety and had a physical element for some children. Furthermore, homesick boys mostly showed internalizing behaviour, but some acted in an externalizing way, like delinquency and nightmares.
See for details: Thurber, C.A. (1995). The experience and expression of homesickness in preadolescent and adolescent boys. *Child Development*, *66*, 1162-1178.

life is marked by anger, depression, acknowledgement of loss and mourning. Resignation, detachment, adaptation, and hope indicate that the individual is prepared to accept and make the best of the new life situation" (p. 16). Thus, not only the confrontation with the new and unfamiliar environment, but also the loss of the home environment and important relationships can be crucial factors in homesickness.

Prevalence of homesickness

Homesickness is experienced by people of all cultures and all ages. Nevertheless, to provide estimations of the prevalence of homesickness is rather problematical. Apart from the above mentioned definition problems, there are good reasons to assume that the homesickness experience is, at least partially, situation specific. Prevalence rates are, therefore, always limited to specific contexts like holidays, hospitals, universities, school camps, or the army. Moreover, homesick feelings are generally not experienced continuously. Furthermore, there is evidence that only intense homesickness experiences are reported spontaneously. In a study among boarding school pupils the spontaneously reported incidence of homesickness was 18%. But when the question was probed, 60-70% reported that they had suffered from homesickness to some degree (Fisher *et al.*, 1984). This may be due to the fact that, while homesickness experiences generally are episodic, in severe cases these feelings are continuous. In the episodic homesick, periods of homesickness are predominantly reported at the beginning and the end of the day. Moreover, they occur more frequently during mental (rather than physical) and passive (rather than active) tasks. However, as homesickness is linked to depression, it could also be that this passivity is a consequence of the homesickness experience rather than a cause (Fisher, 1989).
Fisher (1989) concludes that 50-75% of the general population have had at least one homesickness experience, whereas serious forms are estimated to occur in 10 to 15% of these cases. In a recent Dutch study (Thijs, 1992) even higher prevalence rates were found: only 7.3 % of a sample of 206 adults reported that they had never experienced any homesickness. However, it should be noticed that in this study other states like, for instance, nostalgia were included in the homesickness category probably resulting in an overestimation. Although no pertinent data are available, results so far strongly suggest that homesickness is a commonly experienced psychological state following leaving the home environment.

Models of homesickness

With the exception of Fisher's (1989; 1990) work, the current work on homesickness is generally not theory-driven. Fisher has put forward the following five theoretical explanations for the distressing effects of leaving home, namely (a) loss, (b) interruption of life style, (c) reduced control, (d) role change and self-consciousness, and (e) conflict[2].

Loss

The focus of the first model is on attachment and loss (see Bowlby, 1969; Ainsworth *et al.*, 1978). The individual is separated from family, friends and acquaintances, which may be experienced as a loss resulting in serious distress. The response of the individual to the loss experience may be a manifestation of separation anxiety or grief. It is characterized by anxiousness, distress, anger and searching behaviour, sometimes shifting to apathy and helplessness at a later stadium. Leaving home is a partial loss, because home still exists and the individual is able to contact or visit home and eventually to return. Therefore, homesickness can be conceived of as a form of reversible bereavement. Besides family and friends, the losses may also include valued possessions, careers, and places of emotional significance. Objects and activities associated with home, but also available in the new environment, can become of transitional value in that they acquire a symbolic value representing lost relationships or objects.

The importance of attachment in the development of homesickness is stressed by several authors (e.g., Brewin *et al.*, 1989; Hamdi, 1974; Porritt & Taylor, 1981) and it is often mentioned as a cause of psychological and physical problems of immigrants (e.g., Aroian, 1990; Hojat & Herman, 1985; Juthani, 1992; Proshansky *et al.*, 1983). Unfortunately, until now this model has not been tested empirically. Aroian (1990) has observed that loss and disrup-

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2 More recently, Eurelings-Bontekoe proposed a psychodynamic theoretical framework in which homesickness is linked to youth experiences. She argued that homesickness is a possible manifestation of separation anxiety due to anxious attachment and narcissistic vulnerability. In this view, a homesick-prone personality is developed on the basis of adverse family experiences during childhood. On the basis of this theory it might be concluded that homesickness occurs when people leave home *and* have a vulnerable personality.

For a more detailed discussion see Eurelings-Bontekoe, E.H.M. (1997). Homesickness, personality and personality disorders: An overview and therapeutic considerations. In: M.A.L. Van Tilburg & A.J.J.M. Vingerhoets (Eds.), *Psychological aspects of geographical moves: Homesickness and acculturation stress* (pp. 197-212). Tilburg: Tilburg University Press.

tion was a predominant theme in interviews with 25 Polish migrants in the U.S. For instance, one of Arioan's subjects described the feeling as: "You have to divorce yourself from the past" (Aroian, 1990: 7). Brewin *et al.*, (1989) found a relation between self-reported dependency and homesickness, in a study among first-year psychology students. They concluded that anxious attachment and dependency on others is a risk factor for developing homesickness, because individuals with these characteristics tend to react intensely to all anticipated separations. Furthermore, many studies have shown a link between anxious attachment and/or dependency, on the one hand, and adult psychopathology, especially depression and agoraphobia, two syndromes associated with homesickness, on the other hand (e.g., Carnelley *et al.*, 1994; Gittelman & Klein, 1985; Pettem *et al.*, 1993; West *et al.*, 1993).

Interruption of life style

The interruption and discontinuity model is the second theoretical framework. This model features the view that interruption or discontinuity of life styles and routines may lead to feelings of anxiety, distress, and fear (Mandler, 1990). These negative emotions can be labelled as homesickness, when being away from home. Old routines, habits, and behaviourial plans become ineffective in the new situation; so, one cannot fall back on them. The person is unable to cope with the situation, because old plans still dominate the present behaviour, which is inappropriate in the new environment. Some support for this view is found in the literature on acculturation, where adjustment problems due to lack of knowledge of how to behave, and disruption of careers and educations are recurring themes (e.g., Aroian, 1990; Grove & Torbiörn, 1985; Juthani, 1992; Westermeyer *et al.*, 1983).

Reduced control

The third model focuses on reduced personal control or mastery over the environment. A move away from home nearly always results in reduction of control. A person does not know how to cope with the demands of the new situation and this results in increased perceived threat. Therefore, homesickness can be seen as a response to strain, created by changed circumstances over which individuals feel they have little or no control. This is in line with the notion that homesickness is best conceived of as a form of depression. The idea is that low control may lead to feelings of helplessness, which in turn are associated with depressive feelings.

Fisher (1989) has reported some support for this hypothesis in a study among first-year university students. It was found that homesick students differed from the non-homesick in terms of both perceived demands of university life and lower control over these threats and requirements. Burt (1993) also has

concluded, on the basis of results from a study among first-year students, that homesickness is a reaction to a lack of control over the environment. Because of the retrospective design of these studies, it can also be hypothesized that homesickness causes lack of control over the environment instead of the other way round. However, this is not very likely, because Lu (1990) found in Chinese students that perceived high social demands, within the two first weeks after arrival in the UK, were a significant predictor for homesickness after two months.

Role change and self-consciousness

Distress can also be assumed to originate from a transition which is accompanied by a change in perceived roles. In the new environment new tasks have to be fulfilled and as a consequence the self-concept needs to be changed, which may lead to raised anxiety. Unfortunately, until now there are no empirical data available supporting or rejecting this hypothesis.

Conflict

The last model proposed by Fisher (1989; 1990) refers to the potential conflict experienced by individuals leaving home. The homesick person is assumed to be torn between approach and avoidance tendencies towards the new environment. There is a conflict between the wish to acquire new experiences, while at the same time wanting to return home. Home is attractive because it is secure and comfortable, whereas new environments are challenging because of the new experiences and opportunities. It is hypothesized that this conflict may create anxiety and, if periods of anxiety are prolonged, homesickness.

Conclusion

These five models are not mutually exclusive. All factors may, to a different extent, contribute to the development of homesickness. How much influence each factor has depends on particular characteristics of the individual and the specific situation. Unfortunately, as already noted, the current homesickness literature generally is not theory driven and, therefore, does not specifically test the above mentioned theoretical explanations. Each of these models suggests certain characteristics of the person and the environment as crucial factors in the development and maintenance of homesickness.

Recent research

The psychological literature on homesickness is mainly directed at personal characteristics which predispose to homesickness and characteristics of the environment or situation. Below we will summarize the main findings.

Personal factors

It is generally believed that homesickness is more common among children than adults, and sometimes it has even been suggested that adults are not susceptible to it at all (Baier & Welch, 1992). Unfortunately, no data are available concerning the difference of prevalence between children and adults. Thijs (1992) found a considerable occurrence of youth histories, when adults were asked about their homesickness experiences. However, this outcome may actually be an overestimation, because adults, compared with children, generally have greater freedom to avoid situations that are associated with negative mood, including homesickness[3]. Moreover, children may feel very distressed when they are separated from their attachment figures, most often their parents[4]. As a consequence, children are often considered to be homesick, while they are actually experiencing separation anxiety.

Whether there are any sex-differences in the experience of homesickness is still unclear. Opposite results have been reported up to now. Fisher (1989), for instance, did not find sex differences in populations of school children, university students, and student nurses. Brewin *et al.* (1989) also reported that homesickness was equally prevalent among male and female students, although they also emphasized sex differences in coping with homesickness. Women were more likely than men to discuss their feelings with others, to look for cheerful company, and to try to find out if others feel the same. Gruijters (1992), on the other hand, found that women were more susceptible to homesickness than men. It remains to be established, however, to what degree such discrepancies are due to differences in sampling or measurement

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3 In an unpublished study Brouwers and Eurelings-Bontekoe found in a group of foreign employees of a Dutch firm, that the younger employees were more susceptible to homesickness than the older employees. It was also found that the homesick lived for a significantly shorter time in the Netherlands than the non-homesick. Unfortunately, they did not correct for duration of stay. Thus, the age difference could be due to the length of stay in The Netherlands.
Brouwers, E., & Eurelings-Bontekoe, E.H.M. (1998). Homesickness and demographic variables: The identification of risk groups. Submitted for publication.

4 In the study mentioned in note 1 it was found that parents, family, friends from home, and pets were missed most frequently by *all* children at summer camp, regardless of homesickness (intensity).

methodology. For example, women generally have higher scores on symptom checklists (e.g., Gijsbers-van Wijk & Van Vliet, 1989; Verbrugge, 1985). Whether or not gender differences are found, may therefore depend on the operationalization of homesickness, in particular on how many items refer to symptoms.

Differences between cultures in the occurrence of homesickness have not been studied systematically. As far as we know, the only studies on homesickness across cultures have been performed by Carden and Feicht (1991) and Hojat and Herman (1985). In the latter study no differences between Iranian and Filipino physicians in the US were found in means and standard deviations of scores on the item 'I feel homesick'. In a sample of 144 Turkish and American female first-year college students, attending universities in their own country, Carden and Feicht (1991) found that 19% of the American and 77% of the Turkish students could be classified as being homesick, which is a significant difference. Further studies, however, are needed before any definite conclusions can be drawn about cultural differences and the experience of homesickness.

Thus, it is not yet clear whether homesickness varies with gender, age, and culture. These issues are still open for examination. In spite of that, it is safe to say that homesickness is a disorder of all ages, cultures, and sexes.

Freedom of choice has been emphasized by Fisher (1989) as an important factor. If the choice to leave was made by persons themselves, then, according to Fisher, they will experience less homesickness compared with persons who were in some way obliged to leave their house and home. Indeed, Fisher found an effect of perceived level of responsibility in homesick university students, but not in boarding school children. According to Fisher (1989), this can be attributed to the absence of expectation of control over decisions in the latter group. Burt (1993), in a study among first-year Australian students, also found that perceived control regarding the decision to relocate was a significant predictor of the intensity of homesickness. Moreover, in refugees, who are in many ways obliged to leave their country, it has been found that feelings of hopelessness, helplessness and homesickness are very common (De Vries & Van Heck, 1994). For example, 53% of Khmer adult refugees reported feelings of hopelessness, which were extreme in 29% of the cases (Mollica *et al.*, 1994). There are at least two ways to interpret these findings. First, freedom of choice implicates controllability of the situation. If one is forced to leave, the situation will not be perceived as controllable. As a consequence, feelings of helplessness develop, which in the end result in homesickness. Alternatively, people who know, or anticipate, that they will easily develop homesickness, will presumably be less inclined to

move. So, their option for not leaving will result in a selection bias in study samples.

In a recent longitudinal study, it was shown that 'dependency on others' is another predictor of homesickness (Brewin *et al.*, 1989). This finding supports the linkage of homesickness to separation anxiety. Dependency on family and parents was also found to be a characteristic feature of homesick students compared with non-homesick students (Carden & Feicht, 1991).

Moreover, Fisher (1989) found in first-year university students substantial links between introversion, depression, and obsession, on the one hand, and homesickness, on the other hand. Introverts reported slightly more homesickness. Levels of depression and obsession were already heightened in homesick persons prior to leaving home, indicating the existence of a possible vulnerability factor.

Eurelings-Bontekoe *et al.* (1994) compared homesick military conscripts with normal controls and patients with psychiatric symptoms of a different nature. They reported the following characteristics of the homesick military conscripts: (a) high levels of rigidity, somatization, and introversion, (b) low levels of dominance and self-esteem, (c) a high need for social support, while at the same time lacking adequate social skills, and (d) from an early age onwards, homesickness experiences, problems with separation from parents, a strong emotional bond with parents, fewer or shorter vacations without parents or alone, and avoidance of dating and going out. Rigidity proved to be the best predictor of homesickness. It was shown that homesick conscripts clung to their old habits and were strongly attached to a regular life, tending to avoid new situations requiring adaptation[5].

With regard to self-esteem, contradictory results have been reported. For instance, Eurelings-Bontekoe *et al.* (1994) and Voolstra (1992) found lower self-esteem among homesick adults, whereas Fisher (1989) obtained no difference between self-esteem in homesick and non-homesick students. These findings possibly reflect cultural differences, or differences in the operationalization of homesickness and self-esteem. Besides self-esteem, dominance

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5 In two more recent studies a high prevalence of personality disorders among both males and females was found. Typically homesickness was associated with traits of the anankastic/obsessive-compulsive, dependent and avoidant/anxious personality disorders.
For details see Eurelings-Bontekoe, E.H.M., Duijsens, I.J., & Verschuur, M.J. (1996). Prevalence of DSM-II-R and ICD-10 personality disorders among military conscripts suffering from homesickness. *Personality and Individual Differences, 21*, 431-440; Eurelings-Bontekoe, E.H.M., Brouwers, E., Verschuur, M.J., & Duijsens, I.J. (1998). Prevalence of DSM-II-R and ICD-10 personality disorders among women suffering from homesickness. Manuscript submitted for publication.

was negatively, and neuroticism and social inadequacy positively related to homesickness in Voolstra's study (1992). Homesick women were also more rigid and discontented. Three further temperament variables, namely strength of excitation (SE), strength of inhibition (SI) (only for women), and mobility (MO), were negatively associated with homesickness. SE reflects the ability to react adequately during very long or very intense stimulation. High-scorers on SI can easily abandon the expression of socially unexpected or undesirable behaviour. They can also postpone their reactions, or suppress the expression of emotions, if that is required by the situation they are in. MO refers to the ability to react effectively to changes in the environment (Van Heck *et al.*, 1993). In a regression analysis, MO appeared to be the strongest predictor of homesickness (Voolstra, 1992).

Studies on acculturation have stressed the importance of coping or adaptation styles in mental and physical health of immigrants (e.g., Khoa & Van Deusen, 1981; Lin *et al.*, 1982; Mesxaros, 1961; Schmitz, 1992, 1994). Berry (1994) has distinguished the following four acculturation styles (a) *assimilation*, which means relinquishing one's cultural identity and moving into a new society, (b) *integration*, which implies some maintenance of the own culture and at the same time becoming an integral part of the new societal framework, (c) *segregation* or *separation* in which case no relations with the new society are entertained, while the original ethnic identity and traditions are maintained, and (d) *marginalization*, in which individuals lose contact with both their traditional culture and the new culture. It is generally acknowledged that each acculturation style can be experienced as stressful. Integration, however, is assumed to be the least stressful and the most effective strategy. The other adaptational strategies may cause several health problems. Although the relation between homesickness and acculturation styles has not explicitly been studied yet, it is tempting to speculate that persons employing a segregation or separation adaptation style are most likely to suffer from severe homesickness, because these persons continue to live mentally in their previous environment. However, Schmitz (1992; 1994) found no relation between these acculturation styles and depressive reactions in immigrants and foreign students.

Situational factors

Certain characteristics of the situation apparently promote the occurrence of homesickness. 'Geographical distance' is such a factor, but its role in the development of homesickness is not yet clear. Fisher found opposing results in university students (Fisher *et al.*, 1985) and boarding school children (Fisher *et al.*, 1986). Whereas in the group of students the average distance to home was significantly higher in the homesick group compared with the

non-homesick group, no significant differences were found in the group of school children. Other factors like psychological distance, opportunities for communication with the home base, and similarity of environment appear to moderate the effect of geographical distance.

Gruijters (1992) presented 12 hypothetical situations to subjects and asked them to indicate the intensity of their homesickness, if they would find themselves in such an situation. The 12 situation descriptions differed systematically in terms of distance (nearby *vs.* far away), length of stay (short *vs.* long), and companionship (alone *vs.* with acquaintances or close persons). It was not surprising that the situation 'nearby, short, with trusted persons' was indicated as arousing the least homesick feelings and 'long, far away, and alone' the most. More interesting, however, was the observation that length of the stay and type of companionship were of more importance than distance. Thus, the results of this study suggest that the risk of becoming homesick increases, if (a) there are no trusted persons, or worse, no companions at all in the new situation, and (b) the length of the stay away from home increases.

If the environmental demands are high, then there is a good chance of developing homesickness. Percy, a military surgeon in the seventeenth century, observed that the cases of homesickness increased significantly as soon as the French armies suffered reverses and were no longer victorious (Rosen, 1975). However, under the same situational demands not all individuals develop homesickness. 'Perception of the demands' and 'perception of control over the demands' are two factors which have been shown to be of the utmost importance in the development of homesickness (Fisher, 1989; Lu, 1990).

Social support is a factor that has been shown to diminish the stressfulness of various problematic situations (for an overview, see Alloway & Bebbington, 1987; Sarason *et al.*, 1990). Thus, more social support should be associated with less homesickness. This is in line with the results of Eurelings-Bontekoe *et al.* (1994), which demonstrate that seeking social support is a preferred coping strategy for homesick conscripts although they lack the social skills to acquire it. Nevertheless, social support might also have a negative influence. Several studies have shown that homesick persons are inclined to affiliate with other persons who have similar or relevant experiences (Brewin *et al.*, 1989; Fisher, 1989; Porritt & Taylor, 1981). These contacts can intensify the homesickness through modelling and positive reinforcement. Indeed, Fisher (1989) found that the presence of a sibling in boarding school led to more severe rather than to less intense homesick complaints. These children might 'infect' each other. Burt (1993), on the other hand, failed to find differences

in the intensity of the homesickness for those first-year students who relocated alone and those who came with a friend.
Another way to find out about the circumstances is to ask for a description of situations in which feelings of homesick have occurred, as Thijs (1992) did among a group of Dutch adults. Holiday experiences were most often mentioned (20%), especially when these were disappointing for some reason (e.g., arguments with fellow travellers). The second category concerned a longing for bygone days or the future, or a discontentment with the present (18%). Furthermore, youth experiences (12% for stay overs and 10% for boarding school) and specific references to persons who are missed (8%) were mentioned. A residual category consisted of hospital experiences, moves, etc.

Fisher's multi-causal model of homesickness

On the basis of the above it can be concluded that little is known about the exact relation of specific personal and situational factors to homesickness. In addition to the wide variety in definitions, the relevant literature is rather fragmented, and virtually no replication studies have been done. Furthermore, there is no trace of an integration of the findings into a comprehensive, all embracing theoretical model. Fisher (1989) was the first to attempt to summarize a number of the following key findings into a multi-causal model. According to this model, homesickness is a complex syndrome associated with distress, psychoneurotic symptoms, absent-mindedness, intrusive home-related thoughts, dissatisfaction with the new situation, high demands of and low control over the new situation, low decisional control over the move, and depressive feelings before the move. It occurs in 50-70% of most populations and is independent of age and sexe. Only in severely homesick individuals the homesickness experience is continuous; otherwise it occurs in episodes, mostly in the morning and the night and during passive and mental tasks.
These observations led to the formulation of a descriptive, composite model of homesickness. In this model a two-part challenge is reflected: (a) the separation from the familiar environment and (b) the entrance into the new setting. Separation from home can be accompanied by perceived loss, interruptions of plans, and withdrawal which leads to psychological disruption and compulsive ruminative thoughts about home. At the same time the confrontation with the new environment can give rise either to strain and dissatisfaction or to commitment. These strains and dissatisfactions may lead to compulsive ruminations about home, whereas commitment to the new environment

ensures that the person is challenged by it and looks out for more information and new experiences. Commitment can block the psychological disruption due to leaving home. Information from the new environment competes for attentional resources with ruminations about home. Thus, if the degree of commitment is high, information concerning the new environment competes successfully with homesick thoughts, resulting in successful adjustment and adequate adaptation to the new situation. In contrast, those who are unable to become committed to a satisfactorily degree, are more likely to become homesick.
So, both separation from the old home environment and the experience of the new environment are regarded as important factors in the development of homesickness[6]. What is lacking in the model, however, are factors that determine the intensity of the feelings associated with both the new and the old environment. In addition, neither the specific elements of the old environment that cause the distress (e.g., persons or the physical environment), nor the personal characteristics of homesick-prone persons are addressed.

Methodological issues

Assessing the presence and intensity of homesickness objectively is problematical. The major problems concern criterion validity, because there are no clinical criteria for diagnosing homesickness. Furthermore, interpretation of test-retest reliability coefficients is not easy. The homesickness phenomenon is not likely to be stable, gradual adaptation to the new environment decreases the intensity of the homesickness; sometimes to such an degree that it ceases to exist. Stressors, on the other hand, may reactivate or intensify these feelings. Thus, low test-retest reliability coefficients can be due to low reliability of the test or to recovery of homesickness.
Despite of these methodological difficulties, three homesickness questionnaires have been developed which seem to have satisfactory reliability and validity. The Dundee Relocation Inventory (DRI; Fisher, 1989) measures homesickness following the transition from home into residence at school or university. It consists of 24 items referring to cognitions and feelings concerned with missing home, and two dummy questions. The test-retest reliability of the DRI was 0.59 across two weeks and 0.21 across six months in homesick university students, whereas these values for the non-homesick were 0.71 and 0.81, respectively. Data from a study among boarding school children provided support for the content validity of this instrument, but obviously more data are needed. A major drawback of the DRI is that it is specifically developed to measure homesickness in students and school children. Therefo-

re, in its present form it cannot be applied in other contexts like moves, migrations, hospital admittances, and holidays[6].

Eurelings-Bontekoe *et al.* (1994) developed a Homesickness Decision Tree (HDT) to identify the presence of homesickness. This questionnaire is composed of nine items, covering cognitions as well as symptoms. It is partly derived from the criteria for a major depression in DSM-IV (1994). In a study among military conscripts, it was established that identification of homesickness on the basis of the HDT has a considerable overlap with clinical judgments of homesickness, suggesting good construct validity (Fontijn, 1990). Unfortunately, no data are available concerning the reliability of the instrument. However, until now it is the only instrument that is able to distinguish the homesick from the non-homesick in a broad variety of situations.

The third instrument is a 29-item questionnaire to measure the vulnerability to develop homesickness (Eurelings-Bontekoe *et al.*, 1995). Five subscales are defined: Extraversion, Dominance, Rigidity, Earlier Homesickness Experiences, and Assertiveness. The internal consistency of these scales range from 0.62 to 0.86. Homesick conscripts, classified on the basis of clinical judgments, differed significantly from conscripts suffering from other psychopathology and healthy controls on all the five scales. In addition, applying discriminant analysis, 74% of the homesick could be classified correctly when compared with the psychopathology group, and 83% when compared with healthy controls[7].

To conclude, further research should deal more adequately with assessment issues and the definition of homesickness. Especially in children the danger

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6 Smrcek and Stiksrund, examined Fisher's model in a sample of 183 freshman. They factor analyzed an adapted form of the Dundee Relocation Inventory (Fisher, 1989). The factor analysis revealed five factors: Missing, Satisfaction, Loneliness/commitment, Achievement, and a Residential factor. They concluded that the resulting factors of this German version of the DRI are comparable to the structure found by Fisher. In addition, the authors felt that each of the five factors can be classified as either being caused by the new or the old environment. Therefore, they concluded that the results support Fisher's multi-causal model of homesickness.
This study is published in: Smrcek, M.A., & Stiksrud, H.A. (1994). Commitment and homesickness during post-adolescence. *Studia Psychologica, 36*, 211-221.

7 Results from a recent study among homesick females were highly similar to those found among homesick male conscripts. Almost similar subscales appeared with comparable discriminant power, except for Dominance which did not seem to play a role in homesickness for women.
For details see: Eurelings-Bontekoe, E.H.M., Tolsma, A., Verschuur, M.J., & Vingerhoets, A.J.J.M. (1996). Construction of a homesickness questionnaire using a female population with two types of self-reported homesickness: Preliminary results. *Personality and Individual Differences, 20*, 415-421.

exists that one actually focuses more on separation anxiety than on homesickness. But, also in adults adverse aspects of the new situation may activate the attachment system resulting in an intense desire to go home, but without the ruminative thoughts and obsession with home characteristic of the homesick.

Interventions

The possibilities for intervention appear to be rather limited. What strikes one most in the spare literature on help for the homesick (Chartoff, 1975; Dijkstra & Hendrix, 1983; Fisher, 1989; Hamdi, 1974) is that often only returning to the old home environment brings real relief. Several other strategies and interventions have been proposed, but until now none have been adequately tested empirically[8].

Fisher (1989) has proposed a stress-management therapy for the homesick, directed at the expression of feelings and the formation of commitment to the new environment. Expression of feelings through writing has been proven to be beneficial for college freshman (Pennebaker *et al.*, 1990). Hamdi (1974) and Taylor (1986) also have suggested that expression of feelings can be helpful to the homesick. Furthermore, reassurance, sensitivity to the problems of the homesick, ego enhancement, and contact with family members (either by telephone or visits), have been proposed to help the homesick child. Chartoff (1975) has reported some success with Rational Emotive Therapy (Ellis, 1957; Ellis & Grieger, 1986) in reducing homesickness in

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8 In order to design successful interventions for the homesick, it is important to know how people cope with their homesickness, and what are (in)effective coping strategies. Thurber and Weisz investigated coping with homesickness in children in two recent studies. It was found that multiple methods for coping with homesickness were frequently used. Nearly every child mixed primary and secondary control to cope with their homesickness; secondary control was, however, largely favoured over primary control. The most common way to cope was to do something fun in order to forget about homesickness. Relinquishing control by simply emoting or anxiously ruminating was least effective in reducing homesickness and promoting adjustment.
See the following studies for more details: Thurber, C.A., & Weisz, J.R. (1997). Describing boys' coping with homesickness using a two-process model of control. *Anxiety, Stress, and Coping*, *10*, 181-202. Thurber, C.A., & Weisz, J.R. (1997). "You can try or you can just give up": The impact of perceived control and coping style on childhood homesickness. *Developmental Psychology*, *33*, 508-517. Thurber, C.A. (1997). Children's coping with homesickness: Phenomenology and intervention. In: M.A.L. Van Tilburg & A.J.J.M. Vingerhoets (Eds.), *Psychological aspects of geographical moves: Homesickness and acculturation stress* (pp. 143-164). Tilburg: Tilburg University Press.

youngsters. More effective, however, were telephone calls, that is, allowing youngsters to speak for five minutes to their parents. In Chartoff's study, parents were instructed to express understanding, but to deny permission to come home. Porritt and Taylor (1981) have suggested that exploration of other problems and support in resolving them might reduce the need to cling to old attachments, and demonstrated that behaviourial techniques, e.g., thought stopping and time-outs for worry can give some relief. Furthermore, they suggested that the use of fantasized conversation with support figures. Finally, Dijkstra and Hendrix (1983) have distinguished three goals for intervention in homesick conscripts: (a) to alter the situation (e.g., by sending them home), (b) to enhance the adjustment abilities of the conscripts (e.g., by training assertive behaviour), and (c) to dispel the homesickness through psychotherapy. Unfortunately, it is not made clear by these authors what this therapy exactly implies[9]

Because of the scarce knowledge of the effectiveness of intervention techniques, we have to limit ourselves to emphasizing the following points:

1 Homesickness occurs frequently among both children and adults. It is often perceived as socially undesirable, which frequently leads to feelings of shame and withdrawal. Therefore, it is important to create more acceptance of these particular feelings. Then, homesick people will no longer be reluctant to express their feelings, which leads to more social support. In addition, homesick individuals are no longer urged to 'hide' themselves, which obviously interferes with explorations of the new environment.
2 It is important to create involvement and a certain degree of commitment with the new environment. Exploration has to be stimulated and the individual has to be intrigued by appealing aspects of the new behaviourial context.
3 Active and physical activities, like sports, games, museum visits, etc., take one's mind of things. In contrast, passive and mental activities (e.g., reading) cannot compete very well with the feelings of homesickness.

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9 Eurelings-Bontekoe argued that an appropriate treatment should combine psychodynamic and behavioral aspects and should aim at: (1) confrontation with, tolerance for, and integration of negative feelings, (2) confrontation with the defensive character of idealization, (3) clarification of cognitive beliefs about dependency and control, (4) increasing social skills and social contacts, and (5) increasing self-esteem and autonomy.
See Eurelings-Bontekoe, E.H.M. (1997). Homesickness, personality and personality disorders: An overview and therapeutic considerations. In: M.A.L. Van Tilburg & A.J.J.M. Vingerhoets (Eds.), *Psychological aspects of geographical moves: Homesickness and acculturation stress* (pp. 197-212). Tilburg: Tilburg University Press.

4 For critical moments, e.g. unavoidable passive situations as eating and going to sleep, it is important that both potential sufferers and accompanying persons anticipate these situations and are aware of these 'high risk' moments.
5 Homesick individuals have a high need for social support. However, they often lack the appropriate skills to acquire it. Learning new social skills and training assertive behaviour is therefore of the utmost importance.
6 It is important to scrutinize the cause of the homesickness experiences, because different causes may require different interventions. For example, if the adversity of the new environment is the major cause of homesickness, then skills to cope more adequately with the new environment and direct manipulations of problematic situations should be the core of the intervention program. If, however, missing the old environment or significant persons is the major cause, then, other approaches will be more appropriate.

Conclusions

In spite of the confusing literature and the lack of a clear definition, there is a strong agreement that homesickness is a psychological state that is primarily centred on a preoccupation with the home environment. This state is accompanied by specific physical, cognitive, emotional, and behaviourial reactions. Until now, psychologists have not paid much attention to homesickness. It turns out that there are firm associations with personal characteristics, like rigidity, neuroticism, and lack of self-confidence. Furthermore, homesick persons seem to have a strong need for social support, but they lack social skills to acquire it. The latter finding offers a lead for possible psychological interventions.
Distance from home proved to be of less importance than length of the stay and the presence of acquaintances or familiar persons. In addition, freedom of choice over the move reduces the likelihood of becoming homesick. These findings suggest that the occurrence of homesickness feelings in situations like a hospital admittance, cannot be precluded. Serious forms of homesickness may hamper recovery (Baier & Welch, 1992) and an intervention or even replacement into the home situation might be necessary[10].

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10 In Leicester and innovative project is aimed at preventing hospital admissions for people aged 55 and up, because it is believed that people recover more quickly at home than they do in hospitals, particularly the elderly. The project 'Hospital at Home' is being evaluated by the university of Leicester, but no results are available yet. The staff feels that the

More in-depth research of the above-mentioned aspects is needed. However, it is important to focus future research first of all on a conceptual analysis of homesickness. The relation with other syndromes, e.g., separation anxiety, agoraphobia, adjustment disorder, nostalgia, etc., should be made explicit. Then, it should be explored whether different forms of homesickness with different symptomatology and aetiology can be distinguished.

Furthermore, it is of utmost importance to develop instruments by which the presence of homesickness and the kind of homesickness can be identified. Eurelings-Bontekoe *et al.* (1994) were the first to develop a questionnaire for homesickness applicable in a broad variety of situations. Although the specificity of this instrument can be further improved, it nevertheless might be worthwhile to use this questionnaire in all future research regarding homesickness, in order to attain a more unequivocal and standardized operationalization of the concept.

As soon as homesickness is clearly defined and can be diagnosed on the basis of self-report instruments, the following questions have to be studied: (a) what is the role of personal factors like temperament, coping styles, and social skills in homesickness?; (b) What is the role of homesickness in the psychological adaptation to new environments? Is it the result of unsuccessful adaptation or does unsuccessful adaptation promote feelings of homesickness?; (c) What factors aggravate or alleviate the homesickness intensity?; (d) How stable and consistent is the occurrence of homesickness over different types of situations like hospitalizations, holiday trips, etc.?; and (e) What is the exact role of somatic complaints in the development and/or maintenance of homesickness and what is the impact of homesickness on physical well-being? Furthermore, we recommend attention being paid to psychobiological factors. The systematic study of these factors should be embedded into the existing theoretical frameworks, which have been developed within the context of modern stress and emotion research. Only then it might be expected that real progress can be made and more insight can be obtained into this highly intriguing, but regrettably neglected phenomenon.

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3 The psychological context of homesickness

Miranda A.L. Van Tilburg

Introduction

Homesickness is studied and discussed in relation to all kinds of variables and in a variety of situations. A central question that remains concerns the nature of homesickness. Studies have shown that everybody has an intuitive idea about homesickness and how it is experienced. Many of us can even draw from personal experiences with this psychological state. Throughout history it has also been subject of many poets and writers. The first written accounts of homesickness can be found in the Bible, Psalm 137: "By the rivers of Babylon there we sat down, yeah wept when we remembered Zion" and in Homer's description of Ulysses who was weeping and rolling on the floor when he was thinking of home. From the 17th century onward systematic (case) studies of homesickness have been reported, although they are sparse. For instance, one case described by the 17th-century Swiss physician Johannes Hofer (cited in Rosen, 1975) is of a young man who was lying on his death-bed when homesickness was diagnosed. When he was sent home his condition improved immediately. Another illustration is the case, described by Jaspers (1909), of a 16-year-old maid who starts fires in four places in order to destroy the house. As a consequence she would be useless to the lady of the house and be sent home.

These personal accounts, in either prose or case studies, probably do not do justice to the very different manifestations of homesickness. However, insight into the psychological context of homesickness is very important for the generation of hypotheses. Furthermore, it is helpful in distinguishing homesickness from other more or less related concepts like nostalgia, depression and separation anxiety. The current scientific literature is rather slim and scattered. Therefore, in this chapter I will integrate these findings and discuss the nature of homesickness and the corresponding reactions. However, first homesickness will be differentiated from related concepts like nostalgia and grief.

How does homesickness relate to other concepts?

Homesickness is an emotion which is felt after leaving house and home and is characterized by negative emotions, ruminative cognitions about home,

and somatic symptoms. The question is how this feeling can conceptually be distinguished from related emotions and syndromes like nostalgia, separation anxiety, school phobia, grief, depression, adjustment disorder, agoraphobia, depletion anxiety, claustrophobia, and topophilia. In this section homesickness will be compared with each of these concepts and resemblances and differences will be highlighted.

Nostalgia

Nostalgia is a literal translation of the German 'Heimweh' into Greek and was first introduced by Hofer (cited in Werman, 1977). The two terms are often used interchangeably the by non-expert as they bear great resemblance. Also, some authors regard homesickness and nostalgia as the same phenomenon (Rosen, 1975; Zwingmann, 1973a, b). However, in a stricter sense they are conceptually different (Werman, 1977). Nostalgia is a yearning or longing for bygone days. In the Oxford Dictionary (1989) it is defined as 'a sentimental longing for things that are in the past.' Homesickness, on the other hand, is defined as 'sadness because one is away from home' (*Oxford Advanced Learner's Dictionary*, 1989). The homesick longings for returning to an existing home place and reunion are, at least theoretically, possible. In addition, homesickness is associated with overwhelming sadness and a negative mood, while the affective coloration of nostalgia can best be described as bittersweet, including both joy and sadness (Werman, 1977).

Separation anxiety and school phobia

In DSM-IV (*American Psychiatric Association*, 1994) separation anxiety and school phobia are described as youth disorders. Separation anxiety is defined as an excessive anxiety concerning separation from attachment figures.

School phobia refers to a fear and avoidance of school. In DSM IV homesickness is included as one possible manifestation of separation anxiety. Thus, in both homesickness, separation anxiety and school phobia the child is extremely upset after separation and longs for his or her mother. Therefore, it is very difficult to make a differentiated diagnosis. The concepts can be distinguished on the basis of the kind of separation situation that evokes the feelings of fear and avoidance. The phobic child is fearful of and avoids *school* alone. The separation-anxious child is fearful of and avoids a host of situations related to *separation from an attachment figure*. The homesick child is characterized by fear and avoidance of situations related to *separation from home*. The problem is that, practically, separation from home and from attachment figure often go together.

Baier and Welch (1992) performed a conceptual analysis in order to distinguish homesickness from related concepts such as separation-anxiety and

school phobia. These authors state that separation anxiety is a more serious condition than homesickness: "... homesickness could be present with any one of the DSM-III-R criteria for separation anxiety enumerated under 'A. Excessive anxiety ...,' but three additional criteria would be necessary for a diagnosis of separation anxiety" (p. 58). Furthermore, school phobia is differentiated from homesickness in that school phobia is an emotionally paralysing condition while homesickness is not, according to these authors.

Grief

Grief is an emotional pain or anguish one feels after the loss of a loved one. Bowlby (1980) indicated that after a loss of an attachment figure the person moves through four phases: (1) numbing, unbelief and outbursts of intense distress; (2) yearning and searching for the lost person; (3) disorganization and despair; and (4) reorganization. A move implies multiple losses of persons and objects like house, places of emotional significance, possessions, friends and family, jobs, roles, etc. Thus, homesickness can be conceived of as a grief-like reaction to losing home. Especially Bowlby's (1980) second phase, yearning and searching, bears many resemblances to homesickness.
Fisher (1989) concludes that grief and homesickness are similar in that they are both very specific manifestations of distress associated with a known cause, i.e., a loss. The only way the two concepts can be distinguished is on the basis of the nature of the loss and the associated cognitions. Grief is felt after the loss of a beloved *person*. Missing the deceased person and longing for reunion with this person are associated cognitions. Homesickness, on the other hand, is experienced after leaving home, which is why cognitions are centered on missing home and longing for reunion with home. Leaving home is, however, a reversible loss. Home does not cease to exist and can be contacted, either symbolically or by visits.

Depression

The essential feature of a major depressive episode in DSM-IV (American Psychiatric Association, 1994) is either a depressive mood or the loss of interest in nearly all activities. Other criteria are: weight loss or decrease or increase in appetite, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness or excessive guilt, diminished ability to think or concentrate, recurrent thoughts of death or suicide. All these symptoms have been observed in the homesick as well. Therefore, homesickness is often considered to be a reactive depression to leaving home (e.g., Baier & Welch, 1992; Eurelings-Bontekoe, Vingerhoets, & Fontijn, 1994; Fisher, 1989). Characteristic of the homesick, as opposed to the depressed, are the ruminative and obsessive thoughts about home and the desire

to return home. As there are no generally accepted criteria for the diagnosis of homesickness, many homesick adults are being diagnosed as depressed. Whether therapy for depression is also helpful for the homesick has not been systematically evaluated until now.

Adjustment disorder

Homesickness is related to adjustment disorder. According to the DSM-IV (American Psychiatric Association, 1994) criteria, adjustment disorder is a maladaptive response to an identifiable psychosocial stressor occurring within three months and remitting within six months of the termination of the stressor. The reaction must be in excess of a normal and expectable reaction to the stressor(s) and/or it has to impair school or work performances and hinder social activities or interpersonal relationships. Six subtypes have been distinguished which characterize the predominant symptoms. Severe homesickness may be seen as a particular form of two of these subtypes, namely *adjustment disorder with depressed mood* or *adjustment disorder with physical complaints*, when two other conditions are fulfilled, namely being away from home (the stressor) and thinking a lot about home. But if homesickness is not severe enough to hamper daily activities like work and social activities then, according to DSM-IV criteria, homesickness has to be viewed as a *normal* reaction to being away from home. Homesickness can both be labelled as an *acute adjustment disorder* (remittance of symptoms within six months), in the case of persons whose homesickness feelings disappear or persons who return within six months, and as *chronic adjustment disorder* (persistence of symptoms for six months or longer) in cases of severe homesickness.

Agoraphobia

Homesickness also shares some characteristic features with agoraphobia. Agoraphobics fear being in places or situations from which escape might be difficult (or embarrassing), or in which help might not be available, in the event of sudden incapacitation or panic attack. (DSM-IV, APA, 1994). In DSM-IV, a distinction is made between agoraphobia with and without a history of panic disorder. Common agoraphobic situations include being outside home and travelling, which are also common homesick situations. In addition, Fyer (1987) classifies the multiple fears and avoidance behaviors of agoraphobics in: fear of leaving home, fear of being alone, and fear of being away from home. Anxiousness and distress in these situations can either be labelled as agoraphobia or as homesickness. Homesick women have been reported to develop fear-of-fear like cognitions, characteristic for panic disorder with or without agoraphobia (Van Tilburg, Vingerhoets, Kirschbaum, & Van Heck, 1996). However, the homesick do not fear incapacitating or em-

barrassing symptoms like loss of bladder control, becoming dizzy, fainting, etc., rather they fear the homesickness itself (Van Tilburg, Vingerhoets, Kirschbaum, & Van Heck, 1996). Furthermore, agoraphobia is rare in children (Tearnan, Telch, & Keefe, 1984), while homesickness is quite common in children. In addition, the homesick have not been reported to fear being alone. Thus, although agoraphobia and homesickness have much in common they are conceptually distinct syndromes.

Depletion anxiety

Verwoerdt (1976, 1980) distinguished three types of anxiety in the elderly: (1) primary anxiety, in response to an overwhelming influx of stimuli; (2) secondary or depletion anxiety, referring to the anticipation of loss of external supplies; and (3) tertiary anxiety, signalling unacceptable impulses or fantasies. Secondary or depletion anxiety is developmentally related to separation anxiety according to Verwoerdt. The anxiety arises due to anticipation of loss of external supplies or object loss and the possibility of isolation and loneliness. This depressive, helpless kind of anxiety is often precipitated or exacerbated by a loss or an environmental change. Thus, homesickness can be conceived of as a special case of depletion anxiety due to the anticipation of losing home. However, depletion anxiety has only been described in the elderly, while homesickness is a psychological state experienced in all age groups.

Claustrophobia

Claustrophobia is an abnormal fear of being in an enclosed space (*Oxford Advanced Learner's Dictionary*, 1989). Claustrophobia is classified under specific phobia, situational type in DSM-IV (American Psychiatric Association, 1994). The diagnosis of a specific phobia is appropriate when there is avoidance, fear, anxious anticipation of encountering the phobic stimulus, interference with daily routines and recognition that the phobia is excessive or unreasonable. In a study among homesick women (Van Tilburg, Eurelings-Bontekoe, Vingerhoets & Van Heck, 1998) it was found that claustrophobia coincides with homesickness. Not only do many homesick women report being claustrophobic, the intensity of the claustrophobic feelings seem to vary with the intensity of the feelings of homesickness also. In the homesick the enclosed spaces are feared because escape is difficult or impossible. They express the need to be able to go home whenever they want to. This need is expressed for example by fearing an unknown room when doors en windows are closed because this will hamper their return home. The fear of not being able to return home in enclosed spaces is sometimes transferred to enclosed spaces in home. Thus, it is as if home has to be near and accessible

for the homesick all the time even when being away from home for only a few minutes. Characteristic claustrophobic situations in the homesick are public transport, unknown rooms, crowds, and elevators.

Topophilia

Tuan (1974) described the topophilic sentiment in his book *Topophilia: A study of environmental perception attitudes and values*. Topophilia refers to the affective ties of human beings with their material environment. According to this author the environment can become a carrier of emotionally charged events or the environment can be perceived of as a symbol. In these cases the topophilic sentiment will be very strong. We then say we are attached to a place. Attachments to surrounding develop naturally. Tuan states: "Beyond clothing, a person invests bits of his emotional life in his home, and beyond the home in his neighborhood. To be forcibly evicted from one's home and neighborhood is to be stripped of a sheathing, which in its familiarity protects the human being from the bewilderments of the outside world" (p. 99). Thus, the topophilic sentiment can be an origin of feelings of homesickness. Homesickness is evoked when people leave the surroundings which they are extremely attached to.

The homesickness experience

Thus, on the basis of the above it can be concluded that homesickness is conceptually distinct from related emotions and syndromes. Here, I will turn to the homesickness experience itself. The discussion will be guided by a model of the emotion process as developed by Scherer (1986). This model consists of four interrelated aspects: (1) the antecedent situation, (2) the person, (3) the response and reactions, and (4) social regulation and control. The discussion will be based upon knowledge drawn from the literature as well as from an unpublished study of our research group[1]. In this study 229 homesick women filled out a questionnaire designed to explore several dimensions of the homesickness experience, namely, antecedents, reactions, symptoms, coping and control processes, and causes (derived from Aebischer and Wallbott, 1986). The questionnaire was partly based upon Wallbott and Scherer's (1986) questionnaire for studying emotional experiences. The subjects com-

1 See chapter 7 in this book for details on this study.

pleted the questionnaire referring to the last time they were in a homesickness situation.

The antecedent situation

The antecedent situation is incorporated into the definition of homesickness. Specifically, homesickness is considered to be a reaction to having left one's home. Thus, the antecedent situation is the transition from an old familiar environment to a new situation/environment. Which of these two situations, the new or the old, causes the homesickness feelings? Fisher (1989) suggests that both difficulties in separating from the old environment and difficulties in adapting to the new environment can elicit homesickness feelings. However, unpublished data from our own research suggests that difficulties with the new environment might not be a major cause or even sufficient condition for the development of homesickness[1]. In contrast, it appears to be the separation from the old environment that elicits the homesickness. For example, our data indicate that homesickness is a *direct* reaction to the separation from home[1]. Most subjects in our study felt homesick before they have had time to explore the new environment. In addition, quite a large number of these subjects were in pleasurable holiday situations with their families and still developed severe homesickness. Moreover, we have recently described a phenomenon we called 'anticipation homesickness' which is experienced before having left the old environment (Van Tilburg, Vingerhoets, Kirschbaum, & Van Heck, 1996). The obsessive thoughts about and the focus on the old environment of the homesick inhibit and interfere with the exploration of and adaptation to the new environment.

As homesickness is a reaction to leaving a familiar environment, it is generally studied in those who have to leave their homes like, conscripts (Bergsma, 1963; Dijkstra & Hendrix, 1983; Eurelings-Bontekoe *et al.*, 1994), migrant populations and refugees (e.g., Eisenbruch, 1990; Hertz, 1988; Hojat & Herman, 1985; Larbig, Xenakis, & Onishi, 1979; Schmitz, 1994), non-resident students, student nurses and boarding school children (Brewin, Furnham, & Howes, 1989; Carden & Feicht, 1991; Fisher, 1989; Fisher *et al.*, 1984, 1985, 1986; Fisher & Hood, 1987, 1988; Miller & Harwell, 1983; Porritt & Taylor, 1981), and institutionalized people (Taylor, 1986).

One intriguing question concerns the most frequent types of antecedent situations in homesickness. Thijs (1992) asked a group of Dutch adults to describe the situations in which they had ever been homesick. Holiday experiences, stay overs and boarding school were mentioned most frequently. Furthermore, in our study among homesick adult women we also found moves and

holidays to be the predominant homesickness eliciting situations. When moving or on holiday, one does not have to leave behind those who are most close and intimate like partner and children. It was found that only 15% reported to be alone in the homesickness situation, indicating that separation from attachment figures does not play a causal role in homesickness. Separation can, however, aggravate the homesickness. Family can give support when in a stressful situation, thereby alleviating the homesickness a little bit. In addition, leaving one's family behind also implicates a greater change in habits and way of living, which can be an important facilitating factor in homesickness.
In the same study it was found that geographical distance does not play a role in the development of homesickness. For about 6% of the cases the old situation was within walking distance ($\leq$ 5 kilometers). Most women in a homesickness situation were, however, not able to return home untimely even when on a holiday. If one does not go back to the old environment at all the homesickness usually fades away after some time. Yet, there is no guarantee for curing, because homesickness can last a life time. One women in our study indicated to have been homesick for 58 years.

The person

People differ in their reaction to leaving home for longer or shorter time periods. Some people are thus more prone or vulnerable to developing homesickness than others. From several studies (see for an overview Eurelings-Bontekoe, Van Heck, Vingerhoets, Voolstra, Gruijters, Thijs, & Van Tilburg, 1997) and data of our own research group, it emerged that rigidity is especially important for the development of homesickness. Rigidity causes strong attachment to regular life and an aversion of new situations. Rigid people thus have more difficulties in separating from an old environment and entering a new environment, which means that there is more of a risk for them to become homesick. For the interested reader I refer to the previous mentioned studies. Here, I will focus on biographical variables.
Homesickness is generally thought of as being more common among children than adults. Baier and Welch (1992) even suggested that adults are not susceptible to homesickness at all. However, there is ample evidence of homesickness in adults, like conscripts (Bergsma, 1963; Dijkstra & Hendrix, 1983; Eurelings-Bontekoe *et al.*, 1994) and adult migrants and refugees (e.g., Eisenbruch, 1990; Hertz, 1988; Hojat & Herman, 1985; Larbig, Xenakis & Onishi, 1979; Schmitz, 1994). Unfortunately, no data are available concerning the difference of prevalence between children and adults.

Results on gender differences with respect to homesickness have been mixed. Fisher (1989) failed to find any sex differences. Brewin *et al.* (1989) reported sex differences in coping with homesickness and Gruijters (1992) in the prevalence of homesickness. This issue requires more investigation, taking into account differences in sampling and measurement methods, and differences in culture.

Cultural differences have not been studied systematically. Hojat and Herman (1985) found no cultural differences between Irian and Fillipino physicians in the US in the prevalence of homesickness. In contrast, Carden and Feicht (1991) reported greater prevalence figures of homesickness among Turkish than among American first-year students attending universities in their own country.

Thus, until now there is no reason to assume that homesickness is not a universal phenomenon given that homesickness is experienced in all age groups, genders, and cultures. Which biographical variables then do differentiate between people with and without homesickness? Eurelings-Bontekoe *et al.* (1994) found youth histories to be important. Homesick conscripts were characterized by from an early age onwards, a history of homesickness experiences, problems with separation from parents, fewer and shorter vacations without parents or alone, and avoidance of dating and going out.

A final issue is the role of family background. There is now some evidence from unpublished studies of our own and others (for instance, see the Eurelings-Bontekoe, 1997; and Hannigan, 1997) that attachment issues might play an important role in the development of homesickness. Insecure attachment to care-givers can make one more vulnerable to homesickness. Insecurely attached persons experience great anxiety when separated from their attachment figure and long desperately for reunification with the attachment figure. This anxiety can be expressed in terms of feeling homesick because one longs to return home in order to reunite with the left-behind attachment figure. In addition, the image of the attachment figure as inconsistently responsive can be transferred to the home environment, thereby establishing an insecure attachment to the home environment resulting in intense longing for home and anxiety when separated from home. Until now, the exact relation between insecure attachment and homesickness is still unclear, however. In DSM-IV (American Psychiatric Association, 1994) homesickness is incorporated in the description of separation anxiety, a youth disorder related to attachment problems.

Response/Reactions

Both characteristics of the antecedent situation and person characteristics determine the intensity and nature of the emotional reaction. A reaction pattern includes cognitions, physiological symptoms, behavioral tendencies, and subjective feelings. I will discuss these separately.

Cognitions
At the cognitive level missing home, obsessional thoughts about home, aversion to and negative thoughts about the new environment and absent-mindedness are reported (for an overview of the literature see Van Tilburg, Vingerhoets, & Van Heck, 1996). Attention is not primarily directed at problems at home, but rather at idealizing home. These cognitions characterize the homesick best. Therefore, it is only on the basis of these cognitions that homesickness can best be distinguished from related concepts like nostalgia and depression.

Physiological symptoms
A diverse palette of minor aches and vague complaints associated with homesickness have been described (Van Tilburg, Vingerhoets, & Van Heck, 1996). The most frequently reported physical symptoms are: stomach and intestinal complaints, sleep disturbances, appetite loss, headache, fatigue and a 'funny feeling' in the legs. We found crying to be one of the most common reactions to homesickness in our group of adult females, which is remarkable because it has never been reported in previous studies on homesickness. Furthermore, not only minor aches were reported as a manifestation of homesickness but also some more severe clinical pictures, for instance binge eating, suicide attempts, tightness of the chest, heart complaints, etc. This indicates that homesickness is linked with psychobiological reactions which can have rather severe and even hazardous health consequences.

Behavioral characteristics
The homesick are generally described as apathetic, listless, lacking initiative, and having little interest in their current environment (Van Tilburg, Vingerhoets, & Van Heck, 1996). These observations led some researchers and clinicians to consider homesickness as being a reactive depression (e.g., Baier & Welch, 1992; Eurelings-Bontekoe et al., 1994; Fisher, 1989).

Emotional manifestations

Homesickness is generally characterized by a depressive mood. Moreover, feelings of insecurity, loss of control, nervousness, and loneliness are frequently reported (Van Tilburg, Vingerhoets, & Van Heck, 1996). Our unpublished data[1] indicate that almost 50% of those in chronic homesickness situations (e.g., after a move) reported being frustrated, while this feeling did not play a significant role in short-term homesick situations (e.g., a holiday). As most of these subjects felt that the only solution to their homesickness is returning home, those in unchangeable situations like in a move feel frustrated not being able to do anything about their homesickness.

Social regulation and control

There is evidence that homesickness is socially sanctionized and therefore not expressed easily. Baier and Welch (1992) observed that homesickness is sometimes experienced with embarrassment or denial. Feelings of homesickness are frequently not acknowledged nor processed intrapersonally and homesick children are generally encouraged to suppress their feelings. Fisher (1989) found that homesick students were rated as less successful, less intelligent, and less socially desirable by their fellow students. Fisher observed in her study that sufferers of homesickness think it is childish or silly to be homesick. In the unpublished study of our group the same pattern emerged[1]. About 50 to 60% of our sample of homesick adult women did not express their feelings to others. Furthermore, sufferers thought of themselves as a child, a mother's darling, not grown up, etc. They did not expect to become homesick, even though they have had homesickness experiences before. One women said: "I thought I had grown over it ... I thought I was more mature now and could handle it." Being homesick generally lowers the self-esteem significantly. As a consequence expression of homesickness was inhibited and in some cases subjects even denied their feelings to others and themselves. In addition, data from the same study revealed that homesickness is typically not anticipated even though most of the subjects have had homesickness experiences before. One may wonder whether most persons, due to the fact that it is conceived as something immature, think that their vulnerability of homesickness disappears with time. People again and again try to leave their house for a short or longer period of time, although homesickness strikes almost every time.

Conclusion

Homesickness is a reaction to leaving one's home and house and occurs often during holidays and after a move. There are indications that the separation from the old environment causes the homesickness feelings, but it is not known what factors are most important. Separating from persons in the old environment does not always play a significant role.
Rigid people are most vulnerable to become homesick as they have difficulties altering their routines and way of living. Homesickness generally starts from an young age onwards and continues into adulthood. There are some indications that insecure attachment is related to feelings of homesickness.
Homesickness can be an extremely intense and overwhelming emotion. Merely missing home or having a dim desire to return home does not make one homesick. Homesick persons feel miserable and depressed. They are apathetic and listless. Various minor and major pains and aches are felt, mostly stomach and intestinal complaints, appetite loss, sleep disturbances, crying, and headaches. Attention is focused (almost) completely on the old environment and the possibility of return. Homesick persons miss home desperately, they have obsessional thoughts about home, idealize home and wish to return home. They continue to live mentally in their old environment. The new situation is avoided as much as possible and thought about negatively. Thus, homesickness hampers adaptation to the new situation.
As homesickness is seen as something childish, it is socially sanctionized even among children. Therefore, the feelings of homesickness may be suppressed and denied. The response pattern of homesickness bears many resemblances to other syndromes and emotions. However, homesickness appears to be a distinct concept because it can be distinguished on the basis of the cognitive orientation of the homesick person. To quote Fisher (1989): "If, for example, a person who was bereaved was in one room and a person who was homesick in another, and the job of the investigator was to decide which person was homesick and which was bereaved by asking only one question, that question should concern the focus of cognitive activity and not the nature of the distress symptoms" (p. 22). This statement is applicable to all other of the discussed concepts related to homesickness, not only grief.
As homesickness is a conceptually distinct manifestation of distress with a known cause it is important to acknowledge it as such. At this moment there are no diagnostic criteria for homesickness nor valid measurement tools that can truly separate the homesickness reaction pattern from other emotions. Therefore, it is of utmost importance to develop diagnostic criteria for clinicians and valid measurement tools for researchers. Up to that moment homesick persons run the risk of being diagnosed with another syndrome, receiv-

ing therapy which might not be helpful and in some cases even counterproductive.

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4 Conceptual analysis of homesickness: A study on personal meanings

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Abstract

Homesickness is an ill-defined concept. Until now, there is no agreement among researchers and therapists on the diagnostic criteria of homesickness. This has serious consequences, like incomparable research results, homesick people receiving therapy that is unrelated to their problems, etc. Therefore, it is important to develop a general descriptive classification of homesickness, which can be used in both therapy and research. A first step may be to find out what the implicit common beliefs about homesickness are. Therefore, the present study was designed to analyse lay-conceptions of homesickness. A community sample of 436 Dutch adults completed open-answered questions on personal meanings of (aspects of) homesickness. Answers were categorised and differences between those with self-reported homesickness and those who had never experienced homesickness were investigated applying a HOMALS analysis. It appeared that there is general consensus on the definition of homesickness: Homesickness is defined as a longing for home and aspects of home, due to transition from home, accompanied by negative affect. In addition, the homesick might suffer from several physical and psychological symptoms. The homesick and non- homesick and men and women, however, differed with respect to the reported specific behavioural, cognitive, emotional, and physical aspects of homesickness. Most striking was the finding that homesick men were generally less able to describe aspects of their homesickness. It is concluded that the cognitive activity of the homesick has key-diagnostic value, while the other affected areas may differ on the individual level. Future research should focus on the (differential) diagnostic value of the aspects identified in the present study.

Introduction

When one person tells the other that he or she is homesick, it is unlikely that the latter will ask him/her to explain what 'homesickness' means. In many languages the 'term' homesickness exists, for example, Heimweh (German), heimwee (Dutch), añoranza (Spanish), sila hasleti (Turkish), hemlängtan (Swedish). Generally, it is a well-understood term in all these languages,

implying that almost everyone knows that homesickness indicates a state of distress following a transition from home. Dictionary definitions of homesickness are: "Sad or depressed from a longing for home or family, while away from them for a long time" (Webster's Encyclopedic dictionary); "Depressed in consequence of a longing for home during absence of it" (The Oxford English Dictionary); "Acutely longing for one's family and home" (The American Heritage Dictionary); "Depressed or melancholy at being away from home and family" (Collins Dictionary of the English Language); "Pining for home" (Chambers Twentieth Century Dictionary). Common elements in all these definitions are 'being away from home', 'longing for home', and 'depressed/negative mood'.

Thus, generally, homesickness can be defined in terms of feelings of depression and a longing for home when one is away from home. However, for research and clinical purposes, these definitions of homesickness are not clear enough to distinguish the homesick from the non-homesick. Since homesickness may be a 'normal' reaction to the transition from home, it is important to be able to differentiate non-clinical from clinical cases. Unfortunately, formal classification or diagnosis rules are lacking until now. In DSM-IV (APA, 1994) homesickness is included as a possible manifestation of separation anxiety, a youth disorder. However, homesickness is also very common among adults like immigrants and asylum seekers (see e.g., Eisenbruch, 1997; Hertz, 1997; Schmitz, 1997). Thus, in research and clinical practice there is need of a 'Golden standard', by which clinical homesickness can be diagnosed. In order to develop such a standard, the exact meaning of the word 'homesickness' has to be known. A first step in this process is to discover the implicit common beliefs about homesickness. In other words, how is homesickness defined by lay people, and what is their 'golden standard' by which they diagnose their own and someone else's homesickness, and when do they consider it to be 'pathological'?

Fisher (1989) tackled the issue of personal meanings of homesickness among university students and boarding school children. The participants in her studies were asked to provide a written definition of the 'term' homesickness. These descriptions were partitioned in elements and each element was classified. The elements concerned cognitive, emotional, and motivational phrases. The most frequently endorsed elements concerned missing parents, home environment, and friends. The homesick and the non-homesick did not differ in their reported definitions, neither in terms of the identification of relevant characteristics nor in terms of number of reported elements. These findings indicate that the non-homesick, who have had no personal experience, were able to imagine what feeling homesick must be like. On the basis of these results, Fisher (1989) described homesickness as a complex cognitive-motivational-emotional state focused on missing home. This definition has been used widespread by other

researchers since then. The most frequently used definitions of homesickness, nowadays, contain elements of Fishers' definition. Homesickness is generally described as a depressive-like reaction to the transition from home, characterised by obsessive thinking about home and the desire to return home, and accompanied by somatic symptoms (for an overview of the recent literature see, Van Tilburg, Vingerhoets & Van Heck, 1996).

In addition to the problem of the lack of a clear descriptive classification of homesickness, there is also the problem of differential diagnosis. Homesickness is often mixed up with other concepts, which have more or less similar symptomatology, like grief, separation anxiety, and nostalgia. For instance, in some languages (e.g., Dutch, Spanish, and French), homesickness (a state of distress following a transition of home) is not clearly distinguished from nostalgia (a longing for bygone days). In a study on the free description of homesickness situations among Dutch adults (Thijs, 1992), it was found that 20% of the reported 'homesickness experiences' were actually descriptions of nostalgia. Because there is no generally accepted description of homesickness, we have the impression that not only lay people, but also clinicians and researchers have difficulties differentiating homesickness from related concepts. That would imply that the homesickness remains undiagnosed, resulting in un- or counter-productive interventions, which are not directed at the real problem. Van Tilburg (1997) discussed nine syndromes and concepts related to homesickness, namely nostalgia, separation anxiety and school phobia, grief, depression, adjustment disorder, agoraphobia, depletion anxiety, claustrophobia, and topophilia. Her main conclusion supports the observation made by Fisher almost ten years earlier: Homesickness can be distinguished from closely related concepts only on the basis of the focus of cognitive activity and not on the basis of the nature of the distress. These conclusions underline the importance of a generally accepted descriptive classification of homesickness and diagnostic rules by which homesickness can be distinguished from related concepts.

In order to develop diagnostic rules and valid measurement instruments, it is essential to know what the implicit common beliefs of lay people about homesickness are. In research on illness beliefs Leventhal and his colleagues (Leventhal *et al.*, 1980; Leventhal & Nerenz, 1985) identified the following five cognitive dimensions of illness beliefs: (i) identity, (ii) perceived cause of the illness, (iii) time line, (iv) consequences, (v) curability, and (vi) controllability. Although, illness beliefs might not be necessarily 'true', they are valuable in terms of the common sense knowledge they provide about a disorder and how this knowledge will influence appraisal and coping processes. The present study was designed to analyse lay-conceptions of homesickness. Although, the first dimension of Leventhal and his colleagues, Identity, (referring to the label that is given to a pathological condition and its accompanying symptoms) is the most

important aspect for developing diagnostic tools for homesickness, the present study also focused on several other dimensions. Besides the general meaning of homesickness, this study included causes and behavioural, physical, cognitive, and emotional reactions of homesickness. In this way it can be determined whether several of the causes and reactions, which have been found to be associated with homesickness, are also thought of as being relevant to homesickness by (non)- homesick lay people.

Method

Participants

Participants were recruited by telephone. They were randomly selected from the postal code directory, but stratified for urbanity. A total of 600 adults were recruited. Seventy-three percent of the questionnaires were returned (N = 449), of which 13 were incomplete. More women (N = 259; 59.4%) than men (N = 177; 40.6%) participated. Age had a normal distribution, ranging from 18 to 87, with means of 43.6 (SD=15.7) for women and 47.3 (SD= 15.3) for men. On the basis of the question on the telephone whether they had ever been homesick, the group was divided into those who have had homesick experiences (N = 215; 52%) and those who were never homesick (N = 200; 48%; N = 21 missing data). It appeared that significantly more of the female participants (58.5%) than of the male participants (42.0%) reported to have had homesickness experiences ($p \leq .05$). Seventy-six percent of the respondents was married or had a long-term intimate relationship. The educational level of the group was slightly higher than the educational level of the Dutch population.

Questionnaire

Besides demographic variables like age and sex, the following ten open-questions were included: (1) According to you, what is homesickness?; (2) Under which circumstances does one become homesick?; (3) What kind of thoughts does a homesick person have?; (4) Which feelings does a homesick person experience?; (5) How does a homesick person cope with his/her feelings of homesickness?; (6) Is homesickness accompanied by physical complaints? If so, which?; (7) Is homesickness accompanied by psychological complaints? If so, which?; (8) According to you, why does one person become homesick, while the other does not?

Analyses

Three of the authors (M.V.T., C. L., and M. V.) independently made an inventory of the answers on the ten open questions of 60 randomly selected questionnaires. Then, answers were partitioned in elements, and elements with similar meanings were clustered into categories. These categories were compared and discussed by the three investigators until consensus was reached. Subsequently, all three investigators scored another 60 questionnaires on the basis of the identified categories, in order to test whether the categories covered all the varieties in answers. The same procedure was followed and eventually the investigators agreed upon the final categories. Then, each questionnaire was scored by one of the three investigators. When elements of the answers could not be clearly classified, they were discussed among the three researchers until consensus was reached on how to classify the answer. Due to this procedure inter-judge discrepancy was minimised. The final categories were entered into a HOMALS-analysis (HOMogeneity analysis by means of Alternating Least Squares) in SPSS (see for details Van de Geer, 1985). HOMALS is a computer program that searches for homogeneity among categories of variables. Categories that are related are plotted close together.

Results

The results will be presented per question. First, the categories per question are reported. Because of space limitations only the most frequently endorsed answer categories (in more than 10% of the sample) will be described[1]. The percentages reported here do not add up to 100%, since respondents could give more than one category. Second, in order to determine whether answer categories are associated with sex and homesickness experiences, HOMALS analyses for each question were performed. All categories that were reported by 5% or more of the respondents were included in the analyses. On the basis of sex and self-reported homesickness experiences, four groups were identified, and entered into the HOMALS analyses: (i) men with homesickness (N = 71), (ii) men without homesickness (N = 98), (iii) women with homesickness (N = 144), and (iv) women without homesickness (N = 102).

According to you, what is homesickness?

The answers on the first question could be divided into the following main categories, which each includes several subcategories: (i) *longing for* things,

1 The whole category list can be obtained from the first author.

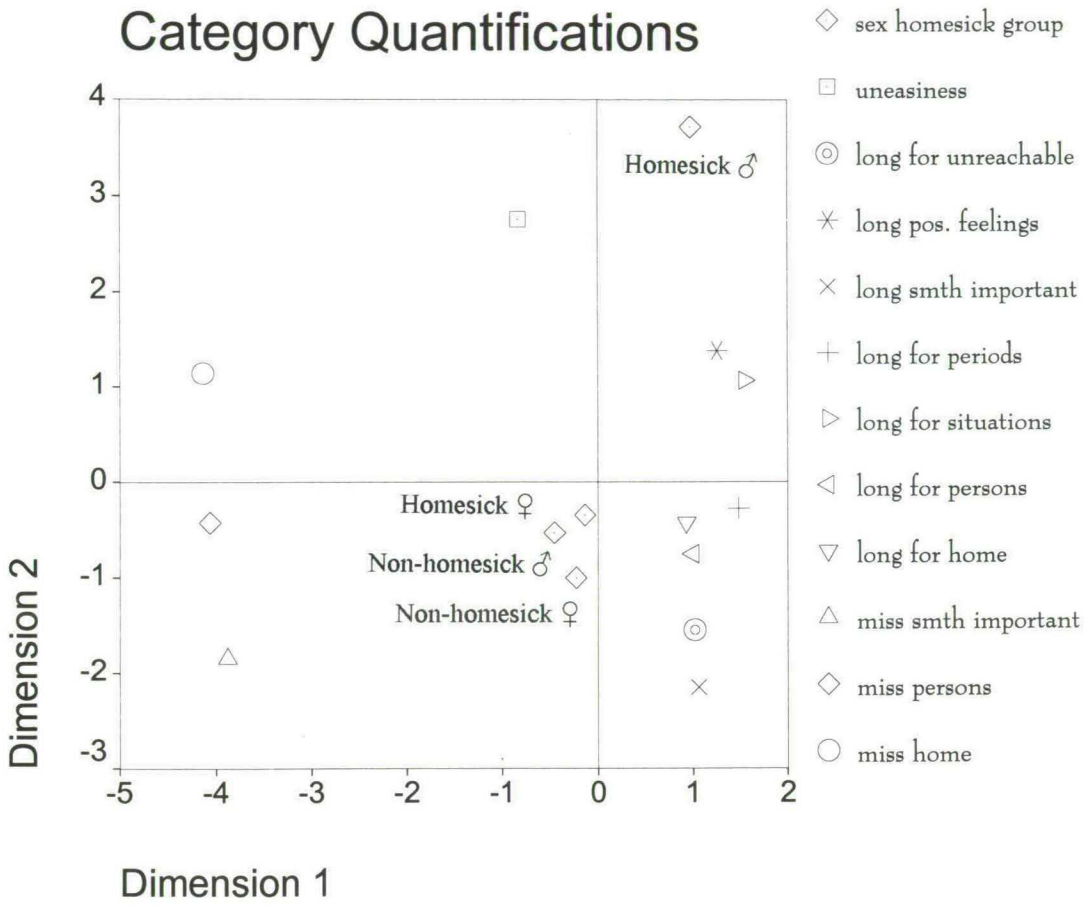

Figure 4.1. Category Quantifications for meaning of homesickness

persons, home, etc., (i) *missing* things, persons, home, etc., (iii) *feelings*, (iv) *thinking* of home, bygone days, etc., (v) *dysfunctioning*, (vi) *physical complaints*, (vii) *being separated* from things, persons, home, etc., and (viii) *adaptational problems*. The most frequently reported subcategories were: (i) longing for home (environment) (30.0%); (ii) longing for persons, like family and friends (22.2%); (iii) uneasiness (13.3%); and (iv) longing for certain time

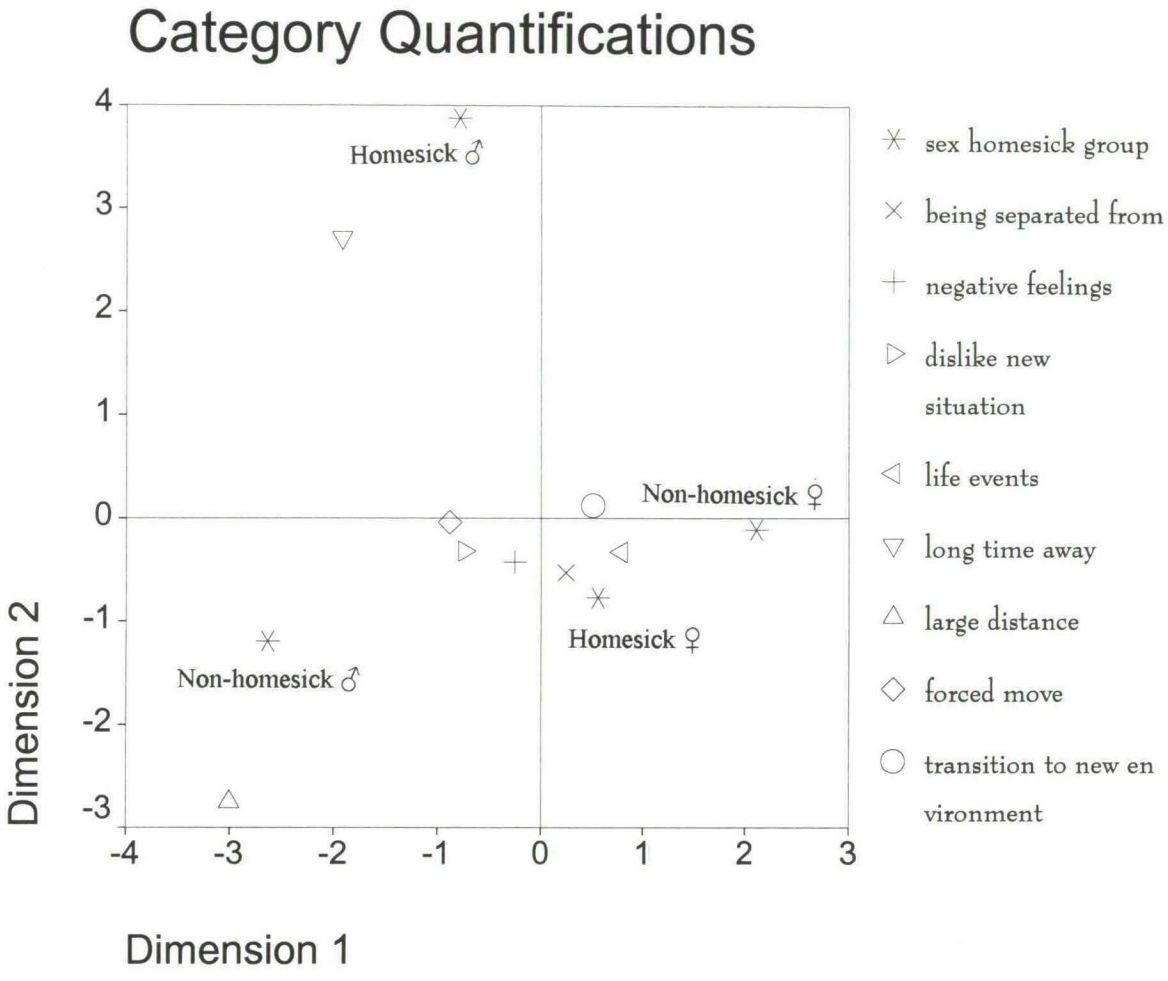

Figure 4.2. Category quantifications for circumstances in which one becomes homesick

periods in the past (10.6%).

From the HOMALS solution (see *Figure 4.1*), it can be seen that homesick as well as non-homesick women and non-homesick men cluster with *longing for* persons and home, and somewhat less with longing for something unreachable and longing for bygone periods, but not with *missing* these things. These three groups are plotted closely, indicating that they use the same answer categories

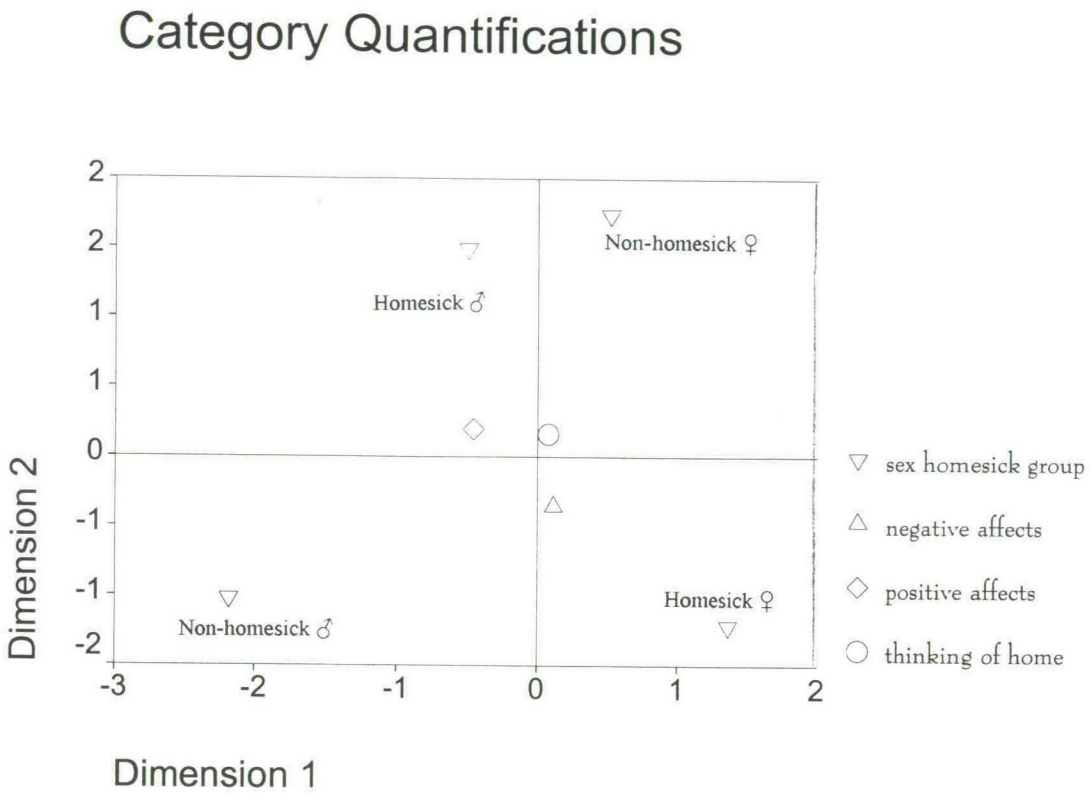

Figure 4.3. Category Quantifications for homesick thoughts

to define homesickness. In contrast, men with homesickness associate homesickness in particular with feeling uneasy.

Under which circumstances does one become homesick?
Most respondents (60.6%) mention a change of environment, for example holidays, moves, migrations, hospital stays, etc. Furthermore, 20% reported

discontent with the current (new) environment, 15.8% negative affects (e.g., depressed, uneasiness), and 13.5% life events (e.g., death of a family member) as circumstances in which one becomes homesick.
The HOMALS solution (see *Figure 4.2*) showed that for non-homesick men geographical distance is important. Homesick men cluster with 'being away for a long time'. While both male groups cluster with only one category, women, on the other hand, had no difficulties in imagining a variety of circumstances in which one becomes homesick. The homesick women referred to affect related circumstances, mainly 'being separated', and 'life events', and somewhat less to 'transition to a new environment', 'forced move', and 'negative feelings'. Non-homesick women referred mainly to 'transition to new environment' and 'life events'.

What kind of thoughts does a homesick person have?
The variety in cognitions could be divided into the following categories: (i) cognitions related to home (e.g., thinking of a person or a situation at home, being obsessed by thoughts of home, thinking of returning home; 59.6%), (ii) negative affects (towards the new environment; 35.6%), and (iii) positive affects (towards home, the old environment, or a previous situation; 20.2%). The HOMALS analysis did not yield differences between groups (see *Figure 4.3*). The three cognition categories were plotted near the centre, and the homesick groups in a square around them (each in a different quadrant of the figure). This indicates that the answer categories do not differentiate between groups.

Which feelings does a homesick person experience?
Five percent of the respondents reported in addition to feelings, of homesick, also physical complaints. All answers referring to physical complaints were scored at the sixth question (see below) and were excluded in the analyses of this question. The most frequently reported emotions were: (i) grief/sorrow/unhappiness (51.1%), (ii) loneliness (24.1%), (iii) longings (18.8%), (iv) feeling depressed (13.8%), and (v) fears/feeling unsafe (11.9%). The HOMALS analysis (see *Figure 4.4*) yielded four clusters: (i) homesick men, (ii) non-homesick men clustered with depression, (iii) homesick women, clustered with loneliness, fear and somewhat less with sorrow, and (iv) non-homesick women, clustered with restlessness.

How does a homesick person cope with his/her feelings of homesickness?
Homesick persons were thought of as coping by: (i) seeking distraction (36.2%); (ii) contacting persons in the old environment (e.g., writing letters, visiting, telephoning; 21.1%); (iii) seeking (social) support (18.1%); (iv) not leaving home (not at all, only for a short time period, or not too far away from

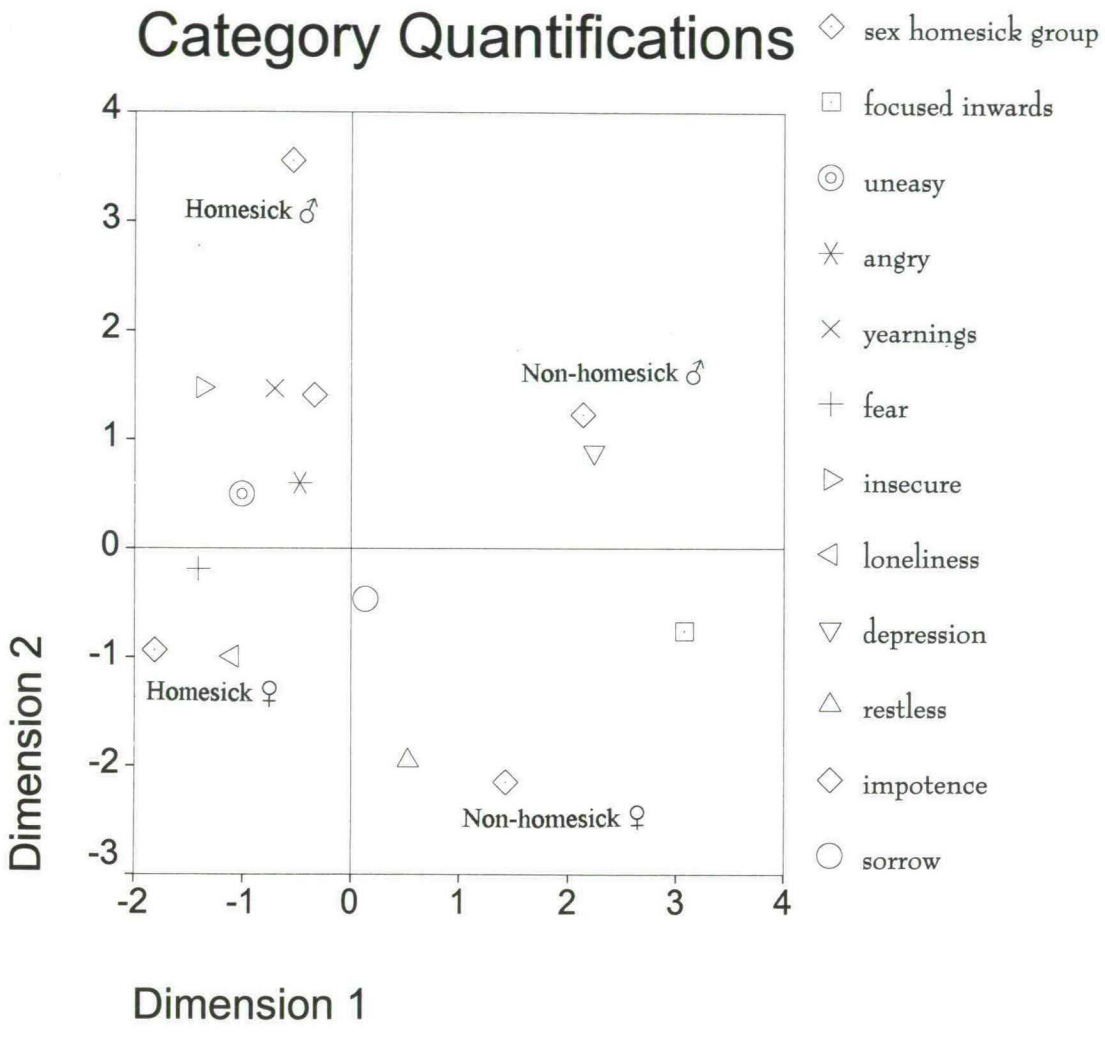

Figure 4.4. Category quantifications for homesick feelings

home; 12.4%); (v) being passive (11.7%); (vi) trying to adapt to the new environment (e.g., making new friends, learning about the new environment, etc.; 10.6%), and (vii) withdrawal (10.3%).

The HOMALS solution shows that the non-homesick men are not clustered with any of the coping strategies (see *Figure 4.5*). Homesick men point at keeping emotions in check. Female respondents mention a variety of coping styles.

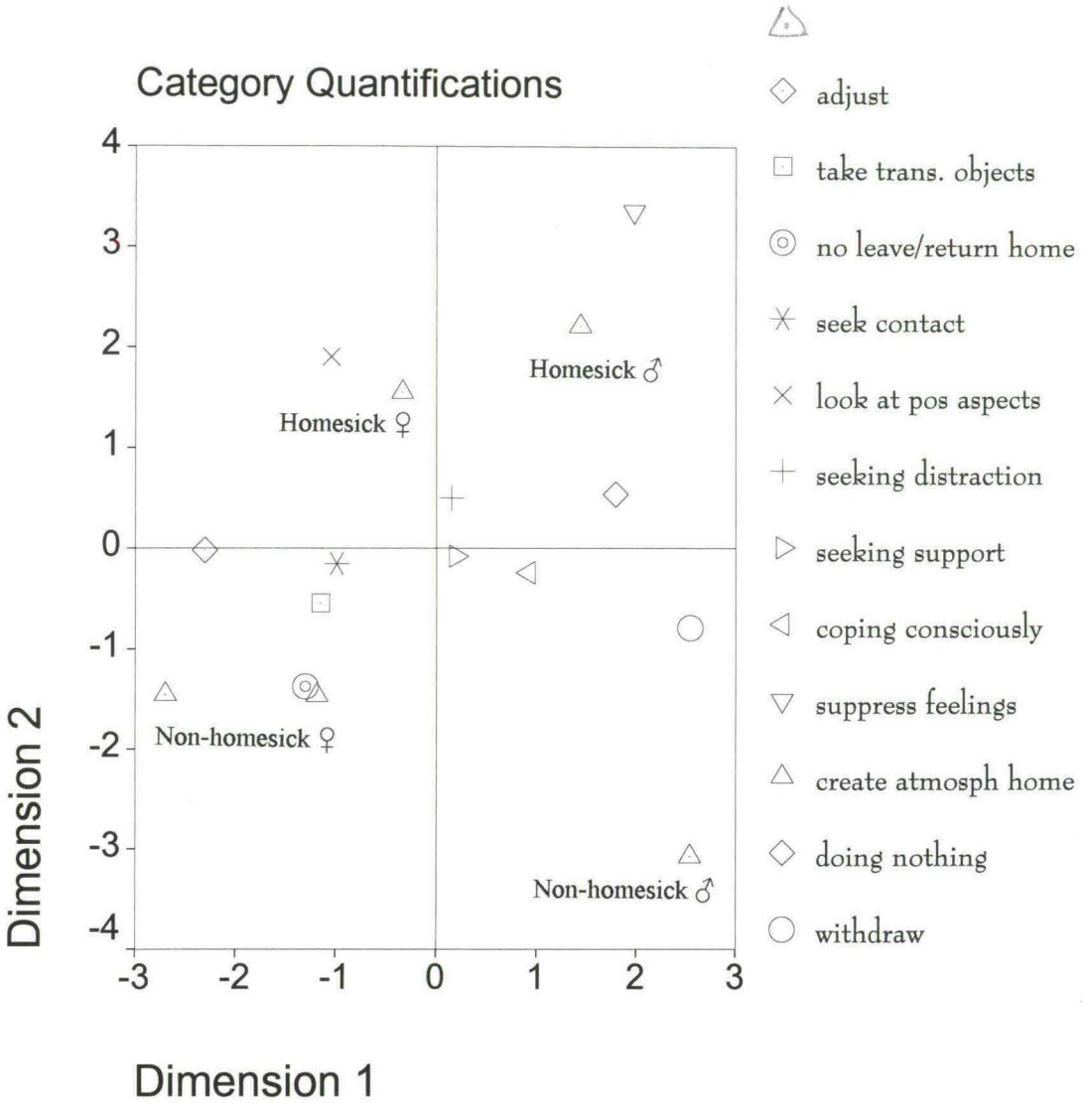

Figure 4.5. Category quantifications for coping with homesickness

Homesick women mainly refer to trying to see things positively and to seek distraction. The non-homesick women predominantly refer to 'creating the atmosphere of home', and 'not leaving or returning to home'.

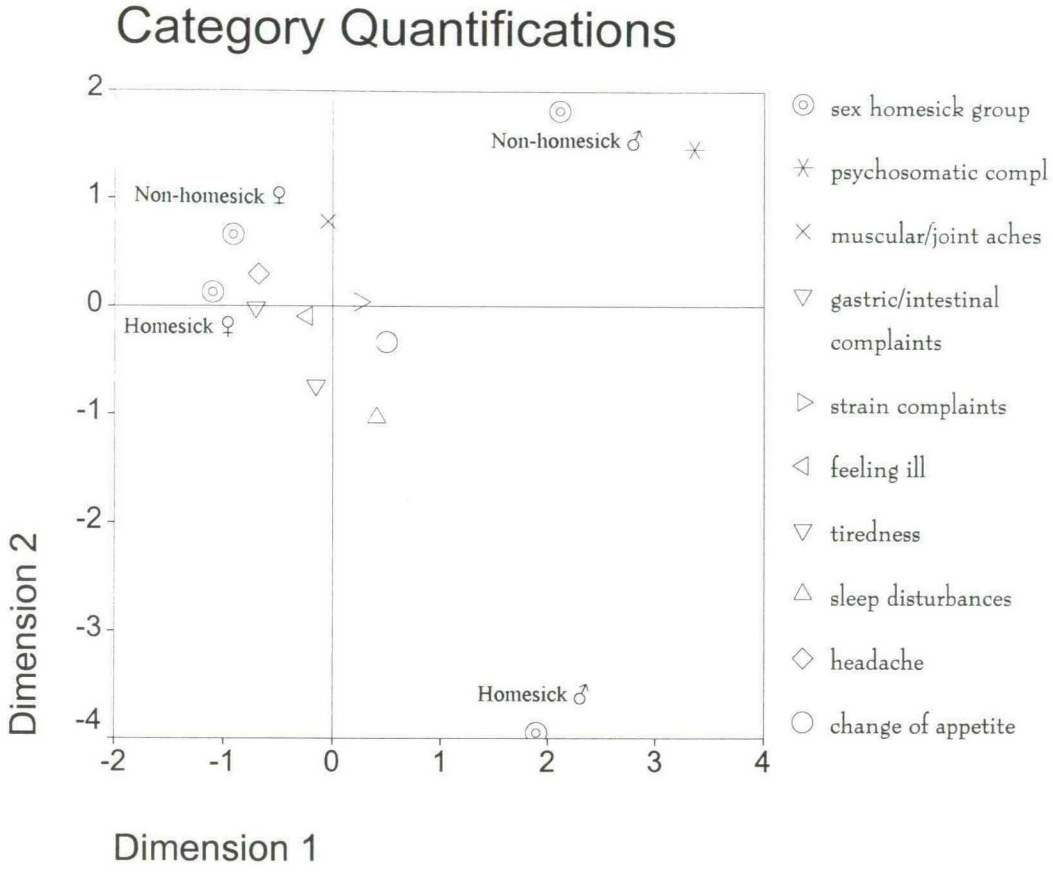

Figure 4.6. Category quantifications for physical complaints

Is homesickness accompanied by physical/psychological complaints? If so, which?

Only 9.6% of the respondents felt that homesickness is *not* accompanied by physical complaints. The main physical complaints were headaches (40.8%) and gastric and intestinal complaints (40.8%). Furthermore, the homesick were

thought of as suffering from total malaise (18.8%), sleep disturbances (16.5%), change in appetite (both more and less appetite; 15.6%), and fatigue (12.6%). Only 6.9% of the respondents indicated that homesickness is *not* accompanied by psychological complaints. A total of 18 psychological complaints were reported. The most frequently mentioned were: depression (27.5%), with drawal (16.1%), and tension (11.5%).
The results of the two HOMALS analyses (one including physical and the other psychological complaints) showed that both the physical and the psychological complaints tend to cluster around the middle point, which indicates that they have little discriminating power (see *Figures 4.6 and 4.7*). Women mentioned a wide variety of physical complaints (mainly headaches and gastric/intestinal complaints), while homesick men did not cluster with any of them. The non-homesick men associated homesickness with psychosomatic complaints. Various psychological complaints clustered with the group of homesick women, mainly 'crying', 'withdrawal', and 'depression'. The group non-homesick men were plotted closely to 'strain'. The other two groups did not cluster with any of the psychological complaints.

According to you, why does one person become homesick, while the other does not?
The answers were divided in reasons why someone becomes homesick, and reasons why someone does not become homesick. Answer categories related to: (i) age, (ii) aspects of how children were raised, (iii) aspects of the environment, and (iv) personality. When the answers referred to both reasons for becoming homesick and for not becoming homesick, like "That depends on the personality of these persons", than the answer was scored on both the personality category for the homesick as well as for the non-homesick. It appeared that the respondents mainly reported personality traits. For the homesick the following personality traits were reported: (i) emotional/sensitive (25.7%), (ii) personality unspecified (22.5%), (iii) poor adaptational skills (18.3%), and (iv) dependent/strong attachment (14.7%). For the non-homesick, the opposites of the above traits were reported: (i) being confident (25.9%), (ii) personality unspecified (21.6%), (iii) adequate adaptational skills (18.3%), (iv) independent/self-reliant personality (13.1%).
Two HOMALS analyses were performed: One for the categories concerning reasons why one becomes homesick (see *Figure 4.8*) and another for the reasons why one does not become homesick (see *Figure 4.9*). Regarding reasons for being homesick it can be seen from figure 8 that the homesick men cluster with 'strong attachment/dependency'. The non-homesick men are plotted most closely to 'aspects of the environment in general' and 'personality in general'.

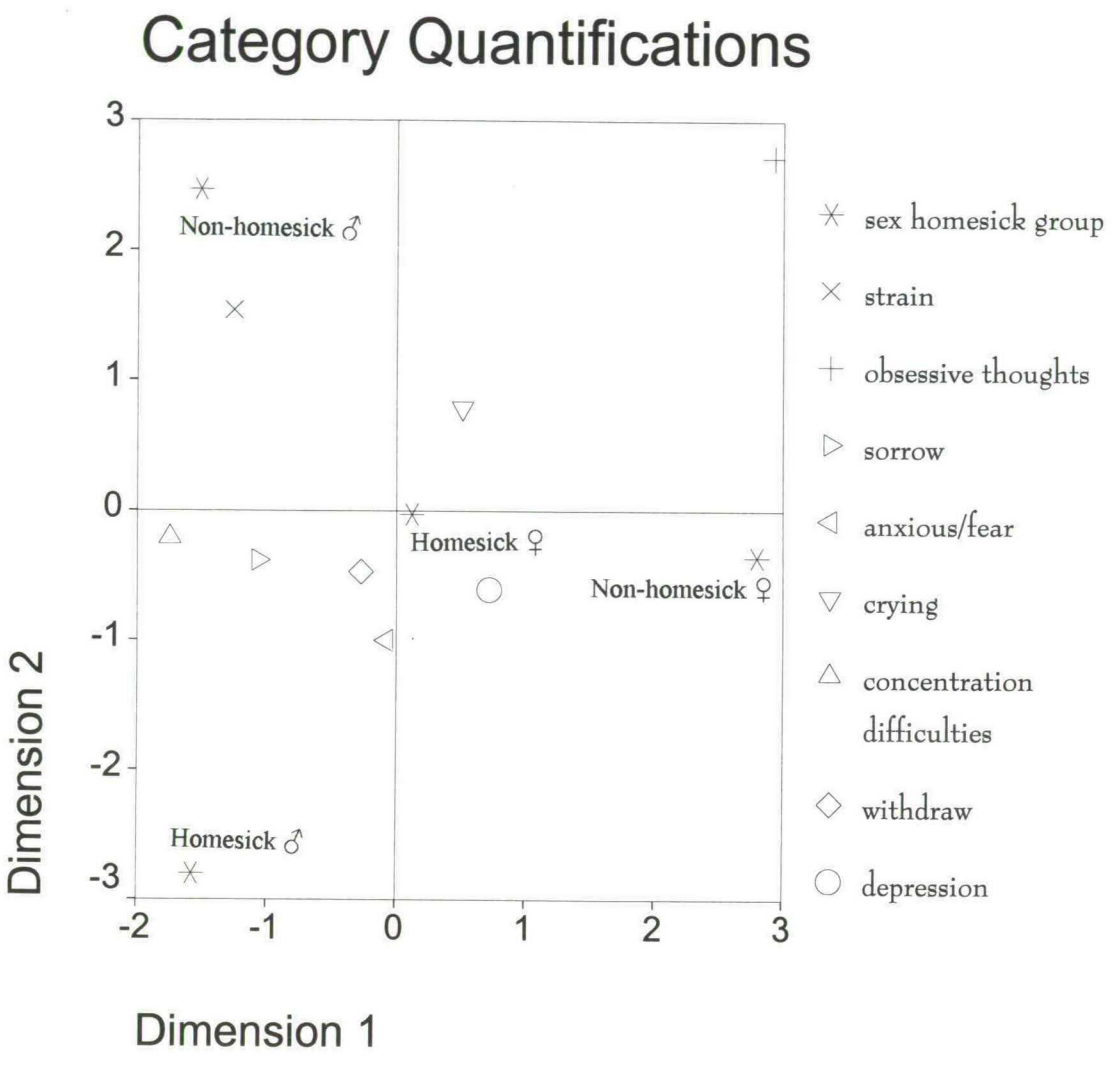

Figure 4.7. Category quantifications for psychological complaints

Women without homesickness tend to mention 'poor adaptational skills' most often. In contrast homesick women feel that homesickness is associated with 'being sensitive' and 'negative aspects of upbringing'. Regarding reasons for not being homesick it can be concluded from *Figure 4.9* that the group non-homesick males are most closely plotted to 'personality in general'. For the non-homesick women, 'adequate adaptational skills' is most important. The

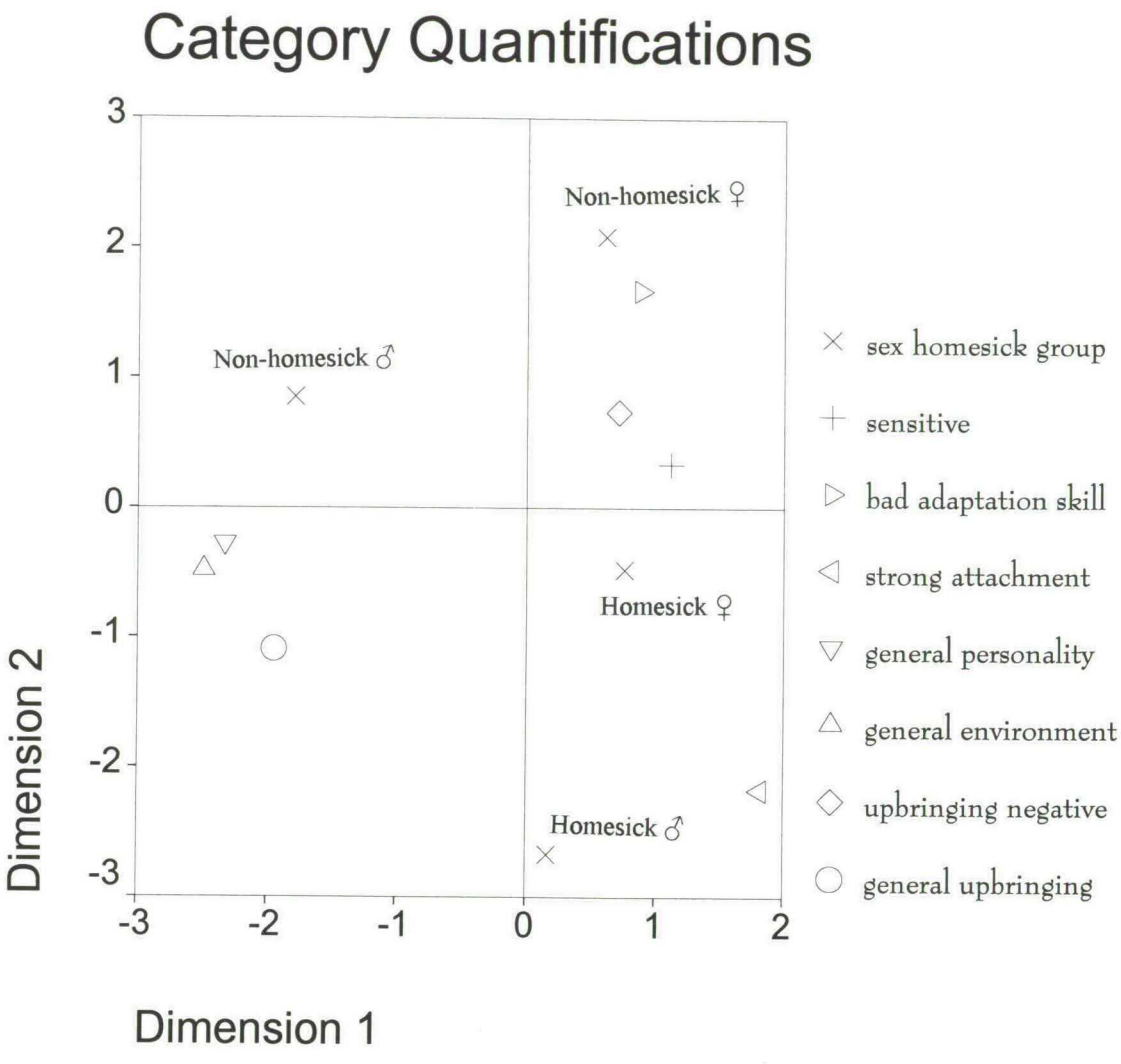

Figure 4.8. Category quantifications for reasons to become homesick

homesick men are plotted most closely to 'independence'. Homesick women are clustered with 'self-confidence' and 'positive aspects of upbringing'.
Table 4.1 summarises the results of all the HOMALS analyses. The main categories associated with the four groups are reported for each question.

Table 4.1. Summary of the results of the HOMALS analyses

	Homesick		Non-homesick	
	Males	Females	Males	Females
What is homesickness?	Feeling uneasy	Longing for persons/ home	Longing for persons/ home	Longing for persons/ home
Under which circumstances does one become homesick?	Being away for a long time	Being separated Life events	Distance from home	Transition to a new environment Life events
What kind of thoughts does a homesick person have?	Thinking of home Negative affects Positive affects	Thinking of home Negative affects Positive affects	Thinking of home Negative affects Positive affects	Thinking of home Negative affects Positive affects
Which feelings does a homesick person experience?	/	Loneliness Fear	Depression	Restlessness
How does a homesick person cope with his/her feelings?	Suppress feelings	See things positively Seek distraction	/	Create atmosphere of home Not leaving or returning home
Is homesickness accompanied by physical complaints?	/	Headaches Gastric/intestinal complaints	Psychosomatic complaints	Headaches Gastric/intestinal complaints

Table 4.1. Summary of the results of the BOMALS analyses (continued)

	Homesick		Non-homesick	
	Males	Females	Males	Females
Is homesickness accompanied by psychological complaints?	/	Crying Withdrawal Depression	Strain	/
According to you why does a person become homesick while the other does not? Reasons for:				
1. becoming homesick	Strong attachment Dependency	Being sensitive Negative aspects of upbringing	Aspects environment Personality	Bad adaptational skills
2. Not becoming homesick	Independence	Positive aspects of upbringing	Personality	Good adaptational skills

Discussion

The present study focused on the personal meaning of homesickness. The main purpose was to formulate a clear descriptive classification of homesickness based on the insight of lay people. It appeared that elements of the general definition the participants reported could be categorised in eight main categories, namely: (i) missing things, persons, home, etc., (ii) longing for things, persons, home, etc., (iii) thinking of home, time periods, etc., (iv) feelings, (v) physical complaints, (vi) adaptation problems, (vii) dysfunctioning, and (viii) being separated from things, persons, home, etc. According to lay perceivers, homesickness implies a longing for home due to a separation from home, accompanied by negative affect (mainly feelings of uneasiness), thoughts of (returning) home, adaptational or dysfunctional behaviours, and somatic complaints. This descriptive classification has a considerable overlap with definitions commonly used in the psychological literature (see for an overview Van Tilburg *et al.*, 1996) in which homesickness is described as a depressive-like reaction to the transition from home, characterised by obsessive thinking about home and the desire to return home, and accompanied by somatic symptom. These personal definitions of homesickness further show that lay people feel that homesickness is manifested in physical, cognitive, behavioural, and emotional symptoms, as was previously observed by Fisher (1989). As longings are mentioned most frequently, it seems that cognitions are thought of as most important, which corresponds to the statements of both Van Tilburg (1997) and Fisher (1989) that homesickness can be distinguished from closely related concepts only on the basis of the focus of cognitive activity and not on the basis of the nature of the distress.

While in Fisher's (1989) studies, 'missing' is a dominant cognitive theme, the present study shows that 'longing for' seem far more important. This could be due to language and/or cultural differences, age or other background differences between groups (Fisher's samples were on average much younger than ours), and varieties in coding and categorising the answers. In dictionary definitions, homesickness is also described in terms of 'longing/pining for' rather than 'missing of'. When someone misses home, this does *not* necessarily mean that (s)he is homesick, at least not in teh Dutch language. Obviously, there seems to be a subtle semantic difference between the words 'longing' and 'missing'. This may have implications for construction of questionnaires on homesickness. Rather than asking for 'missing' of home or aspects of home, apparantly one should ask about 'longing for home'. The Homesickness Questionnaire (Eurelings-Bontekoe, *et al.*, 1994), by which homesickness can be assessed in a wide variety of situations, uses the phrase 'longing for home', while The Dundee Relocation Inventory (DRI; Fisher, 1989) uses the term 'missing'. On

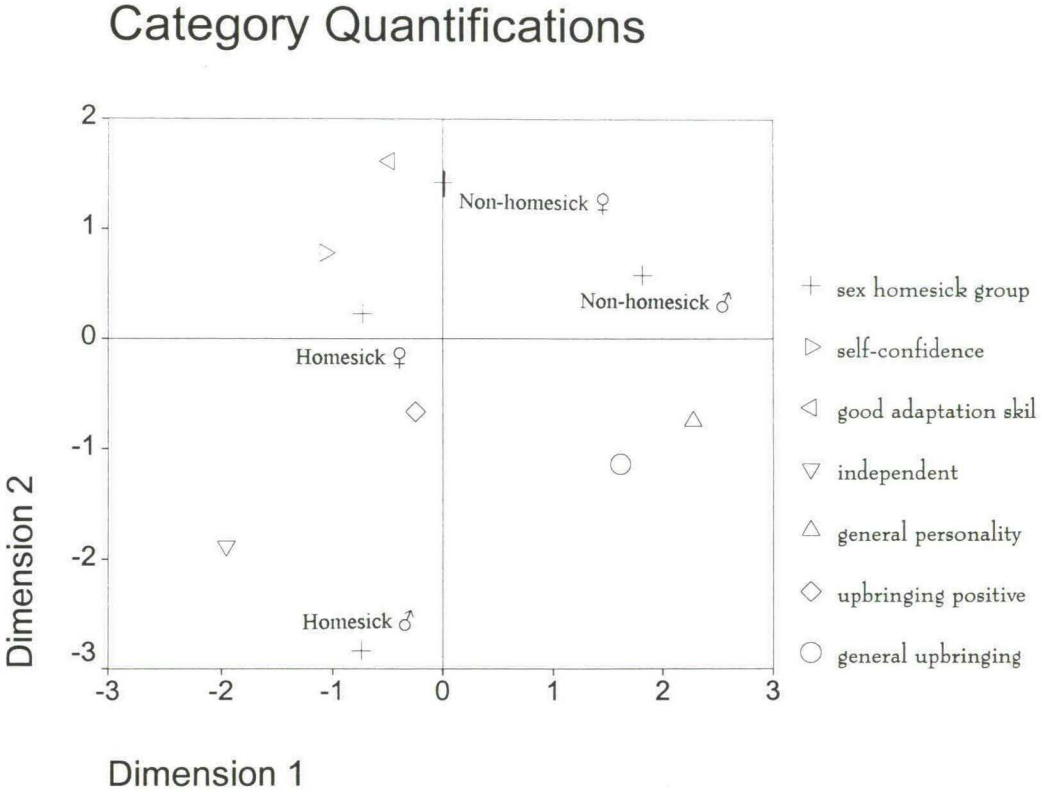

Figure 4.9. Catgegory quantifications for reasons to not become homesick

the basis of the current findings the DRI might need a revision in this respect, at least in the Dutch version.

Besides on the general meaning of the term 'homesickness', the present study also focused on specific behavioural, physical, cognitive, and emotional manifestations, because characteristic reactions in these areas have been observed by several authors (Baier & Welch, 1992, Carden & Feicht, 1991;

Dijkstra & Hendrikx, 1983; Fisher, 1989; Van Tilburg, 1997). The same physical manifestations of homesickness were found as in these studies, that is, mainly headaches, gastric/intestinal complaints, sleep disturbances, and loss/increase of appetite, and total malaise.

At the cognitive level, thinking of home, being obsessed by home, and wanting to return home are most important. This is in accordance with the observation that 'longings' are most characteristic of the homesick. In addition, negative thoughts towards the new environment and idealising the old home environment were mentioned frequently. It seems that the homesick make an unequal comparison between the new and old environment. Positive aspects of the old environment are overemphasised (negative aspects 'forgotten' or repressed), while in the new environment everything is considered to be negative (positive aspects are overlooked).

In the literature (cf. Van Tilburg *et al.*, 1996) the following behavioural characteristics of homesickness are identified: listlessness, lack of initiative, or withdrawal. Surprisingly, these were not mentioned very often as reactions to homesickness in our study. Active behaviours like seeking diversion and seeking social support were thought of as more likely displayed by the homesick. However, when inquiring about psychological complaints, many respondents mentioned depression (28%) as a psychological complaint associated with homesickness. Thus, at least some of the homesick might manifest listlessness, lack of initiative and withdrawal. So, in general the present data suggest that homesick persons are not as passive as is previously described in the literature (cf. Van Tilburg *et al.*, 1996). Homesick persons try to cope actively with their homesickness, in order to overcome it. Active coping and trying to adjust to the new environment may alternate apathy and listlessness, accompanied by ruminations of home. A homesick person can shift from loss orientation to adaptation orientation. A similar model for coping with grief has been developed by Stroebe, Schut, and Stroebe (1996). Oscillation is crucial in this model. Next of kin are hypothesised to alternate from confrontation with the loss to suppressing every thought about the loss. Homesick people might do exactly the same. Oscillating between confrontation with the separation form home, and suppressing every thought about home. Emotional manifestations of homesickness were investigated by asking for feelings and psychological complaints that accompany homesickness. The five most frequently mentioned feelings were sorrow, loneliness, longing for, depression, and fear. With the exception of 'longing for', these feelings were all to a different extent also reported as 'psychological complaints'. The most frequently reported psychological complaints were depression, withdrawal, and tension. The results correspond to the findings form previous studies on emotional manifestations of homesickness (for an overview see Van Tilburg et al., 1996).

To summarise, homesickness is perceived as manifested in somatic complaints, mainly headaches and gastric/intestinal complaints, thinking of (returning) home, withdrawal *and* seeking diversion, and sorrow, loneliness and depression. These results support the findings of previous studies (Baier & Welch, 1992, Carden & Feicht, 1991, Dijkstra & Hendrikx, 1983; Fisher, 1989; Van Tilburg, 1997). The most remarkable result was that the present findings suggest that the homesick are seen as less apathetic and withdrawn as suggested before. The picture that emerges is that they actively do things in order to cope with their homesickness, like enjoying exercise, work, hobbies, etc. However, these findings could also be due to the way we asked for coping behaviours. Our way of questioning may have probed active instead of passive behaviours.

Most participants felt that homesickness occurs when one leaves home for shorter or longer time periods, like after a move, on a holiday, during a hospital stay, etc. In the dictionary definitions of homesickness (see the introduction) transition from home is always included. In addition to the transition from home, dissatisfaction with the new environment was thought of as leading to homesickness. Life events, especially death or illness of a family member, were also mentioned frequently as circumstances in which one becomes homesick. The respondents thus either mix up grief and homesickness, or they mean that the death of a person causes, besides grief, also homesickness because those persons were living in the old environment. Geographical distance, length of absence from home, and freedom of choice over the transition, are not thought of as very important, while these have been associated with homesickness in previous research (e.g., Burt, 1993; Fisher, 1989; Gruijters, 1992).

Reasons for becoming homesick (while others do not), mainly focused upon personality. The homesick are thought of as more emotional/sensitive, dependent, and having poor adaptational skills. These conceptions of the reasons why someone becomes homesick are supported by studies in which it was found that the homesick, compared to the non-homesick, were indeed more neurotic and dependent (see for an overview Eurelings-Bontekoe, 1997).

Exploring differences between men and women, and the non-homesick and homesick, demonstrated that the general personal definitions of homesickness do not vary in content across the homesick and non-homesick as well as across sex (see *Table 4.1*; question 1). For both homesick and non-homesick women and non-homesick men, homesickness is mainly a longing for home and persons left behind. It seems that the homesick males are reluctant to describe what homesickness is, besides a feeling of uneasiness. This could be due to the suppression of feelings of homesickness, leading to the false impression that nothing is 'wrong' with them. Denying one's own feelings leads to greater difficulties in describing aspects of homesickness. However, these expectations

are only hypothetical. In general, men score higher on alexithymia scales, which implies that they have more difficulties describing any of their moods, not only homesickness, in comparison to women (e.g., Vingerhoets, Van Heck, Grim & Bermond, 1995). Thus, it seems that the homesick men come off worse than homesick women do. While it would be helpful to men, as well as to women, to seek emotional and social support, they have more difficulties to express their feelings verbally.

As general personal meanings of homesickness do not vary significantly among different subgroups, one general descriptive classification of homesickness will suffice in order to distinguish the homesick from the non-homesick across all groups. On the other hand, besides the cognitions of the homesick there is no large agreement on specific circumstances, emotions, coping behaviours, physical/psychological complaints and causes of homesickness; not even among the homesick them selves. It is important to keep in mind that these associated features may differ among sex. In general, males may have more difficulties in describing aspects of homesickness than females.

Due to its explorative en descriptive nature, the present study has some major limitations. Because of the open-ended questions, only spontaneous answers were obtained. This implies that this study depends more on recall than recognition. Prompted questions might have resulted in more people reporting a particular category. When a category is not mentioned spontaneously, it does not mean that the category is not relevant, it is only less important or less top-of-mind. In addition, the open-ended answer format forced the researchers to interpret vague and ambivalent answers, which might lead to bias. Moreover, for qualitative data the possibility to apply statistical testing is rather limited. Therefore, the reported results of the HOMALS analyses have to be interpreted with some caution. No firm conclusions can be drawn. Future research should include prompted questions and preferably at least interval scaling. Furthermore, participants were divided in homesick and non-homesick groups on the basis of a simple yes/no answer format on the question whether they have ever been homesick. As is known from Thijs (1992) study many people who have had nostalgic feelings label these feelings as homesickness. Therefore, it could be the case that among the homesick group there were some participants who have never been homesick, but have suffered from nostalgia. In future research this should be avoided by: (1) Including more objective measurements of homesickness like the Homesickness Decision Tree (Eurelings-Bontekoe, *et al.*, 1994); however, most homesickness questionnaires have the disadvantage of detecting only the severely homesick; or (2) Asking people in what circumstances one has been homesick, so those who describe nostalgic feelings can be excluded.

The present results nevertheless point to some important aspects of homesickness. In order to diagnose homesickness, cognitions are most important, but causes, circumstances, and specific manifestations at the behavioural, physical, en emotional level, have some diagnostic value too. Homesickness can be defined as: *Longing for home and aspects of home, due to transition from home, accompanied by negative affect*, most likely feelings of sorrow, loneliness, depression and fear. In addition, the homesick might suffer from several *physical and psychological symptoms*, like headaches, gastric/intestinal complaints, depression, withdrawal, and tension. It is important to determine diagnostic rules upon these aspects of homesickness. In order to do so, future studies should focus upon the potential of the above-mentioned symptoms, to distinguish between (i) the homesick and the non-homesick; (ii) homesickness and related syndromes, like nostalgia and grief; and (3) 'normal' homesickness and 'pathological' homesickness. We hope this study will stimulate the development of these diagnostic criteria in order to bring the necessary uniformity in diagnosis, which is of utmost importance for clinical and research issues.

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5 An exploratory investigation into types of homesickness

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Abstract

In this exploratory study, the focus was on whether homesickness can be considered a homogeneous syndrome or whether there are distinct subtypes which differ in etiology and manifestations. In-depth interviews were held with 31 participants, who have had homesickness experiences. Using a checklist, interview transcripts were searched for meaning for several topics. Categories were formed for each topic and used in a HOMALS analysis. It was concluded that there are good reasons for assuming the existence of subtypes of homesickness. First, a 'healthy' subtype of homesickness was identified, *recovered homesickness*, that reflects a normal adjustment problem when people make a residential move to another culture/environment. Second, a more complex psychopathological subtype of homesickness was found, *recurrent homesickness*, which is associated with separation anxieties and conflicts around anger. A third, very tentatively, subtype which could be distinguished was *holiday homesickness*. Major characteristics of this group are rigidity and a lack of flexibility. Consequences for research and therapy concerning homesickness are discussed.

Introduction

Leaving a familiar environment, in order to resettle somewhere else, implies numerous changes, losses and adjustments: changes in roles, habits and routines; loss of friends, family, home and possessions; adjustments to new living conditions and new rules, which require adequate coping resources and energy from the individual. The multiplicity and diversity of the stressors can make geographical transitions a very stressful episode in one's life, enhancing the probability of mental and physical health problems. For example, geographical transitions have been found to be associated with the onset of depression (Ekblad, 1993; Leff, Roatch, & Bunney, 1970; Schmitz, 1992; Weissman & Paykel, 1973), deficiencies in the immune system (Schmitz, 1992), and leukaemia (Jacobs & Charles, 1980). The more adverse the situation, as for refugees, the more likely it is that problems will occur. However, even upward social mobility has been found to result in distress, depressive mood, and a sense of helplessness (e.g., Fried, 1962).

A typical reaction to the separation from home is missing home and yearning for home, the so-called grieving for home, or homesickness. It has been estimated that 50-97% of the general population have had at least one homesickness experience (Fisher, 1989; Thijs, 1992). However, in spite of the commonality of this condition, the scientific literature on homesickness is rather slim and scattered (for an overview see Van Tilburg, Vingerhoets, & Van Heck, 1996). It is generally acknowledged that homesickness is a complex syndrome associated with distress, intrusive home-related thoughts, dissatisfaction with the new situation, depressed mood, and somatic complaints. Homesickness is considered by many authors to be a reactive depression to leaving home, comparable with depression following grief (Dijkstra & Hendrix, 1983; Eurelings-Bontekoe, Vingerhoets, & Fontijn, 1994; Fisher, 1989; Hamdi, 1974; Porritt & Taylor, 1981; Taylor, 1986).

Until now, very little has been understood about this condition and its causes and consequences. In addition, there is no clear definition of the concept. Other states like nostalgia (a yearning for bygone days) or missing deceased persons are viewed by the general public as manifestations of homesickness (Thijs, 1992; Van Tilburg, 1997). Even experts have difficulty in defining the concept, as indicated by Fisher's (1989: 28) statement that "there are no clinical experts who could provide diagnostic criteria." Problematic in this respect is that homesickness is not a category in DSM IV (except as a manifestation of separation anxiety disorder). As a consequence, severely homesick persons might be classified as having adjustment disorder, separation anxiety, or agoraphobia (Van Tilburg, 1997). To complicate matters further, it is not yet clear whether or not homesickness is a uniform concept. Some authors have proposed different subtypes or forms of homesickness, such as homesickness for the familiar environment or area versus homesickness for persons in the familiar environment (see Van Tilburg *et al.*, 1996). Since there may be great differences between various subtypes of homesickness regarding etiology, causes, manifestations and consequences, a distinction of subtypes may have far-reaching implications for research and therapy.

Until now, there has been very little theorizing in the homesickness literature. Fisher (1989) described five theoretical frameworks which might explain the distress after leaving home, focussing on loss, interruption of life style, reduced personal control, role change, and conflict. These five models are not mutually exclusive. All factors may, to a different extent, contribute to the development of homesickness. How much influence each factor has depends on characteristics of the individual and the specific situation. Unfortunately, there is no all-embracing theory integrating all these aspects. Fisher (1989) has summarized a number of her key findings into a multi-causal model of homesickness. In this model a two-part challenge to the individual is reflected: (i) the separation from

the familiar environment and (ii) the entrance into the new setting. Separation from home can be accompanied by loss, interruptions of plans, and withdrawal which leads to psychological disruption and compulsive ruminative thoughts about home. At the same time the experience with the new environment can give rise either to strain and dissatisfaction or to commitment. Feelings of strain and dissatisfaction may lead to compulsive ruminations about home, whereas commitment to the new environment will rather enhance the possibility that the person feels challenged by it and looks out for more information and new experiences. This model is still very unspecific. For example, it does not state which aspects in the old environment promote or diminish the feelings of homesickness, and why a transition to a new environment triggers homesickness in one person ans is experienced as a challenge to adapt by the other one. The main question is in fact whether homesickness cn be considered as a homogeneous condition.

We conducted an exploratory study to find out whether homesickness can be considered a homogeneous syndrome or whether there are distinct subtypes which differ in etiology and manifestations.

Given the lack of empirical data, we started with in-depth interviews. The most important issues addressed in the interviews were the homesickness experiences, i.e. what persons felt when homesick, how they cope, how others reacted to their homesickness, etc. The second part of the interviews was directed at: (i) the occurence of related symptomes of psychopathology like agoraphobia, claustrophobia, separation difficulties and depression, (ii) relationships with important persons, and (iii) separations from parents in childhood ($\geq$ 7 days).

Method

Subjects

Fourty-eight participants were randomly selected from a group of 314 persons (of which 94% was female) who participated in a survey study on homesickness (see Van Tilburg, Vingerhoets, & Van Heck, 1997). These subjects had been recruited through magazines and newspapers announcements, asking for volunteers for a study on homesickness. A total of 31 subjects participated in the interviews (2 males; 29 females). Age ranged from 22 to 74 years (M = 42.7; SD = 11.6).

A necessary condition for participating in the interviews was that one had to be homesick at the time of the investigation or had homesick experiences as an adult when being away from home. However, during the interviews it appeared that five women were only homesick as a child or adolescent, but no longer as an adult. Furthermore, one women rather expressed grief for her dead mother,

who she lost at a young age when living in another country, then homesickness. These subjects were left out of any further analyses. Of the remaining subjects one became extremely upset during the interview. She was so distressed that it turned out to be impossible to continue the interview. Thus, a total of 24 interviews were suited for analysis.

Procedure

Each participant was interviewed by the first author for about 1½ to 2 hours. At the beginning of the interviews the interviewer took time to get acquainted and to explain the purpose of the interviews. Then, participants were asked to tell about their homesickness experiences in chronological order starting with the first homesickness experience they ever had. All interviews were tape-recorded and the verbal scripts were typed out. The authors then decided which topics were most important to pursue for further analyses given the purpose of this study of differentiating subjects. These were: (i) time periods and situations in which one became homesick; (ii) feelings and cognitions when homesick; (iii) childhood homesickness; (iv) current separation difficulties; (v) agoraphobia, separation anxiety, claustrophobia, and depression (vi) relationship with parents; (vii) first thing to do after returning home when having been homesick. Other topics did not yield much variability among the participants. Some examples are the following. No participant felt there was any change in the homesickness experience over time (except for lower intenties) or across homesickness situations. As for coping styles, participants generally were unable to diminish the homesickness significantly. The reaction of intimate others was one of understanding but intimates generally avoided to talk about the homesickness.

Statistical analysis

All text related to the above mentioned topics was extracted from the written transcripts for each subject. The text was first analyzed searching for meaning and categories and afterwards coded and used in a HOMALS analysis. HOMALS is a statistical procedure that searches for homogeneity among categories of variables. Categories which are related are plotted closely together (de Heus, Gzaendam, Van De Leeden, 1997).

Results

Time periods and situations in which one became homesick

The situation and time period in which one becomes homesick can tell much about etiology. Therefore, it can be fruitful to divide subjects accordingly. In going through the interviews the following groups emerged: (i) those who

recurrently experienced homesickness; they became homesickness (almost) every time they had to leave their house for a more or less extended period of time (after each move, during each stay over and on each holiday; *recurrent homesickness* (N = 11)); (ii) those who only became homesick after one or more moves but never on holidays or stay overs (*recovered homesickness*; N = 11) and who eventually recover; and (iii) those who only became homesick on holidays or stay overs but not after a move (*holiday homesickness*; N = 2).

Feelings and cognitions when homesick
Basically the same results were found as in other studies (for an overview see Van Tilburg *et al.*, 1996). Generally, subjects thought of home and missed home a lot. They reported feeling lonely, miserable and depressed. The only variable on which the subjects seemed to differ to a high degree was on what they missed from home. Since this may be a good indicator of causes of homesickness, we focussed on what the person missed when being away from home. Six categories were constructed: (i) home, (ii) persons, (iii) environment, (iv) mentality, (v) routines, and (vi) atmosphere. We coded whether subjects did or did not indicate missing one of these categories. As almost everyone indicated missing home and persons, these two categories did not differentiate between individuals and were, therefore, left out of any further analyses.

Childhood homesickness, current separation difficulties, agoraphobia, claustrophobia, and separation anxiety as a child
All these variables may be considered as indicators of possible psychopathology and as such useful in distinguishing participants. It was coded whether participants did or did not experience one or more of the above mentioned conditions.

Relationship with parents
Relationship with parents was included to study the association with attachment disrupting experiences. Very strong or negative relationships with parents were often reported as belonging to the etiology of homesickness. The quality of relationship with parents varied from very bad to very good. Therefore, the relationship with parents was included and coded as good, bad, or don't know.

Table 5.1. Discrimination measures per variable per dimension

	Dimension	
	I	II
Holiday homesickness	-.68	2.44
Recurrent homesickness	1.06	.01
Recovered homesickness	-.91	-.32
Missing the environment	.10	-.53
Not missing the environment	-.26	1.39
Missing mentality	-1.25	.20
Not missing mentality	.24	-.02
Missing routines	.01	1.82
Not missing routines	.00	-.44
Missing atmosphere	-.45	-.57
Not missing atmosphere	.30	.40
Childhood homesickness	.43	-.02
No childhood homesickness	-.79	.15
Compulsive checking	1.04	.04
No compulsive checking	-.76	.00
Current separation difficulties	.63	.49
No current separation difficulties	-.31	-.13
Childhood separation anxiety	.47	.52
No childhood separation anxiety	-.45	-.12
Agoraphobia	1.36	-.55
No agoraphobia	-.19	.09
Claustrophobia	.52	-.59
No claustrophobia	-0.71	.72
Good relationship with parents	-0.57	-.56
Bad relationship with parents	0.81	.29

First thing to do after returning home when having been homesick

Some subjects reported an uncontrollable urge to check the whole house upon returning home after, for instance, a holiday. They *felt* as if their house would vanish as soon as they left, but they *knew* it would not. Still they had to check if it was still there. As if they could not believe it is. They checked every room because knowing one room is still there does not guarantee the others will also be. We considered these behaviors and cognitions as possible indicators of psychopathology and -as such- important for the distinction between subtypes.

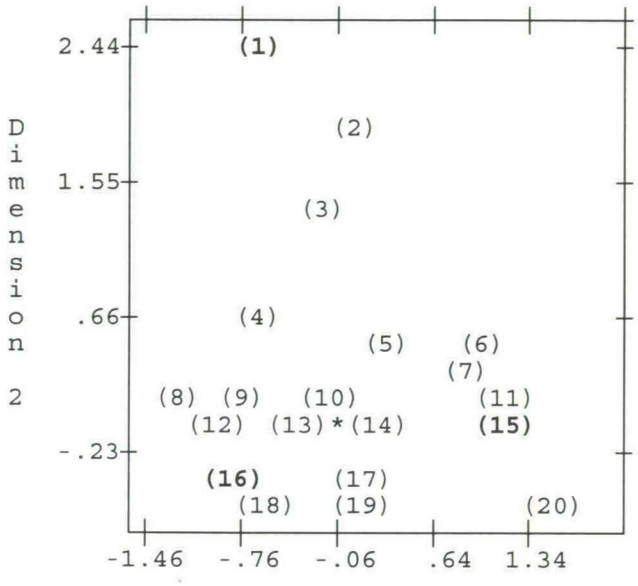
Thus, answers were dichotomized into checking or not checking the house when returning home (*compulsive checking*).

Quantitative analysis
All variables described above were entered into a HOMALS analysis. The HOMALS solution yielded two dimensions (see *Table 5.1*). The first dimension can be described as a psychopathology dimension including agoraphobia, compulsive checking, a bad relationship with the parents, current separation difficulties, separation anxiety, and childhood homesickness. Recovered homesickness loads negatively and recurrent homesickness loads positively on this dimension. The HOMALS solution (see Figure 5.1) shows that those who are relatively free from signs of psychopathology cluster on the left side of dimension 1. These are the subjects who once experienced homesickness after a move, but who recovered since then. They reported having a good relationship with their parents, they did not compulsively check the house and they did not experience separation anxiety and homesickness as a child. They particularly missed the mentality and the atmosphere of the former environment. Those who showed signs of psychopathology cluster on the right side of dimension 1. These are subjects recurrently experiencing homesickness. These subjects reported checking the house upon returning home after an absence, suffering from agoraphobic complaints, having a bad relationship with their parents and suffering from separation anxiety as a child.
The second dimension is strongly dominated by the two subjects experiencing homesickness during holidays only. These subjects particularly miss their routines, but not their familiar environment.

Discussion

Because of the small sample size the results of this study must be interpreted with caution[1]. Any interpretation or conclusion can only be tentative and has to be explored further in empirical studies with larger sample sizes.
It seems that there are reasons to presume the existence of at least two subtypes of homesickness. First, a distinction can be made between homesick subjects with and without signs of psychopathology. Those who developed homesickness only after a move but recovered since then, are relatively free from signs of

1 The results of the HOMALS should be interpreted with caution (because of the small sample size). We conducted two more HOMALS analyses, randomly leaving out one subject each time. The two HOMALS analyses yielded nearly the same solutions so the tentative conclusion can be drawn that the three groups mentioned above can be distinguished.



Point	Actual label or name	Point	Actual label or name
(1)	**holiday homesickness**	(11)	compulsive checking of house
(2)	missing routines	(12)	no compulsive checking of house
(3)	not missing environment	(12)	no childhood separation anxiety
(4)	no claustrophobia	(13)	no current separation difficulties
(5)	not missing atmosphere	(14)	childhood homesickness
(5)	current separation difficulties	(14)	not missing mentality
(6)	childhood separation anxiety	**(15)**	**recurrent homesickness**
(7)	bad relationship with parents	**(16)**	**recovered homesickness**
(8)	missing mentality	(17)	not missing routines
(9)	no childhood homesickness	(18)	good relationship with parents
(10)	no agoraphobia	(18)	missing atmosphere
		(19)	missing environment
		(19)	claustrophobia
		(20)	agoraphobia

Figure 5.1. HOMALS Solutions

psychopathology. This type of homesickness is not associated with adverse attachment experiences, compulsive checking, separation anxiety, and homesickness experiences during childhood. This 'healthy' type of homesickness is related to missing the mentality and atmosphere of the familiar environment.

This implies that there is a type of homesickness that can be considered as a normal adjustment problem, which most people eventually will overcome as they become integrated into the new culture/environment.
In contrast, there seems to be a more pathological form of homesickness, associated with agoraphobia, compulsive checking, adverse attachment experiences and separation anxiety in childhood. This type of homesickness is found among those who tend to experience homesickness recurrently. These persons always become homesick as soon as they leave their house. As recurrent homesickness seems to be associated with a bad relationship to the parents it might be hypothesized that this type of homesickness can be considered as a form of separation anxiety based on an insecure/anxious attachment (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1973, 1980). Separation anxiety and anxious attachment may give rise to agoraphobic complaints (De Ruiter, 1992) and, as is well-known from clinical practice, frequently go together with intense, unintegrated feelings of anger (Bures, Badaracco, Birnbaum & Goisman, 1996). Projection and externalizing of feelings of anger and anxiety to the house (Bures *et al.*, 1996) may explain the preoccupation with fantasies about damage to and vanishing of the house during times of absence, that underlie the compulsive checking of the house upon returning home. Thus, recurrent homesickness seems to be a more complex psychopathological phenomenon, associated with deeply-rooted anxieties and conflicts around anger.
Finally, very tentatively, typical of the two participants, who were only homesick during holidays, was the absence of psychopathology and the presence of difficulties in breaking with old routines. These people tend to become homesick when on holiday; because being on holiday necessitates changes in familiar routines, schedules, way of living, etc. The fact that these people do not become homesick after a residential move may be explained by the fact that a residential move does not necessarily imply changes in personal habits and life-styles. For example, if one is used to having dinner at six, one might not be able to eat at six on a holiday (e.g., because of fixed dinner times at hotels), but this is still possible after a residential move. Thus, rigidity and a lack of flexibility seem to be the major characteristic features of this group. As soon as daily routines are changed they experience distress and anxiety which makes them long for the planned and predictable life they are used to.
As was said before, the distinction between hese subtypes has to be tested in larger samples, and in particular the existence of holiday homesickness as a separate entity needs far more underpinning. However, if the distinction turns out to be valid, this may have rather significant consequences for theorizing, research and therapy. Researchers cannot treat the homesick as a homogenous group. Situational and personal variables which are related to one type of

homesickness might not be related to another type. Finally, the distinction may be a valuable tool in therapy settings. The three types of homesickness seem to have different etiologies and thus may require different therapeutic approaches. First of all, it seems necessary to inquire whether the homesick individual has experienced homesickness before and whether homesickness has been or is being experienced under a variety of circumstances. In addition, one should ask the client whether he/she had adverse attachment experiences, suffers from agoraphobic complaints and/or compulsive checking of the house. If so, the homesickness can be considered as recurrent homesickness and therapy would need to focus on separation/ individuation issues, conflicts centering around anger, anxiety, self-esteem, and autonomy. If this is not the case, those who get homesick after a move might best be helped by support and reassurance that they will overcome this condition and by teaching them skills, for instance, social skills (Eurelings-Bontekoe *et al.*, 1994), to be able to adapt more easily to the new environment. Finally, homesickness occurring during holidays only, might be altered by clarifying and challenging the cognitive beliefs about the necessity of having everything rigidly planned and under control and relaxation exercises to be able to cope with and reduce the anger and tension occurring when one is exposed to a change in routine.

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6 Types of homesickness: A first validation study

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Abstract

The present study examines the validity of three subtypes of homesickness proposed by Van Tilburg, Eurelings-Bontekoe, Vingerhoets and Van Heck (1998): holiday, recovered, and recurrent homesickness. A random sample of 445 Dutch adults (N = 182 males; N = 263 females) completed a self-constructed questionnaire measuring variables associated with these types of homesickness. The present study failed to replicate earlier results (Van Tilburg *et al.*, 1998). Different variables were found to be associated with the three types of homesickness. It is questioned whether recovered and recurrent homesickness are different subtypes of homesickness, which differ in etiology; or, alternatively, whether these reflect the same type of homesickness varying in intensity of feelings. It is concluded that there is only weak support for the existence of three subtypes of homesickness. The determinants associated with these subtypes are not clear yet. More research is needed to untangle these issues.

Introduction

In the literature on homesickness it is often implicitly assumed that homesickness is a singular syndrome. Although, the existence of different subtypes or forms of homesickness has been proposed already several decades ago (e.g., Bergsma, 1963; Jaspers, 1909; Rümke, 1940), nowadays most authors treat homesickness as a homogeneous concept (e.g., Baier & Welch, 1992; Brewin, Furnham, & Howes, 1989; Burt, 1993; Eurelings-Bontekoe, Vingerhoets, & Fontijn, 1994; Fisher, 1989; Lu, 1990). Since there is preliminary evidence suggesting that states of homesickness may differ considerably with respect to etiology, manifestations and consequences, a valid distinction of subtypes may have far-reaching implications for research as well as therapy. An exploratory study into the heterogeneity of homesickness (Van Tilburg, Eurelings-Bontekoe, Vingerhoets, & Van Heck, 1998) provided empirical evidence for the existence of three subtypes of homesickness. First, a 'healthy' form of homesickness was identified, reflecting normal adjustment problems in people making a residential move to another culture/environment (*recovered homesickness*). Second, a more complex pathological subtype of homesickness was found, which was associated with recurrent homesickness

experiences and separation anxieties (*recurrent homesickness*). Finally, a third subtype was characterized by rigidity, lack of flexibility, and homesickness complaints during holidays (holiday homesickness). Because of the qualitative and exploratory nature of this earlier study, it is important to test the existence of these forms of homesickness in a much larger sample. Therefore, the present study focused upon the validity of these types of homesickness.

Method

Study participants

Using recruitment by telephone, participants were asked to complete a mail-questionnaire on homesickness of which the present study was a part. A total of 600 Dutch adults agreed to participate of which 445 completed the questionnaire (N = 182 males; N = 263 females). Age ranged from 18 to 87 years with a mean of 45.1 (SD = 15.7). Most of the participants were married or cohabited (77.4%).

Measures

Participants completed a newly constructed questionnaire including those variables that were associated with the three types of homesickness in an earlier study (Van Tilburg *et al.*, 1998). Van Tilburg and co-authors found that *recovered homesickness* was related, to being homesick only after a move, having a good relationship with parents, and missing the atmosphere and mentality of home. Typically, persons suffering from recovered homesickness did not suffer from agoraphobia, or separation anxiety. Furthermore, they had not experienced feelings of homesickness as a child. *Recurrent homesickness* was associated with recurrent homesickness both after moves and during holidays, separation anxiety, a bad relationship with parents, compulsive checking of house, agoraphobia, and childhood homesickness. Finally, *holiday homesickness* was related to being homesick exclusively during holidays, missing routines, and not missing the old environment.

For the present study, the variables which were associated with the three types of homesickness in an earlier study (Van Tilburg *et al.*, 1998), were incorporated into a 15-item questionnaire (see the appendix). In addition to this questionnaire, respondents also had to indicate on a five-point scale whether they have ever felt homesick (i) when hospitalized; (ii) at boarding school; and (iii) during military service (only men will be compared as women in The Netherlands do not have to serve).

Results

First, respondents were classified according to homesickness type. In order to do so, a set of classification rules was worked out. First, respondents who were not homesick as an adult were excluded. Then, it was examined who was homesick exclusively during holidays, exclusively after moves, or in both situations. So, the following classification rules were implemented. Subjects were considered to be suffering from recovered homesickness if the items 13 and 15 were answered confirmatively, that means > 1, and item 14 negative (< 2). Holiday homesick were those who scored higher than 1 on the items 13 and 14, and lower than 2 on item 15. Confirmative scores (> 1) on all three items (13-14-15) was thought of as indicative of recurrent homesickness. On the other hand, those with a negative score (< 2) on all three items, were considered to be free of adult homesickness. It appeared that 85 persons could be classified as *holiday homesick* (N = 57 females; N = 28 males), 53 as *recovered homesick* (N = 38 females; N = 15 males), 69 as *recurrent homesick* (N = 46 females; N = 23 males), and 102 as *non-homesick* (N = 50 females; N = 52 males). A total of 136 persons could not be classified and were left out of any further analyses. Chi^2-tests revealed no sex differences between the three homesickness groups; in all groups women were over-represented.

Subsequently, a MANOVA was performed to test the differences between the homesick and non-homesick. All questionnaire items were used with the exception of the items 8 to 11 because these items refer to specific homesickness experiences, and the items 13-15 because these were used to identify the four groups. The test of the between-subjects effects yielded significant differences on all items employed, except for 'relationship with parents'. Mean scores for the homesick were significantly higher on all items compared with the non-homesick (see *Table 6.1*).

Differences on the items (except the items 13 to 15) between the three homesick groups were tested using MANOVA and Scheffé *post hoc* tests (see *Table 6.2*). It appeared that the recurrent homesick scored significantly higher than the recovered homesick on 'missing the home environment', 'missing the atmosphere of home' and 'missing own house'. With respect to the last item the holiday homesick also scored significantly higher than the recovered homesick. Furthermore, the holiday homesick reported missing people from the old environment significantly less than the recurrent homesick.

Additional one-way ANOVA's and Scheffé *post hoc* tests were performed in order to test whether some groups have experienced homesickness in some particular situations more often than other groups. No differences were found

Table 6.1. Differences between homesick and non-homesick respondents

	Non-homesick		Homesick	
	M	*SD*	*M*	*SD*
- It is unpleasant to me when I am not able to be my usual self	2.20	1.11	2.75	1.15 [b]
- It is very difficult for me to live among others who have different habits and/or norms and values	1.85	0.96	2.36	1.19 [b]
- I have/had a good relationship with my parents	4.03	1.02	4.01	1.10 n.s.
- I do not like living separated from persons who are important to me	2.87	1.91	3.87	1.09 [b]
- I am afraid in small rooms (e.g., toilet, elevator)	1.31	0.82	1.61	1.14 [a]
- I am afraid in large crowds	1.31	0.68	1.81	1.15 [b]
- I am afraid in closed rooms (e.g., an unknown room with all windows and doors closed)	1.48	0.94	1.94	1.28 [b]
- I have been homesick as a child	1.25	0.65	2.75	1.51 [b]

a $\underline{p} \leq .05$; $\underline{b} \leq .001$.

Table 6.2. Differences among the homesick groups

	Recovered homesick		Holiday homesick		Recurrent homesick	
	M	*SD*	*M*	*SD*	*M*	*SD*
- It is unpleasant to me when I am not able to be my usual self	2.72	1.18	2.71	1.18	2.83	1.11 n.s.
- It is very difficult for me to live among others who have different habits and/or norms and values	2.32	1.27	2.22	1.14	2.58	1.17 n.s.
- I have/had a good relationship with my parents	4.06	1.00	3.95	1.27	4.06	.94 n.s.
- I do not like living separated from persons who are important to me	3.89	0.89	3.74	1.24	4.03	1.01 n.s.
- I am afraid in small rooms (e.g., toilet, elevator)	1.49	1.08	1.56	1.14	1.75	1.18 n.s.
- I am afraid in large crowds	1.72	1.03	1.82	1.25	1.87	1.12 n.s.
- I am afraid in closed rooms (e.g., an unknown room with all windows and doors closed)	1.77	1.08	1.89	1.32	2.12	1.37 n.s.
- When I am homesick, I miss my own house	2.55	1.41	3.32	1.27	3.54	1.40 [c]
- When I am homesick, I miss people from my old environment	3.36	1.32	3.07	1.35	3.74	1.01 [b]
- When I am homesick, I miss my old home environment	3.13	1.36	3.52	1.22	3.96	1.09 [c]
- When I am homesick, I miss the atmosphere of home	3.19	1.36	3.65	1.17	3.86	1.15 [a]
- I have been homesick as a child	2.64	1.51	2.53	1.49	3.10	1.51 n.s.

a $p \leq .05$; b $p \leq .01$; c $p \leq .001$.

between groups on homesickness experiences at boarding school. The recurrent and holiday homesick reported significantly more homesickness experiences during military service and when being hospitalized than the non-homesick and the recovered homesick.
Finally, it was tested whether the three homesick groups differed in terms of *homesickness intensity*. Three items refer to homesickness intensity: "I have been homesickness as an adult" (item 13), "I am homesick during holidays" (item 14), and "I am homesick after a move" (item 15). The three groups were compared using ANOVA and the Scheffé *post hoc* test on item 13. It appeared that the recurrent scored significantly higher on item 13 than the recovered homesick. Furthermore, *t*-tests were performed to test the difference between the holiday and recurrent homesick on item 14 (the recovered homesick were not homesick during holidays), and between the recurrent and recovered homesick on item 15 (the holiday homesick were not homesick after a move). No significant differences were found.

Discussion

In a previous study (Van Tilburg *et al.*, 1998) it was found that homesickness is either related to a rigid personality, or separation anxieties, or adjustment problems in the new environment. The validity of this subdivision in homesickness types will be discussed later. Rigid personality, separation anxieties and adjustment problems have not only been demonstrated to distinguish the homesick amongst one another, but also it has been thought of as distinguishing the homesick from the non-homesick (for example see, Fisher, 1989; Van Tilburg, Vingerhoets, & Van Heck, 1996). The present study shows that the homesick and non-homesick could indeed be differentiated in terms these variables. It appeared that the homesick have more difficulties with new routines, norms and values, and separation from beloved persons. Furthermore, they report more claustrophobic fear and more homesickness in childhood than the non-homesick. These results are in accordance with findings of previous studies in which it was demonstrated that homesickness is associated with, for example, rigidity (see, for an overview of the literature, Van Tilburg, Vingerhoets, & Van Heck, 1996). Quality of the relationship with parents, however, failed to differentiate between the two groups, suggesting that homesickness is not a symptom reflecting insecure relationships with caregivers. However, before any firm conclusions can be drawn, more investigations are needed which incorporate more reliable techniques for the assessment of quality of parental relationship.

With respect to the distinction in terms of different types of homesickness, the present study, in a large community sample, failed to replicate the results of Van Tilburg and co-authors (1998). The recurrent homesick could be differentiated from the recovered homesick by the intensity of missing physical aspects of home. Thus, it seems that these two groups differentiate mainly with respect to the intensity of the homesickness reaction, further implying that these might not be two real distinctive types of homesickness, but only a gradual difference regarding homesickness intensity. In that case, it can be hypothesized that homesickness becomes gradually more intense with each recurrent homesickness situation, eventually resulting in chronic negative affect and an inability to leave home. Indeed, the recurrent homesick, compared to the recovered homesick, reported higher homesickness intensities in general, although their feelings after a move are of equal intensity. Thus, it is not clear whether these two groups differ in homesickness intensity. Future studies with a longitudinal design should test the hypothesis that recovered and recurrent homesickness are different types of homesickness with a different etiology. Alternatively, one may propose that these types of homesickness only differentiate in terms of severity and number of previous homesickness experiences.

The holiday homesick indicated that they missed their own house more, compared with the reactions of the recovered homesick. This might be due to the fact that after a holiday one is able to return home, while after a move this is in many cases impossible. Holiday homesickness could not be differentiated from the other two types of homesickness on the basis of more intense missing of routines. On the other hand, it neither could be demonstrated that the basic distinction between this type of homesickness and the other two is due to homesickness intensity.

In addition, it was tested whether other homesickness experiences distinguished the homesickness groups besides holidays and moves. As recurrent homesick is related to separation anxieties (Van Tilburg *et al.*, 1998), it is expected that they will become homesick as soon as they have to leave their house, irrespective of the new situation. Recovered homesick, is related to adjustment problems (Van Tilburg *et al.*, 1998) and therefore, they are expected to become homesick only in new permanent living environments which differ considerably from their old ones. Finally, as holiday homesick is related to a rigid personality (Van Tilburg *et al.*, 1998), it is expected that they become homesick in particular when changes in routines and habits are required. As expected, the recurrent group were significantly more homesick when hospitalized or in military service compared to the non-homesick and recovered homesick. Hospitalization and military service imply an enormous break with normal routines and habits, which may explain why the holiday

homesick also reported more homesickness in the hospital and during military service than the non-homesick. The findings indicate that results from studies among, for instance, military conscripts and immigrants cannot be generalized to other groups, because the participants in these studies might be predominantly suffering from a different type of homesickness. It has to be investigated whether some types of homesickness are indeed more common among specific groups like, migrants, conscripts, students, asylum seekers, etc.

Although, the results seem to indicate that it is valid to distinguish between subtypes of homesickness on the basis of situations in which one becomes homesick, this study did not find the same pattern of relationships for different types of homesickness as in the study of Van Tilburg and co-authors (1998). Differences between the results of the two studies might have occurred because of bias in the small sample of Van Tilburg and co-authors study (1998). On the other hand, the present study relied totally upon self-reports, in contrast to the study by Van Tilburg and co-authors; in which the researchers themselves categorized the data. This could mean that the items used in the present study did not totally cover the categories employed in the earlier study. In addition, the sample in this earlier study consisted primarily of women, while the present sample also included men. So, it is important for future studies to test whether the three homesickness subtypes have different etiologies in order to really grasp the differences between them.

To summarize, this study found some, but weak, evidence for the existence of three subtypes of homesickness. The determinants associated with these subtypes are not clear yet. More research is needed to untangle the causes and consequences of the three types of homesickness. It has to be stressed that validation of the three types of homesickness and their causes is very important for theory, research, and therapy.

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Appendix

Questionnaire

1. It is unpleasant to me when I am not able to be my usual self
2. It is very difficult for me to live among others who have different habits and/or norms and values
3. I have/had a good relationship with my parents
4. I do not like living separated from persons who are important to me
5. I am afraid in small rooms (e.g., toilet, elevator)
6. I am afraid in large crowds
7. I am afraid in closed rooms (e.g., an unknown room with all windows and doors closed)

The following items refer to homesickness situations

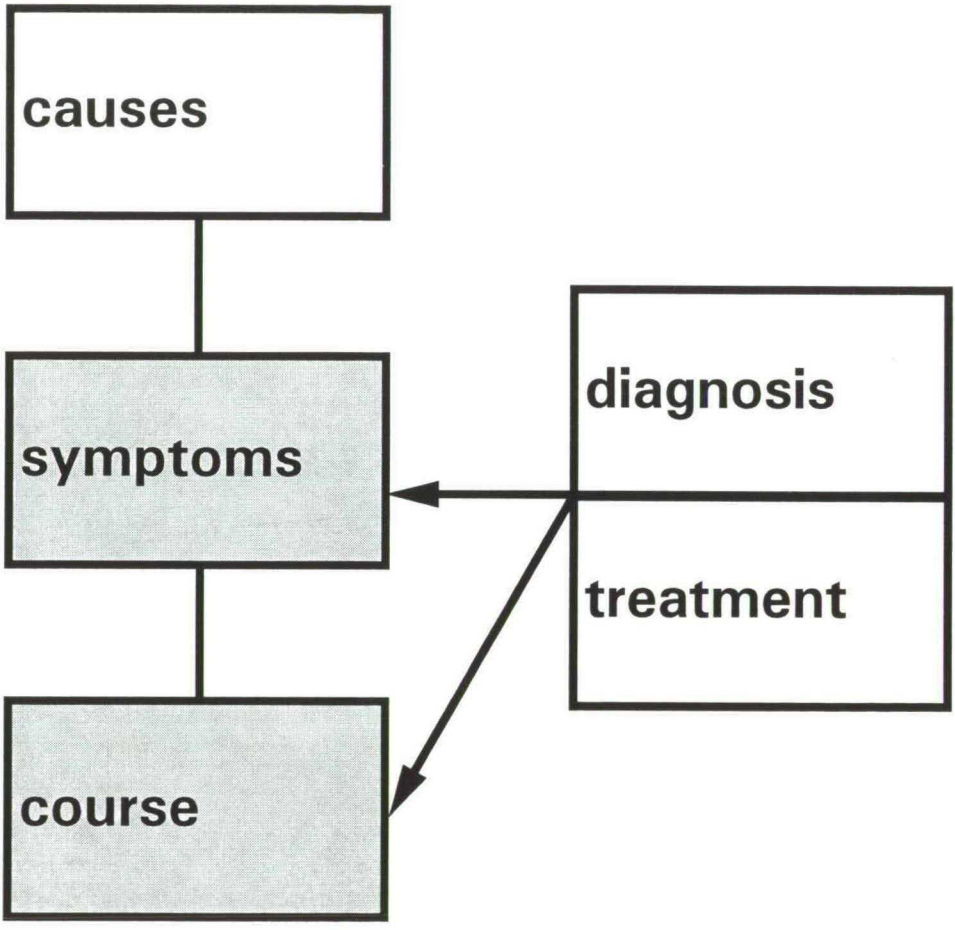
8. When I am homesick, I miss my own house
9. When I am homesick, I miss people from my old environment
10. When I am homesick, I miss my old home environment
11. When I am homesick, I miss the atmosphere of home
12. I have been homesick as a child

The following items were used to classify the three homesickness groups

13. I have been homesickness as an adult
14. I am homesick during holidays
15. I am homesick after a move

Note: Subjects had to answer on a five-point scale raging from 'not at all' (1) to 'very much' (5).

PART II



7 Longing for home: An exploratory investigation into homesickness

Miranda A.L. Van Tilburg, Ad J.J.M. Vingerhoets, Guus L. Van Heck

Abstract

The present exploratory investigation focused upon the psychological context of homesickness in adult women. The data revealed that feelings of homesickness occur mainly after a move or during a holiday. Homesickness is accompanied by a depressive mood and psychosomatic complaints. It is generally unexpected even if it has been experienced before. Since homesickness appears to be a direct reaction to leaving home it is hypothesized that separation from home is the major cause of homesickness feelings. It is emphasized that future research should especially focus upon factors in the old environment, personality, and personal history which predispose to homesickness, and factors in both the new and old environment which moderate the homesickness experience. Finally, more attention should be drawn to homesickness in common situations like holidays.

Introduction

Separation from home has been acknowledged to be a significant stressor linked to major and minor somatic health problems, like deficiencies in the immune system (Schmitz, 1992), and leukaemia (Jacobs & Charles, 1980). It may also be associated with psychological problems. Frequently, mental health problems in those who have left their homes are connected with homesickness (Brown & Harris, 1989; Ekblad, 1993; Leff, Roatch, & Bunney, 1970; Schmitz, 1992; Weissman & Paykel, 1973). Homesickness is characterized by negative emotions, ruminative cognitions about home, and somatic symptoms. Unfortunately, very little systematic research has been done into this phenomenon (for an overview of the literature see Van Tilburg, Vingerhoets and Van Heck, 1996). Fisher (1989) has done the most extensive research in this area. She concluded that homesickness is a complex syndrome associated with distress. It occurs in 50-70% of most populations and is independent of age and sexe. The homesickness experience is continuous only in the severe homesick. Otherwise, episodes of homesickness occur mostly during passive and mental tasks and in the morning and at night. Homesick subjects are more likely to report psychoneurotic symp-

toms, absent-mindedness, intrusive home-related thoughts, dissatisfaction with the new situation, high demands of and low control over the new situation, low decisional control over the move, and depressive feelings before the move.

The scarce psychological studies on homesickness are rather limited due to the narrow focus on specific groups of homesick people like conscripts (Bergsma, 1963; Dijkstra & Hendrix, 1983; Eurelings-Bontekoe, Vingerhoets, & Fontijn, 1994), migrant populations and refugees (e.g. Eisenbruch, 1990; Hertz, 1988; Hojat & Herman, 1985; Larbig, Xenakis, & Onishi, 1979; Schmitz, 1994), non-resident students, student nurses, and boarding school children (Brewin, Furnham, & Howes, 1989; Carden & Feicht, 1991; Fisher, 1989; Fisher, Frazer, & Murray, 1984, 1986; Fisher & Hood, 1987, 1988; Fisher, Murray, & Frazer, 1985; Miller & Harwell, 1983; Porritt & Taylor, 1981), and institutionalized people (Taylor, 1986). To our knowledge, there has not yet been an investigation of homesickness phenomena in those who are 'homesickness-prone', that means those who do not suffer from homesickness at the moment, but will develop homesickness if they have to leave their familiar surroundings temporarily or permanently. Thus, very little is known about the antecedents and context of homesickness.

We conducted an exploratory investigation of homesickness experiences in a more general sample. Two groups were distinguished: (i) persons who are currently in a long-lasting or *chronic homesickness* situation, for instance, due to a permanent move, and (ii) *homesick-prone* persons who feel comfortable in their living situation but have had homesickness experiences previously and who expect to develop acute homesickness when they have to leave their house, for instance, due to a holiday or a move. The present study thus deals with the context and antecedents of homesickness over a wide range of homesickness-eliciting situations. The purpose of this explorative study is to obtain a better insight into the context of homesickness. Based on present findings, we want to formulate hypotheses to be tested in future research.

Method

Subjects

Two-hundred twenty-nine females participated in this study. Their age varied from 18 to 79 years (M = 41.1). Eighty percent of the respondents were married or had a stable relationship with a partner. Half of them had secondary education, 25% higher education, and the remaining fourth part lower education.

Subjects were recruited through magazine and newspapers announcements, asking for volunteers for a study on homesickness. A total of 314 respondents completed the questionnaire, of which 231 were suited for further analysis. The other 83 questionnaires were left out because of one of the following reasons: (i) the subject was not above 18 years of age; (ii) the subject described another phenomenon instead of homesickness; or (iii) the subject had suffered from homesickness in the past but recovered a long time ago. Moreover, because only 8 men participated, they were left out of analysis.

Measures

A Homesickness Experience Questionnaire (HEQ) was developed partly based upon Wallbott and Scherer's (1986) questionnaire for studying emotional experiences. The HEQ was designed to explore several dimensions of the homesickness experience. These were: antecedents, reactions, symptoms, coping and control processes (derived from Aebischer and Wallbott (1986)), and causes (derived from Fisher (1989)). Questions covered Fisher's multicausal theoretical framework of homesickness (Fisher, 1989). In this model a two-part challenge is reflected: (i) the separation from the familiar environment and (ii) the entrance into the new setting. Both are regarded as important factors in the development of homesickness.

The HEQ consists of open and closed answer alternatives focussing upon the characteristics and evaluation of the homesickness situation (e.g. 'Can you describe the situation or what happened that makes/made you homesick?', 'From which important persons are/were you separated?', 'Do/did you feel secure in the homesickness situation?', 'Are/were you able to influence the homesickness situation?'), the emotional and physical reaction to the homesickness (e.g. Which of the following bodily reactions do/did you experience? headache, gastric complaints, sleep disturbances, lack of appetite, funny feelings in the legs, crying, other reactions'), the characteristics of the homesickness experience (e.g. 'How intense are/were your feelings of homesickness?', 'Did you expect yourself to become homesick in this situation?'), and the attributions of homesickness (e.g. 'How important were the following factors for the development of your homesickness? Missing the old environment, missing persons from the old environment, etc.'). The subjects completed the questionnaire referring to the last time they were in a homesickness situation.

Results

Eighty-one subjects were currently in a long-lasting or *chronic homesickness* situation. They had been homesick for 3 months to 56 years (Mode= 1 year; Mean= 8 years). The others (N = 142) could be classified as *homesick-prone*. The time since the homesick-prone were in a homesickness situation ranged from 1 to 58 years (Mode= 1 year; Mean= 10 years), indicating that some subjects successfully avoided homesickness-eliciting situations, sometimes even from youth onwards. The chronic and homesick-prone groups were compared on the basis of Chi^2 tests. Because of the large amount of data gathered only the most important results will be presented here.

Characteristics of the homesickness situation

The most frequently mentioned homesickness-eliciting situations in the chronic group were moves and migrations (95.5%). Of those who moved, 28% spontaneously mentioned that they had to move due to their husband's change of job. In the homesick-prone group, the following situations were mentioned: vacations (63.9%), moves and migrations (11.1%), short stays away from home due to work or study (9.7%), hospital admittances (4.9%), and a rest category including living in a foster home, staying at a boarding school, being an au-pair, and anticipating homesickness-eliciting situations (8.3%).

In the chronic homesick group, 85% reported that this homesickness-eliciting situation continued for an indeterminate period of time. In contrast, the homesick-prone reported a duration of a few days to a few weeks (72.2%). An untimely return was/is less possible for subjects in the chronic (82.7%) than in the homesick-prone group (61.2%; $p \leq .05$). Still 61% of the subjects in the homesick-prone group were not able to return home untimely, for example, because of pressure by family or the fact that they had already booked return tickets for boat, train, or aeroplane. Subjects were less than 1 (1.5%) to more than 9000 (6.4%) kilometers away from the place they were longing for (Mode = 100; Median = 200; Mean = 1199.4). The old situation was within walking distance ($\leq$ 5 kilometers) in 6.4% percent of the cases, indicating that geographical distance is only of minor importance for the development of homesickness. Furthermore, no significant differences were found in homesickness intensity in those who were within walking distance ($\leq$ 5 km), in the direct surroundings of their home town (5-30 km), in The Netherlands (30-300 km), in Europe (300-2000 km), and outside Europe ($\geq$ 2000 km).

In the majority of the cases the partner and/or children were present (74% versus 55% for the chronic homesick and the homesick-prone group, respectively). In both groups 15% was alone. Eighteen percent of the homesick-

prone mentioned the company of others than family or friends, for instance, colleagues. Important persons who were left behind were parents and/or brothers and sisters (approximately 47% in both groups), spouse and/or children (chronic 10% *versus* prone 26%, $p \leq .01$), other family (chronic 48% *versus* prone 12%, $p \leq .0001$), and friends and acquaintances (chronic 59% *versus* prone 21%, $p \leq .0001$). Contact with these persons was possible in most of the cases. They stayed in contact by telephone (chronic 85% *versus* prone 66%, $p \leq .01$) or by writing letters (chronic 51% *versus* prone 14%, $p \leq .0001$). Those who were alone in the homesickness situation did not report more negative feelings and physical symptoms, although they rated their homesickness as more intense ($p \leq .01$). This may be due to the fact that in addition to being separated from home, they were also separated from significant others.

Evaluation of the homesickness situation

As can be seen from *Table 7.1*, the homesickness situation was not evaluated positively. Homesick-prone subjects, however, had a more negative opinion on the situation than chronic homesick subjects. Furthermore, in both the chronic and the homesick-prone, the situation was considered as having no effect on one's career and ambitions in approximately 73% of the cases. The career and ambitions of significant others were also perceived as predominantly unaffected in the homesick-prone group (82.3%). In contrast, 42% of the chronic homesick reported that the new situation was important for the career and ambitions of others. In addition, 62% of these women held their partners and 22.2% authorities, like employers, responsible for the fact that they are in a homesickness situation, compared with 18% and 14%, respectively, in the homesick-prone group. Although one also blamed oneself for it (approximately 51% in both groups).

Two-third (67%) of the subjects could not think of an solution for their homesickness besides going back. Other solutions mentioned were looking for distraction, forms of confrontive coping, ignoring the homesickness, getting over it, waiting until it disappears, trying to accept the new situation or the homesickness itself, adapting to the new situation, talking about the homesickness, understanding and comforting of others, making new friends, going into therapy, visiting the old place, moving (not particularly to the old place), and preparing for an eventual return like persuading one's partner to move or to register with a housing association in the old place.

Emotional and physical reactions

In the chronic homesickness group significantly more emotional reactions ($M = 7.1$) were endorsed than in the homesick-prone group ($M = 4.8$; $p \leq$

Table 7.1. Evaluation of the homesickness situation (percentages)

	Chronic homesickness		Homesick-prone		
	not at all or a little bit	fairly or extremely	not at all or a little bit	faitly or extremely	Chi^2 sign.
- Feeling secure in the homesickness situation	58.8	41.3	87.9	12.0	a
- Satisfied with the homesickness situation	70.8	29.2	87.0	12.9	c
- Having grip on the homesickness situation	68.3	31.7	85.5	14.5	b
- Being able to influence the homesickness situation	83.5	16.5	92.0	7.9	a
	65.0	35.1	62.9	37.1	n.s.
- High demands of the homesickness situation	56.3	43.7	59.3	40.7	a
- Cope with demands of the homesickness situation	59.3	40.8	40.4	59.6	a
- Difficult to adapt to the new environment					

a $p \leq .05$; b $p \leq .01$; c $p \leq .001$.

.0001). In *Table 7.2* the frequencies of the different emotions are given for both groups. Sorrow, a gloomy mood, and aversion to the new environment were the most frequently mentioned feelings. There is a remarkable difference between the two groups with respect to frustration. Frustration appeared to be a familiar feeling for almost half of the subjects in the chronic homesick group, while it did not seem to play a significant role in the homesick-prone. Frustration might be predominantly felt when the situation is unchangeable like in a move, which was far more often mentioned as the homesickness-eliciting situation in the chronic than in the homesick-prone group.
The chronic as well as the homesick-prone reported on average about three physical reactions ($M = 2.9$, see *Table 7.3*). In both groups the items 'crying' and 'sleep disturbances' were endorsed most frequently. Forty-four percent indicated other physical reactions, including binge eating, hyperventilation, fatigue, concentration difficulties, suicide attempts, nightmares, nausea, tightness of the chest, vomiting, heart complaints, etc.

Table 7.3. Frequency of physical reactions (percentages)

Physical reaction	Chronic homesickness	Homesickness-prone	Chi^2 sign.
Headache	39.5	28.2	n.s.
Gastric complaints	35.8	31.0	n.s.
Sleep disturbance	53.1	61.3	n.s.
Lack of appetite	19.8	42.3	b
Funny feelings in the legs	11.1	14.8	n.s.
Crying	81.5	69.0	a
Other physical reactions	37.0	47.9	n.s.

a $p \leq .05$; b $p \leq .001$.

Characteristics of the homesickness experience
Homesickness feelings developed within one day after the leave for about 50 percent of the subjects in both the chronic and the homesick-prone group. A minority of subjects (6% and 8.5% respectively) even reported to be suffering from homesickness before the leave. The feelings were not expected at all or just a little bit in most cases (73% chronic versus 50% prone; $p \leq .001$). The same pattern was found for the non-expression of homesickness emotions (chronic 59% versus prone 55%, n.s.).

Table 7.2. Frequency of emotions (percentages)

Emotion	Chronic homesickness	Homesickness-prone	Chi^2 sign.
Sorrow	86.4	59.2	b
Gloomy mood	74.1	55.6	a
Tense	54.3	49.3	n.s.
Anger	39.5	16.2	b
Washed-out	49.4	28.9	a
Aversion to the new environment	72.8	47.2	b
Apathy/listlessness	48.1	35.2	n.s.
Despondency	40.7	20.4	b
Frustration	43.2	9.9	b
Indifference	18.5	7.0	a
Pessimism	34.6	17.6	a
Feel ill at ease	54.3	57.7	n.s.
Uninterested in surroundings	32.1	38.0	n.s.
Confusion	28.4	21.1	n.s.
Other emotions	29.6	21.1	n.s.

a $p \leq .01$; b $p \leq .001$.

The intensity of the homesickness was rather high and differed significantly between the chronic and homesick-prone groups. On a 10-point scale the mean scores were 7.8 and 8.6, respectively ($p \leq .001$).
Twenty percent of the chronic homesick and 46% of the homesick-prone reported to be continuously homesick. The other subjects had episodes of homesickness. For the chronic homesick the positioning in time of the episodes varied for most subjects (63%). In the homesick-prone group, 26% had these episodes mainly in the evening or during the night, while 18% reported variable episodes.

Attributions
Missing the old environment, missing its atmosphere, missing persons, and changes in the way of living one's life were regarded as the most important causes of homesickness (see *Table 7.4*). Approximately half of the subjects also indicated disliking the new environment and having no grip on the environment as causes of their homesickness. The latter was significantly more often mentioned in the homesick-prone group as compared with the chronic group.

No significant difference were found between those who were alone and those who were with others in the homesickness situation. If those who were alone are compared with those who were accompanied by close family members like their spouse, children, or parents, then, the singles significantly more often reported causes such as 'giving up old habits' ($p \leq .05$) and 'changing one's way of living' ($p \leq .01$). This may also explain why those who are alone in the homesickness situation experience more intense homesickness feelings compared to those who have company.

Discussion

The primary aim of the present study was to obtain a better insight into the phenomenon homesickness and its context. The results in general seem in accordance with Fisher's multi-causal theory of homesickness (Fisher, 1989) in which both difficulties in separating from the old environment and difficulties in adapting to the new environment are regarded as important causes of homesickness. However, on the basis of the present findings the causal role of characteristics of the new environment in homesickness can be seriously questioned. The homesick-prone were mainly in pleasurable holiday situations together with their families, but they still experienced severe homesickness. In addition, the chronic homesick expressed quite positive cognitions about their new situation. Moreover, homesickness is mainly a *direct* reaction to the separation from home. Subjects thus often did not have had time to explore the new environment. Some even developed 'anticipation' homesickness before having left the old environment. In addition, solutions to overcome homesickness were generally not sought in the new environment.

Thus, our data strongly suggest that difficulties with the new environment might not be a major cause or even sufficient condition for the development of homesickness. It could, however, aggravate the feelings of homesickness. The attributions made to the new environment as the cause of homesickness might be due to the fact that homesickness makes you think negatively of your surroundings even though you have not yet explored it. In turn, these negative cognitions interfere with the adaptation to the new environment and, by consequence, preserve the homesickness. Homesick people ruminate and are going around in circles, thereby preventing a solution. Homesickness makes one think about home, and these thoughts in their turn elicit homesickness.

Table 7.4. Attributions of homesickness feelings (percentages)

	Chronic homesickness		Homesick-prone		Chi² sign.
	not at all or a little bit	fairly or extremely	not at all or a little bit	faitly or extremely	
- Missing the environment	18.5	81.4	25.8	74.2	n.s.
- Missing personss	17.3	82.7	29.2	70.8	n.s.
- Giving up old habits	66.6	33.3	65.9	34.1	n.s.
- Changing the way of living one's life	37.1	62.9	37.0	63.0	n.s
- Dislike of current (work) activities	81.3	18.8	76.4	23.6	n.s.
- Dislike of the new environment	51.3	48.8	53.9	46.1	n.s.
- Insufficient amount of friends in the new environment	58.0	42.0	59.0	41.0	n.s.
- Having no grip on the environment	56.8	43.2	34.1	65.8	a
- Missing the atmosphere of the old environment	12.3	87.7	14.2	75.8	n.s.

a $p \leq .01$

The global picture that emerges from this study is the following:

1 Homesickness experiences occur mostly after a move or during holidays and for most people it is hardly possible to go back untimely.
2 Homesickness typically develops within one day indicating a direct reaction to the move. Those who have had severe homesickness experiences before, sometimes react to anticipation of the move by developing homesickness-like symptoms, when still being at home (for a more extensive description of this phenomenon see Van Tilburg, Vingerhoets, Kirschbaum, & Van Heck, 1996). In contrast, others become homesick years after they have left their home environment. In some cases stressful events in the current or past environment triggered the homesickness, like a death of a left-behind parent or a divorce.
3 Feelings of homesickness are only continuously present in the severe homesick. Otherwise the homesickness strikes at variable times during the day.
4 Homesickness usually fades away after some time. Yet, there is no guarantee for curing, because homesickness can last a life time.
6 The only real solution the homesick individual sees is going back to the old environment. Some try to gain understanding and talk about it, but only a minority thinks this brings relief. Furthermore, when being back in the old environment, people often try to prevent future homesickness by avoiding homesickness-eliciting situations.
7 Separation from those who are most close is not a necessary condition to evoke homesickness. Separation can, however, aggravate the homesickness. Family can give support when in a stressful situation, thereby alleviating the homesickness a little bit. In addition, leaving one's family behind also implicates a greater change in habits and way of living, which can be an important facilitating factor in homesickness.
8 Feelings of homesickness are most of the time not expressed to others, thereby preventing the provision of social support.
9 Homesickness is typically not anticipated even though most of the subjects have had homesickness experiences before. One may wonder whether most persons, due to the fact that it is conceived as something immature, think that their vulnerability of homesickness disappears with time. People again and again try to leave their house for a short or longer period of time, although homesickness strikes almost every time. This can be devastating to one's self-esteem.
10 Geographical distance does not appear to be an important causal factor in homesickness, since serious homesickness complaints can even develop when being within walking distance from home. Moreover, longer distances do not seem to aggravate feelings of homesickness.

11 Homesickness experiences are accompanied by a negative or depressed mood, an aversion to the new environment, crying and sleeping disturbances. It is remarkable that in this study crying seems to be one of the most common reactions to homesickness, while it has never been reported in previous studies on homesickness (Van Tilburg, Vingerhoets, & Van Heck, 1996).

12 Self-reported causes of homesickness are more often attributed to the old than to the new environment. However, negative experiences in the new environment are still indicated as a facilitating factor in almost 50% of the subjects.

13. There appeared to be more similarities than differences between the chronic homesick and the homesick-prone. Differences between the groups were mainly due to the longer time period the chronic homesick were staying in the homesickness situation compared to the homesick-prone. If one has to stay for an indeterminate period of time in a certain situation, some cognitions change in time in order to reduce cognitive dissonance. For example, the situation may be evaluated as less negative, if one knows that it is permanent instead of temporarily.

We want to point at two major drawbacks of this study. First, it depends on self-report data which might be subject to response bias and social desirability. However, as homesickness is a subjective experience much can be learned from these data. We did gather a large amount of information on the psychological context of homesickness which can stimulate further theorizing and research on homesickness. More objective tests of hypotheses based on these results are certainly needed. Second, the self-selection factors play a role in the composition of our group of subjects. It appeared that only those who have or have had rather severe homesickness experiences participated. Furthermore, almost no men participated. Other studies (Brewin *et al.*, 1989; Fisher, 1989; Gruijters, 1992) found almost an equal amount of men compared to women who suffer from homesickness. Thus, men are either reluctant to admit, even in an anonymous situation, that they are homesick, or they label their feelings differently. Therefore, no generalizations can be made from this data to other groups of homesick adults, like men and persons with moderate levels of homesickness.

Future research should specifically focus at the factors in the old environment and the personal history causing the homesickness and the variables moderating the homesickness experience, e.g. change in daily routines, negative experiences in the new environment, geographical distance, coping styles etc.. Furthermore, attention should be drawn at the role of personality

and biographical factors, including life events and previous homesickness experiences. Finally, since the homesickness experience is generally studied in less common situations, like boarding school and university students, it is important to draw attention to those situations where homesickness strikes most often, cf. moves and holidays. In conclusion, much work still has to be done before we gain any real understanding of the causes, consequences, and correlates of this intriguing phenomenon.

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8 Homesickness, mood, and self-reported health

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Abstract

The present study focused on health status, mood, cognitions, saliva cortisol, social activities, in homesick (N = 80), homesick-prone (N = 152), recovered (N = 48), and non-homesick adult women (N = 45). Self-reported health and mood were poorer and cognitive failures elevated in homesick and homesick-prone subjects compared with non-homesick and recovered persons. Cortisol levels, on the other hand, failed to differ among the four groups. Furthermore homesick, homesick-prone and recovered individuals reported more difficulties making friends, fear of heights, dislike to travel alone, school phobia, and less club membership in childhood compared to the non-homesick. It is suggested that a personality linked vulnerability factor is responsible for making anxious individuals prone to develop homesickness.

Introduction

Separation from home has been acknowledged to be a significant stressor linked to somatic health problems, including deficiencies in the immune system (Schmitz, 1992), leukaemia (Jacobs & Charles, 1980), as well as psychological problems, for example, depression (Ekblad, 1993; Jacobs & Charles, 1980; Leff, Roatch, & Bunney, 1970; Weissman & Paykel, 1973; Schmitz, 1992). A common phenomenon in those who have left home is homesickness (Brown & Harris, 1989; Ekblad, 1993; Leff, Roatch, & Bunney, 1970; Schmitz, 1992; Weissman & Paykel, 1973). Homesick persons report feelings of unhappiness, being physical unwell, anxiousness, and depression (see Van Tilburg, Vingerhoets & Van Heck, 1996). On the basis of several studies among university students and student nurses, Fisher (1989) concluded that homesick subjects are more likely to report psychoneurotic symptoms (even before the move), absent-mindedness, and somatic symptoms, than their non-homesick counterparts. These results led Fisher to hypothesize that homesickness might be a specific form of post-traumatic stress disorder. Both the loss of the old environment and the lack of control in a demanding new environment might cause homesickness. In this view, homesickness is a distressing experience which creates increased risk of physical and mental ill health.

It is unfortunate that the scarce psychological studies on homesickness are rather limited to specific groups like conscripts (Bergsma, 1963; Dijkstra & Hendrix, 1983; Eurelings-Bontekoe, Vingerhoets, & Fontijn, 1994), migrant populations and refugees (e.g. Eisenbruch, 1990; Hertz, 1988; Hojat & Herman, 1985; Larbig, Xenakis, & Onishi, 1979; Schmitz, 1994), non-resident students, student nurses, boarding school children (Brewin, Furnham, & Howes, 1989; Carden & Feicht, 1991; Fisher, 1989; Fisher, Frazer, & Murray, 1984, 1986; Fisher & Hood, 1987, 1988; Fisher, Murray, & Frazer, 1985; Miller & Harwell, 1983; Porritt & Taylor, 1981), and institutionalized people (Taylor, 1986). To our knowledge, there has not yet been an investigation of homesickness in those who are 'homesick-prone', that means those who do not suffer from homesickness at the moment, but who anticipate that they will develop homesickness when they have to leave their familiar surroundings temporarily or permanently. Is this group also at risk of developing (mental) ill health in their home surroundings, or only when in a real homesickness situation? Raised levels of psychoneurotic symptoms and decreased mood have been found in those who are prone to homesickness before a planned leave from home (Fisher, 1989; Van Tilburg, Vingerhoets, Kirschbaum, & Van Heck, 1996). But does this also hold when these people are not intending to leave home?

Furthermore, to our knowledge there has been only one study on homesickness which included, besides subjective distress measures, a biochemical stress marker, such as cortisol (Van Tilburg, Vingerhoets, Kirschbaum, & Van Heck, 1996), a hormone which is believed to be indicative of stress. In that multiple case study, no relationship between morning and evening cortisol levels and homesickness was found.

The present exploratory study focussed upon physical and mental health problems, cognitive failures, and cortisol levels associated with homesickness in a more general sample. Four groups were distinguished: (i) persons who are currently in a long-lasting or *chronic homesickness* situation, for instance, due to a permanent move; (ii) *homesick-prone* individuals, who feel comfortable in their living situation but have had homesickness experiences previously and who expect to develop acute homesickness when they have to leave their house, for instance, due to a holiday or a move; (iii) persons who have had homesickness experiences in the past, but they consider themselves to be fully *recovered*; and (iv) persons who have never experienced homesickness (*non-homesick*). This study explores the correlates of homesickness over a wide range of homesick(-prone) and non-homesick persons.

Method

Subjects

Subjects were 325 females, who were recruited through women's magazines and newspaper announcements in which volunteers were asked to participate in a study on homesickness. As very few non-homesick subjects responded, separate announcements were placed in order to recruit non-homesick subjects. Age varied from 18 to 79 years (M = 42.4, SD = 13.4). Seventy-eight percent of the respondents were married or had a stable relationship. Approximately 80% of the sample had the minimum of a high school education, the remaining 20% had followed only basic education.

Subjects were assigned to one of four groups on the basis of their own estimate into which group they fitted best. This means that subjects defined themselves as either chronic homesick (N = 80), homesick-prone (N=152), recovered (N=48), or non-homesick (N=45). These four groups did not differ in age, marital status and educational level. Three years later the chronic homesick were approached again. A total of 39 persons (49%) returned the second questionnaire.

Measures

The Hopkins Symptom Checklist (HSCL; Luteijn, Hamel, Bouwman, & Kok, 1984) was administered to rate somatic (Somatization scale) and psychological subjective health status (Psychological Complaints scale). The reliability and validity of the HSCL and the two subscales is good (Luteijn *et al.*, 1984).

In order to assess mood states, the shortened version of the Dutch Profile of Mood States (POMS; Wald & Mellenbergh, 1990), original version (Goldstein & Chambless, 1978) was used, containing the following subscales: Depression, Anger, Vigor, Tension, and Fatigue. Cronbach's alpha for these scales ranges from .82 to .91 and the validity of the questionnaire is good (Wald & Mellenbergh, 1990).

Self-reported failures in perception, memory, and motor function were measured with the Cognitive Failures Questionnaire (CFQ; Broadbent, Cooper, Fitzgerald, & Parkes, 1982). CFQ scores are reasonably stable and correlate with measures of deficit in memory, absent-mindedness, and slips of actions (Broadbent *et al.*, 1982). The HSCL, POMS, and CFQ had to be completed referring to the last couple of weeks.

The chronic homesick were asked to rate their homesickness intensity on a ten-point scale. Three years later the chronic homesick were approached again and were asked to rate both their present homesickness intensity as well as, retrospectively, the intensity of homesickness three years ago.

In a subgroup of 57 participants (18 chronic homesick, 28 homesick-prone, and 11 non-homesick) saliva cortisol was measured as an indication of biological changes that may occur during homesickness experiences. Saliva samples were obtained using the Salivette sampling device (Sarstedt, Germany) as described by Hellhammer, Kirschbaum, and Belkien (1987). The saliva samples for the determination of cortisol were taken in the morning (between 8.00 and 8.30 AM) and in the evening (between 10.30 and 11.00 PM on a quiet evening, that means not after a quarrel, a sports game, or a scary movie). The subjects had to chew gently on the cotton swab for about one minute to stimulate saliva flow. The samples, together with the questionnaires, were returned by mail. Cortisol analyses were performed with a time-resolved fluorescence immunoassay. This assay has a lower detection limit of 8.6 pg/well (95% confidence interval). Finally, participants were asked about youth experiences, social activities, fear of heights, travel sickness and demographic variables.

Results

One-way ANOVA's with Scheffé post hoc tests were performed to test the between-groups differences on the HSCL, CFQ, POMS scales and cortisol levels (see *Tables 8.1 and 8.2*). For the HSCL the following results were found. The Total score of the HSCL differed significantly among groups. Post hoc tests showed that the chronic homesick and homesick-prone had elevated HSCL scores compared with the non-homesick and recovered individuals. The same between-groups differences were found on the CFQ. The chronic homesick and homesick-prone had higher CFQ scores than the non-homesick and recovered individuals. Analysis of the POMS subscales yielded the following results. The overall test was significant for all scales. Scheffé tests, however, did not reveal any difference between groups for the Vigor subscale. Neither were there any significant differences on the other POMS subscales between the recovered and non-homesick groups. Compared to the non-homesick: (i) the chronic homesick scored significantly higher on all subscales except Vigor, and (ii) the homesick-prone had elevated scores on all scales except Vigor and Fatigue. Furthermore, scores for the chronic homesick were significantly enhanced compared to the other two homesickness groups on the Depression scale. In addition, scores on Anger and Tension were also elevated compared with the recovered persons. The homesick-prone showed significant raised scores on Tension compared to the recovered persons. Analyses of the cortisol data revealed no significant differences between the groups.

Table 8.1. Means of POMS, HSCL, and CFQ scale scores

	chronic home-sickness	home-sick-prone	recove-red home-sickness	non-home-sick	*F*-value
	M	*M*	*M*	*M*	
HSCL					
total	112.11	104.53	91.40	75.69	4.15 b
physical health	13.35	21.16	12.45	10.60	.67
psychol. health	34.54	37.57	26.26	22.78	.96
CFQ	91.77	88.25	83.38	78.98	5.56 c
POMS					
depression	17.30	12.37	10.21	9.75	21.40 c
anger	14.50	12.27	10.42	9.76	8.90 c
vigor	14.72	14.74	15.98	16.63	2.84 a
tension	14.68	12.69	10.02	8.75	17.41 c
fatigue	13.38	12.00	11.49	9.93	3.58 a

Note. HSCL= Hopkins Symptom Checklist (Luteijn, Hamel, Hamel, Bouwman, & Kok, 1984); CFQ= Cognitive Failure Questionnaire (Broadbent, Fitzgerald, & Parkes, 1982); POMS= Profile Of Mood States (Wald & Mellenbergh, 1990).
a= $p \leq .05$; b= $p \leq .01$; c= $p \leq .001$.

Table 8.2. Means of Morning and Evening Cortisol

Cortisol	Chronic homesick		Homesick-prone		Non-homesick		*F*-test
	M	*SD*	*M*	*SD*	*M*	*SD*	
Morning	24.70	13.86	19.60	10.77	19.50	9.65	n.s.
Evening	9.00	22.82	6.88	18.54	11.23	219.45	n.s

In addition, mean HSCL scores per group were compared to norm scores of an adult Dutch sample reported in the Dutch HSCL manual (Luteijn *et al.*, 1984). The chronic and homesick-prone scored high to very high on all (sub)scales. The recovered homesick also scored high on the total score and the Somatization subscale, and above average on the Psychological Complaints subscale. For the non-homesick only the mean on Somatization was high compared to the norm scores, on the other two scales scores were average. One-way ANOVA's with Scheffé post hoc tests and chi-square tests for ordinal variables were used to analyze the data on youth experiences, social activities, fear of heights, travel sickness and demographic variables (see *Table 8.3*). It appeared that the chronic and homesick-prone groups both reported significantly more difficulties in making new friends than the non-homesick. In addition, the homesick-prone reported significantly less often going out, more dislike of going out, and less vacations/stay overs as a child than the non-homesick. Furthermore, the homesick-prone also liked it significantly more to stay at home than the chronic homesick. Significantly more persons in the chronic homesick, homesick-prone, and recovered homesick groups, compared with the non-homesick, suffered from school phobia, and fear of heights as an adult and as a child. Significantly less persons in the homesick groups, compared with the non-homesick, like to go on a holiday unaccompanied, and were members of a club in childhood.

Three years later 51% of the chronic homesick still experienced homesickness (N = 20). The feeling of homesickness had changed for 70%, predominantly in frequency and intensity. In 60% of the cases, there was a decrease of at least 1 point on a ten-point scale measure of homesickness intensity. Those who were not homesick anymore (49%, N = 19) reported to have been homesick for 1 to 25 years (Mean=6.6, Median=5, Modus=2.5). In 74% of the cases, the homesickness disappeared because of a move back home.

Current retrospective estimates of the intensity of homesickness three years ago on a ten-point scale were subtracted from the scores on the same scale administered three years ago. It appeared that, on average, there was a minor underrating of the homesickness intensity in the past (M = .11). There were more people who overrated their homesickness (36%) compared to those who underrated (30.6%), however, the underrating was higher (1 to 6 points) than the overrating (1 to 3 points) This is probably due to a ceiling effect, because mean homesickness intensity three years ago was 7.95. A t-test revealed that there was no difference in homesickness intensity three years ago between those who recovered and those who were still homesick. As only half of the chronic homesick participated in the study three years

Table 8.3. Means and percentages on youth experiences, social activities, fear of heights, travel sickness and demographic variables

Item *(response alternatives (y=yes/n=no))*	Chronic Homesickness % yes	Homesick-prone % yes	Recovered homesick % yes	Non-homesick % yes	Chi^2-test / *F*-test
Are you a member of a club? (y/n)	81.3	81.5	72.9	86.7	n.s.
Were you member of a club as a child (y/n)	53.3	59.3	61.1	75.8	a
Would you enjoy going on a holiday unaccompanied by family or friends? (y/n)	21.1	6.8	18.5	34.8	c
Do you suffer from travel sickness? (y/n)	43.8	45.9	41.7	26.7	n.s.
Did you suffer from travel sickness as a child? (y/n/don't know)	42.6	40.7	31.2	23.4	n.s.
Do you suffer from fear of heights? (y/n)	52.3	50.6	53.7	27.3	b
Did you suffer from fear of heights as a child? (y/n/don't know)	33.8	28.0	22.9	15.6	b
Did you suffer from school phobia as a child? (y/n/don't know)	26.7	39.9	37.0	1.5	c
Does your mother suffer from homesickness? (y/n/don't know)	26.0	23.1	20.5	4.9	n.s.
Does your father suffer from homesickness? (y/n/don't know)	8.7	15.6	6.7	7.3	n.s.
As a child did you ever spend more than one week outside your family? (y/n)	73.8	58.0	66.7	64.4	n.s.
As a child did you ever go on a hoiliday without your parents? (y/n)	53.8	50.3	55.3	66.7	n.s.

(Table 8.3 to be continued)

Table 8.3. (continued)

Item *(response alternatives (y=yes/n=no))*	Chronic Homesickness % yes	Homesick-prone % yes	Recovered homesick % yes	Non-homesick % yes	Chi²-test / *F*-test
How many good friends do you have besides your partner?	4.58	3.97	2.85	3.84	n.s.
How many good friends do you know from primary school?	1.71	1.03	.40	2.59	n.s.
How many good friends did you have as a child?	3.22	2.86	2.98	3.55	n.s.
Is making new friends difficult for you? *(three-point Likert scale)*	1.99	2.01	2.13	2.32	a
How old were you when you had the first romantic relationship which lasted for at least one year?	18.31	19.58	18.43	18.80	n.s.
How often did you stay over or went on vacation as a child? *(1=more than three times a year, 2= 1-2 x per year, 3=once in 2-3 year, 4=1-2 in 5 years or less, 5=never)*	2.34	2.59	2.63	2.00	b
How often did you go out when you were old enough? *1=several times a week, 2=once a week, 3=once or twice per half year, 4=once or twice per year, 5=never)*	2.39	2.59	2.38	2.36	n.s.

(Table 8.3 to be continued)

Table 8.3. (continues)

Item *(response alternatives (y=yes/n=no))*	Chronic Homesickness % yes	Homesick-prone % yes	Recovered homesick % yes	Non-homesick % yes	Chi^{2}-test / *F*-test
How often did you go: *(four-point Likert scale)*					
- go out	1.90	1.80	1.96	2.22	b
- work out/athletics	2.03	2.07	2.26	2.18	n.s.
- meet friends	2.75	2.84	2.92	2.87	n.s.
- stay at home (without visitors)	3.29	3.38	3.33	3.31	n.s.
How pleasant to you is: *(seven-point Likert scale)*					
- going out	5.69	5.08	5.17	5.94	b
- working out/athletics	4.64	4.78	5.20	5.36	n.s.
- meeting friends	6.30	6.24	6.33	6.28	n.s.
- staying at home (without visitors)	5.85	6.36	6.35	6.23	a

a= $p \leq .05$, b= $p \leq .01$; c= $p \leq .001$.

later, these results must be taken with some caution because the sample might be severely biased.

Discussion

The results of this study show that homesickness is associated with lowered mood, health complaints, and cognitive failures. Remarkably, this result did not only apply to those currently in a chronic homesickness situation, but also to the 'homesick-prone'. This might be regarded as evidence supporting a personal or circumstantial vulnerability factor as suggested by Fisher (1989). This author found levels of depression, somatization, and obsession to be raised in potentially homesick students even *before* the move to university. Since our group of homesick-prone individuals were not measured prior to a transition to a new environment, these results suggest that the distress is not causally linked to an expected transition, but rather to a stable personality feature. Thus, the vulnerability seems to be rooted into the personality of the homesick(-prone). In several studies (see for an overview Eurelings-Bontekoe, 1997) it has been found that homesickness is especially related to *rigidity*. Rigid persons will not only feel distressed when they leave a familiar surrounding and have to adapt to different routines and norms in a new environment, they probably will also experience distress in their home environment because of the daily confrontation with situations demanding adjustment. Whereas most people won't even notice such minor changes, severely rigid people experience an enormous amount of effort to cope with these changes, which renders them distressed. Anxiousness and distress might not only lead to lowered mood and more physical ailments, but also to cognitive failures. Both the homesick and homesick-prone individuals seem to be preoccupied with worries and are not able to concentrate themselves as well as the non-homesick do. They are more vulnerable to failures in perception, memory, and motor function.

Homesickness, whether chronic, prone or recovered, was also related to more difficulties with making new friends, fear of heights, dislike to traveling alone, less membership of a club in childhood, and school phobia. These outcomes correspond to the results of Eurelings-Bontekoe and co-authors (1994), who found that homesick conscripts, from an early age onwards, were characterized by, among others, avoidance of dating and going out, fewer or shorter vacations without parents or alone, problems with separation from parents, and a strong emotional bond with parents. Fisher (1989) also found anxiety, measured after a move to university, to be related to homesickness. However, anxiety measured prior to the move did not distinguish

between homesick vulnerables and the non-homesick. In addition, in an exploratory case study among individuals who reportedly experience homesickness during a holiday, it was found that homesick-prone individuals fear the transition, much like the fear-of-fear cognitions in phobias, especially agoraphobia (Van Tilburg, Vingerhoets, Kirschbaum, & Van Heck, 1996). It could be concluded from the above mentioned that higher levels of anxiety might make individuals more vulnerable to homesickness.

In the present study, subjective distress was elevated both in the chronic homesick and the homesick-prone, but there was no clear association with cortisol levels. Although cortisol is traditionally assumed to be indicative of stress, especially in acute stressful situations which are perceived as being uncontrollable (for a discussion of the literature see Vingerhoets, 1985; Vingerhoets & Van Heck, 1993), the relation between stress symptoms and cortisol plasma levels appears not to be as univocal as is generally assumed. For example, it has been found that cortisol levels are sometimes not associated with self-reported complaints; in situations of chronic stressors it has even been observed that cortisol production decreases (see Vingerhoets & Van Heck, 1993; Vingerhoets *et al.*, 1996).

A three-year follow-up study revealed that the prospects for a spontaneous recovery from homesickness are not good. Only 12.5% of the chronic homesick persons reported to be free of homesickness complaints, due to adaptational efforts, or time passing by. Another 37.5% were also recovered, but this was due to a move back to the old home environment. On the other hand, the data of the group of individuals who reportedly recovered from previous homesickness (recovered homesickness group) suggested that they did not seem to be negatively affected anymore. However, it has to be taken into consideration how many of this group recovered from childhood homesickness instead of adult homesickness. Those who participated in the three-year follow up all suffered from adult homesickness. These findings thus suggest that the prospects for recovering from childhood homesickness are much better than for adult homesickness. However, future longitudinal studies are needed for more definite answers to these questions.

Retrospective estimates of homesickness three years earlier showed that about one third overestimated, one third underestimated, and one third made an exact estimation of their homesickness intensity three years ago. As there was only a slight underestimation most individuals were able to give a pretty good estimate of their homesickness in the past. This might indicate that individuals can imagine pretty well how they have felt during that time, which is a promising result for future retrospective research on homesickness. These results have to be interpreted and generalized with caution,

however. From the original sample, only 49% participated in the follow up. So, the attrition rate was quite high, maybe resulting in a biased sample.

In conclusion, the present data suggest that negative mood, ill health complaints and absent-mindedness are not limited to the transitional period. On the contrary, it does not matter whether one is currently in a homesickness situation or not. Those who are vulnerable to homesickness show decreased levels of mental and physical well-being as well, compared to those who are not homesick. The present study did, however, depend to a large degree on self-reported measures. The only objective measure of 'distress', saliva cortisol, did not reveal any significant differences among the groups. It still has to be established to what extent these findings reflect an attribution process. That means, after a move negative feelings might be attributed to the move, although the move is not the real cause of these feelings. Alternatively, it can be hypothesized that homesickness is a consequence of an underlying syndrome, which manifests itself also in other symptoms like ill health. For instance, in a number of studies a positive relation has been found between neuroticism and homesickness (Gasselsberger, 1982; Eurelings-Bontekoe *et al.*, 1994; Voolstra, 1992). In a study among Dutch adults neuroticism was the best predictor of homesickness (Eurelings-Bontekoe *et al.*, 1994). Are the distress symptoms found in the homesick-prone due to a neurotic personality style? It is important for future research to untangle some of these issues. In addition, a sample of men should be included in future research in order to increase the generalizability of the results.

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9 Mood changes in homesick persons during a holiday trip: A multiple case study

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Abstract

Homesickness is generally studied with respect to rather uncommon long-lasting situations such as a (forced) move, while short stays away from home, like holidays, are much more common homesickness situations. Furthermore, little is known about the development and course of homesickness feelings. Therefore, the present multiple case study was designed in order to obtain a better insight into the onset and course of homesickness and patterns of mood changes, as well as saliva cortisol levels during a short stay away from home. Several times before, during and after their holiday, ten adult homesick-prone females completed the Profile Of Mood States (POMS), the Homesickness Decision Tree (HDT) and a Subjective Homesickness Rating (SHR). In addition, saliva samples ware obtained. Data were analyzed individually. Furthermore, days with and without homesickness were compared across individuals using t-tests. Using the HDT, the following typology, based upon four different reaction patterns, emerged: (1) No Homesickness, (2) Anticipation Homesickness, (3) Holiday Homesickness, and (4) a combination of Anticipation and Holiday Homesickness. POMS-scores demonstrated significantly worsened mood when experiencing homesickness. Cortisol levels, however, failed to differ between days with and without homesickness. Thus, homesickness is characterized by negative mood which is not necessarily reflected in significantly changed salivary cortisol levels. Feelings of homesickness are not only experienced during absence from home, but may occur also in anticipation to a leave. Future studies need to focus upon the prevalence, causes and consequences of the different types of homesickness.

Introduction

Homesickness is characterized by a preoccupation with home and an intense desire to return home. It is often considered to be a form of reactive depression accompanied by somatic symptoms, obsessional thoughts about home, and anxiety (Baier & Welch, 1992; Eurelings-Bontekoe, Vingerhoets, & Fontijn, 1994; Fisher, 1989). It has been estimated that approximately 50 to

75% of all people have at least once experienced homesickness, and in 10-15% of the cases severe problems exist (Fisher, 1989).

The scarce psychological literature on this topic focuses mainly on homesickness among those who have left their house and home for longer periods of time, like military conscripts (Bergsma, 1963; Dijkstra & Hendrix, 1983; Eurelings-Bontekoe *et al.*, 1994), institutionalized individuals (Taylor, 1986), university students, boarding school children, student nurses (Brewin, Furnham, & Howes, 1989; Carden & Feicht, 1991; Fisher, 1989; Fisher & Hood, 1987, 1988; Fisher, Frazer, & Murray, 1984, 1986; Fisher, Murray, & Frazer, 1985; Miller & Harwell, 1983; Porritt & Taylor, 1981), and immigrants (e.g., Eisenbruch, 1990; Hertz, 1988; Hojat & Herman, 1985; Larbig, Xenakis, & Onishi, 1979; Schmitz, 1994). Change in residence is known for its association with health problems. It is included in the Social Readjustment Rating Scale (Holmes & Rahe, 1967) and there is data indicating that this event is associated with onset of depression (Ekblad, 1993; Leff, Roatch & Bunney, 1970; Schmitz, 1992; Weissman & Paykel, 1973), deficiencies in the immune system (Schmitz, 1992) and leukaemia (Jacobs & Charles, 1980). In a study among Dutch adults (Thijs, 1992), however, it was found that the most frequently reported homesickness contexts were holidays (20%) and stay overs (12%). Boarding school was mentioned in 10% of the cases and moves only in 3%. Thus, the current knowledge of homesickness experiences and its antecedents and consequences are based on relatively uncommon situations. It would therefore be of interest to study homesickness in the context where it mainly occurs, namely during short stays away from home, like holidays and stay overs.

In addition, little is known about the development and course of homesickness feelings and its accompanying mental and physical symptoms. Generally, it is implicitly assumed that feelings of distress arise at the moment of separation from home. However, in a longitudinal study by Fisher and Hood (1987) an anticipatory response was found before the transition to university suggesting a personal or circumstantial vulnerability factor. Furthermore, the literature (Baier & Welch, 1992; Fisher, 1989; Rosen, 1975) suggests that homesickness and accompanied feelings of low well-being disappear as soon as one returns home. Even homesick subjects who developed a major depression or severe somatic illnesses have been reported to recover within a few hours (Bergsma, 1963; Rosen, 1975).

This multiple case study has been designed in order to obtain a better insight into the development and endurance of homesickness symptoms during a holiday trip. The aim was to explore how mood in homesick people changes before, during and after a holiday trip. The aim was to explore how mood in homesick people changes before, during and after a holiday trip.

Method

Participants

Ten Dutch female subjects (aged 29 to 59 years) participated in this study. These women were selected from a sample of homesick subjects who responded to announcements in magazine and newspapers in which was called for volunteers for a study on homesickness. To be selected three criteria must be met: (a) they had indicated explicitly to experience *severe* homesick problems every time they leave their homes for more than one day, particularly during holidays, (b) in spite of their homesickness problems they nevertheless went on a holiday either because they did not want or were not able (e.g., because of pressure by family) to avoid these situations, and (c) they spent their holiday together with their families. All subjects went on a holiday outside The Netherlands. The length of their trips varied from 1 to 3 weeks.

Measures

In order to identify the presence of homesickness a modified version of the HDT was administered (Eurelings-Bontekoe *et al.*, 1994). The HDT consists of nine items concerning feelings, thoughts, and physical complaints characteristic of homesickness. The original version has a No/Yes answer format. In this study each HDT-item had to be answered on a 6-point Likert-type scale. Support for the validity of the HDT was provided by Fontijn (1990), who found that diagnosis of homesickness with the HDT overlapped considerably with clinical judgements in a sample of military conscripts. Subjects were further asked to rate on a 10-point scale the intensity of the homesickness feelings (Subjective Homesickness Rating, SHR).

In order to assess mood states, the short version of the Dutch Profile of Mood States (POMS; Wald & Mellenbergh, 1990; original version: Goldstein & Chambless, 1978) was used, containing the following subscales: Depression, Anger, Vigor, Tension, and Fatigue. Cronbach's alpha for these scales ranges from .82 to .91 and the validity of the questionnaire appears to be good (Wald & Mellenbergh, 1990).

Finally, saliva cortisol was determined in order to obtain an impression of the biological changes that may occur during homesickness experiences. Saliva samples were obtained using the Salivette sampling device (Sarstedt, Germany) as described by Hellhammer, Kirschbaum and Belkien (1987). The subjects had to chew gently on the cotton swab for about one minute to stimulate saliva flow. Cortisol analyses were performed with a time-resolved

fluorescence immunoassay. This assay has a lower detection limit of 8.6 pg/well (95% confidence interval).

Procedure
At three times before (pre-measurement), several times during (depending on the length of the trip), and three times after (post-measurement) their holiday trip, the subjects completed the POMS, the HDT, and the SHR just before bed time. On the same days the saliva samples for the determination of cortisol were taken in the morning and in the evening. The pre-measurements were taken five days, three days, and one day *before* the trip and the post-measurements one day, three days, and five days *after* their return. *During* the holidays the subjects completed the questionnaires and took saliva samples once every two days.

Results

First, the development and course of homesickness was examined applying the HDT. Four types of subjects emerged: (a) subjects who did not experience homesickness ($N = 1$); (b) subjects who only experienced homesickness *before* the holiday ($N = 2$); (c) subjects who experienced homesickness only *during* their holiday ($N = 4$); and (d) subjects who experienced homesickness both *before* and *during* their holiday ($N = 3$). Since patterns differ considerably in terms of occurrence and development of homesickness, the different patterns will be discussed separately.

No Homesickness
For the subjects (A) who *failed to meet the HDT criterium for homesickness* at any moment, the SHR remained very low (≤ 2). Moreover, the levels of the POMS scales did not differ very much before, during, and after the holiday with the exception of the vigor scale which increased during the holiday. Cortisol data showed no clear pattern.

Anticipation Homesickness
According to the HDT, two subjects (B and C) *only experienced homesickness before the holiday*. Their SHR and their POMS scores were also raised before the holiday with a sudden decrease on the first days of the holiday (Vigour scores were in the opposite direction). SHRs did not exceed its minimum score during and after the vacation. Moreover, the morning cortisol levels of subject C were raised before the holiday. Morning cortisol levels of subject B showed an steadily increase during the whole study.

Evening cortisol levels stayed at about the same level in both persons. *Figure 9.1* illustrates POMS Tension scores and SHR of subject C.

Holiday Homesickness

Subjects D, E, F, and G experienced homesickness *only during their holidays*, both according to the HDT and the SHR. However, the two measures did not match completely. The SHRs were higher during the whole holiday for these subjects, whereas they met the criterium for homesickness on the HDT at the beginning and, for subjects D and F, also at the end of their holiday. The POMS scores were elevated (Vigour in the opposite direction) during the days the subjects met the HDT criterium for homesickness. For only 2 subjects cortisol samples were obtained. The morning cortisol levels of Subject D were raised on the days the subject met the HDT criterium for homesickness. Evening and morning cortisol levels of Subject E were elevated when the SHR scores were raised and this was the case during the whole holiday. Some of these results are illustrated in *Figure 9.2*.

Anticipation Homesickness and Holiday Homesickness

Of 3 subjects (H, I, J, and K), 2 (H and I) met the HDT criterium for homesickness *before and during their whole holiday period*. The other subject (J) was homesick *before, at the beginning, and at the end of their holiday but not during the intermediate period*. However, the SHRs did not differentiate between subjects. Subject I had missing data on this variable, SHRs of subjects H and J were elevated both before and during the holiday.

The POMS scores also failed to show a consistent pattern. Large fluctuations were found in the POMS scores of subject J, without any consistent pattern among the different scales. Subject K's POMS scores showed a steady decrease for Depression, Anger, Fatigue and Tension, and an increase for Vigour after the holiday. The POMS scores of subject I fluctuated largely with increases on the first and last day of the holiday for Anger, Fatigue, Tension, and Vigour (in the opposite direction). The Depression level increased, like SHR, to a maximum on the last day of the holiday and then decreased again. Thus, HDT and SHR did not match closely in these subjects. In addition, no consistent relations were found between the patterns of the POMS scales and the HDT and SHR. Cortisol levels (particularly morning cortisol levels) tended to follow the HDT measure of homesickness. To illustrate this the SHR, Depression and Tension scores of subject H are shown in *Figure 9.3*.

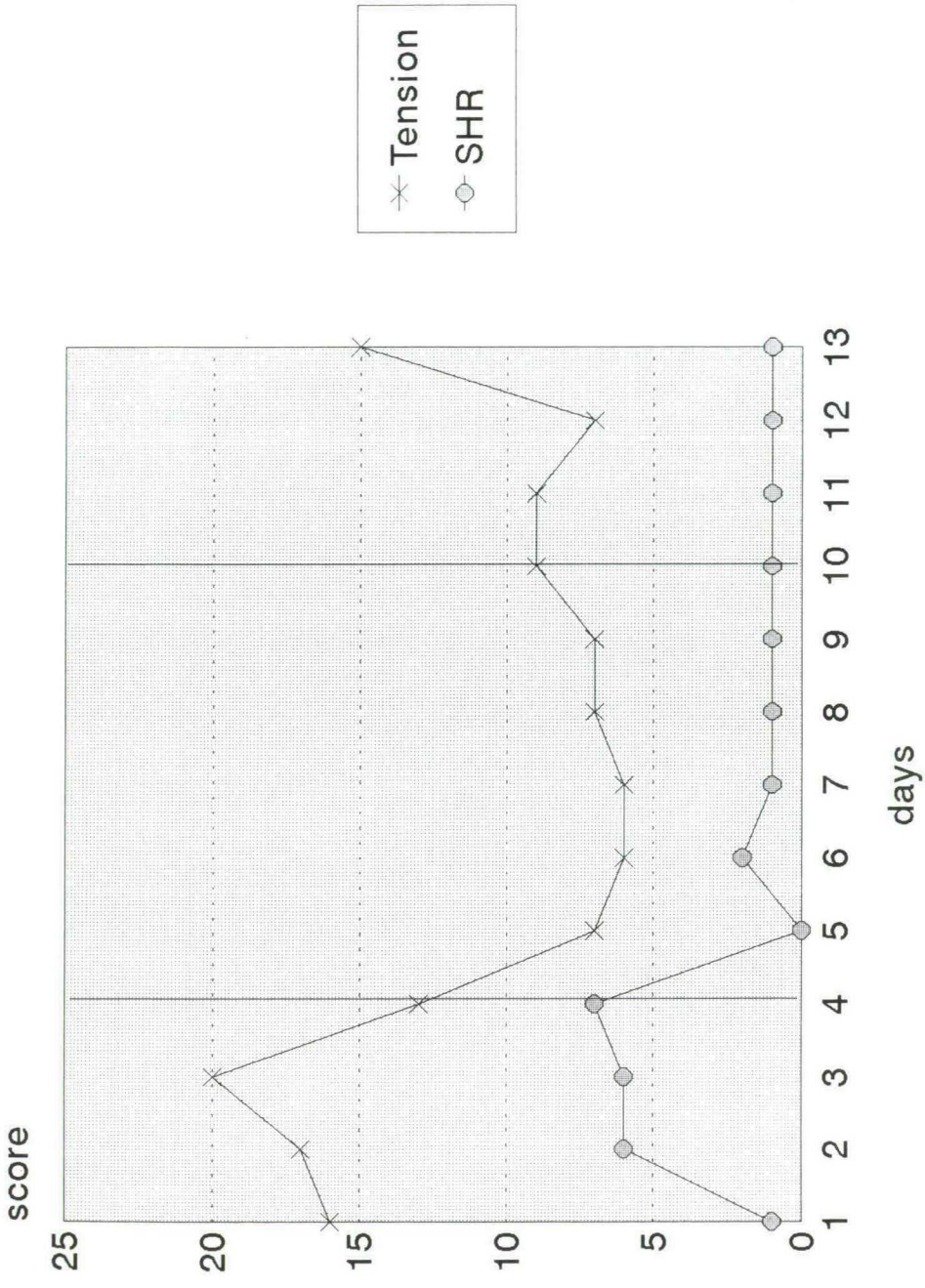

Figure 9.1. Anticipation Homesickness. On days 4-10 subject C was on a holiday and on days 1-3 she met the HDT criterium for homesickness

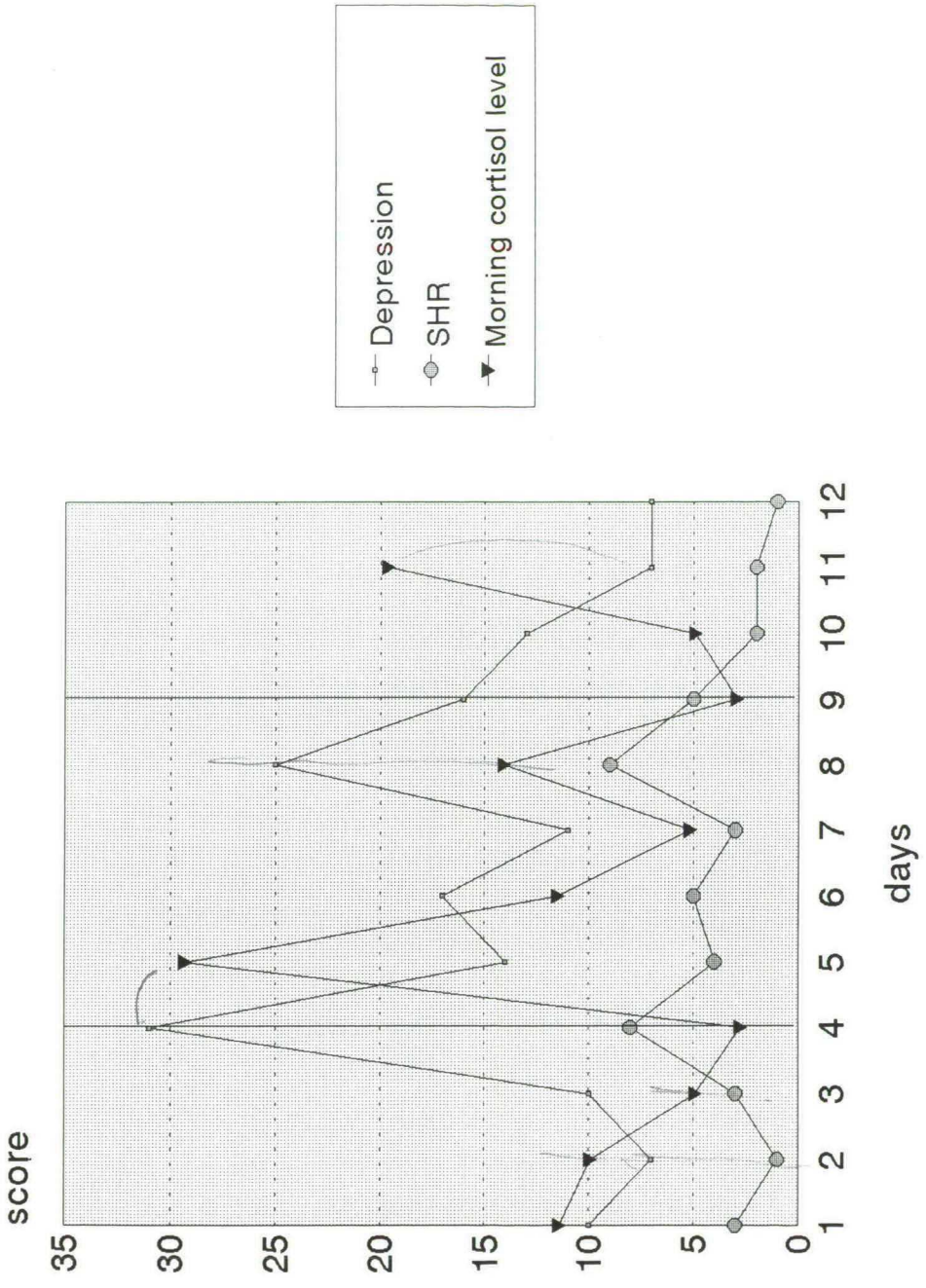

Figure 9.2. Holiday Homesickness. On days 4-9 subject D was on a holiday and on days 4,8, and 9 she met the HDT criterium for homesickness

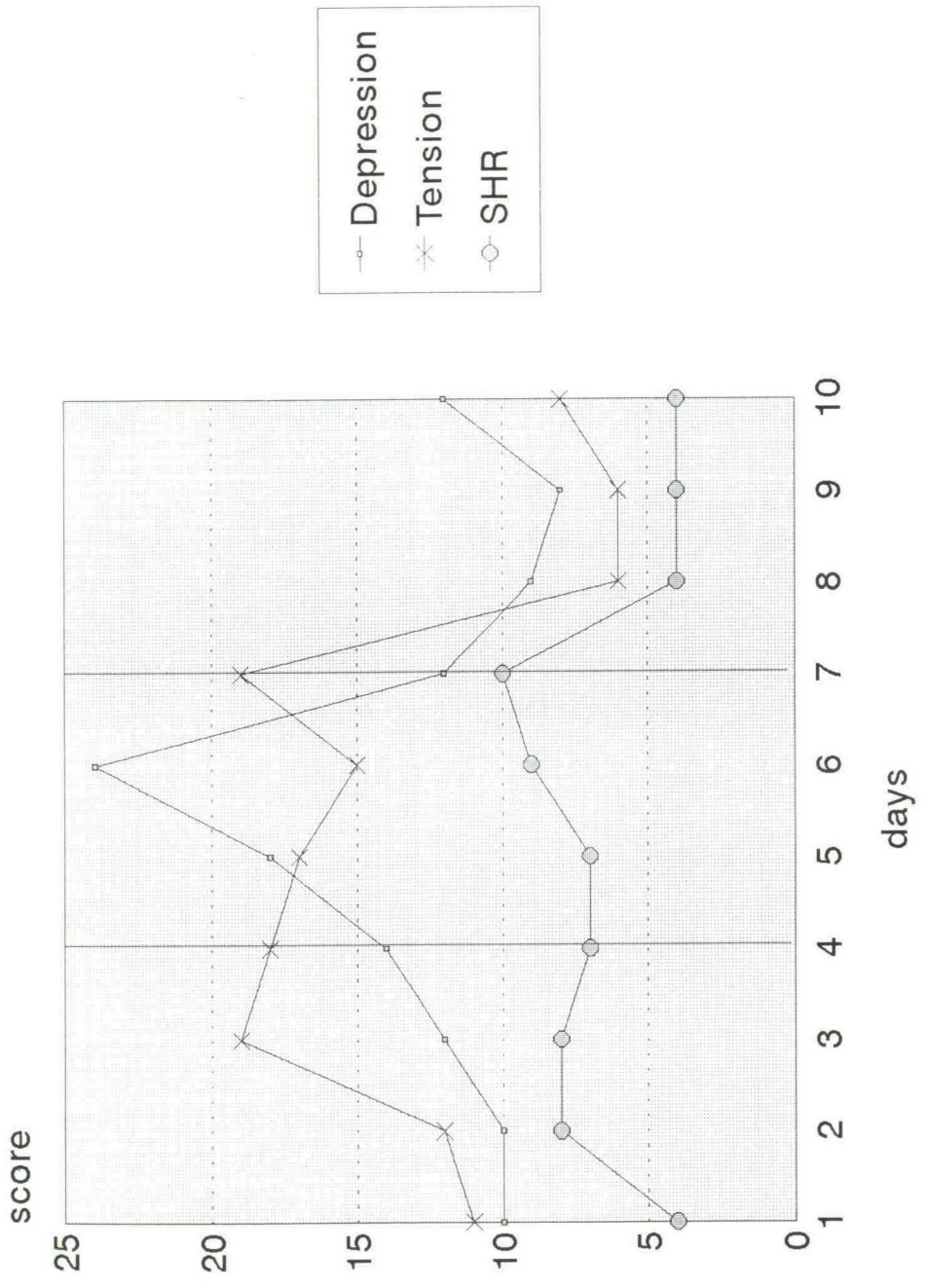

Figure 9.3. Anticipation and Holiday Homesickness. On days 4-7 subject H was on a holiday and on days 1-7 she met the HDT criterium for homesickness

Table 9.1. Means and standard deviations of POMS scores, cortisol levels and SHR on Homesickness days and Non-homesickness days (as determined by HDT)

	Homesickness days		Non-Homesickness days		
	M	*SD*	*M*	*SD*	*t*
POMS					
- depression	12.8	5.1	8.5	2.3	-6.09a
- anger	13.7	4.8	8.5	2.5	-7.61a
- fatigue	16.6	5.8	11.0	5.0	-5.15a
- vigor	12.8	4.2	16.7	4.6	4.12
- tension	14.5	5.2	9.9	4.5	-4.63a
Cortisol (nmol/l)					
- morning	7.7	5.7	9.8	7.7	1.18
- evening	3.2	3.4	2.9	3.2	-0.36
SHR	6.3	2.4	2.4	2.8	-6.08a

a $p < .001$.

Overall HDT, POMS, and Cortisol Data

From the above reported within-subjects results it appears that mood worsens on days the subjects were diagnosed homesick on the HDT, but there seems to be no relation with cortisol levels. *T*-tests were performed to test this assumption, putting together all homesickness days and days without homesickness (according to the HDT criteria) over subjects (see *Table 9.1*). Mean scores of all POMS scales differed significantly between homesickness days and days without homesickness. In contrast, for cortisol no significant differences were found.

Furthermore, correlations between POMS scales, SHR, and cortisol were calculated. Cortisol levels were correlated neither with the POMS scores nor the SHR. The SHR, in contrast, was significantly correlated with the POMS Depression scores ($r = 0.55$; $p \leq 0.001$) and the POMS Anger scores ($r = 0.49$; $p \leq 0.001$).

Discussion

In contrast to previous studies, in which the focus was on homesickness after permanent moves, the present study deals with homesickness during short stays away from home. As holidays and stay overs are the most frequently mentioned homesickness situations, the data of this multiple case study are important for theory development and future research on homesickness.

Although the sample is small, it nevertheless can be concluded that the onset and course of homesickness feelings can differ considerably among individuals. Three types of homesickness could be identified. The first is called *Anticipation Homesickness* and refers to an onset of feelings of homesickness prior to the actual leave and a disappearance of these feelings after departure from home. It is remarkable that homesickness thus does not only occur during actual removal from home, but also during the threat of a move. The second pattern, *Holiday Homesickness*, was characterized by the experience of homesickness during the period of separation from home. The feelings of homesickness might exist during the whole trip, only at the beginning or at the beginning and at the end of the holiday. A combination of the two patterns, Anticipation and Holiday Homesickness, was also found.

In addition, two findings deserve attention. First, homesickness during the holiday was always experienced during the first days and consequently may show a divergent pattern, either a decrease or an increase of distress towards the end. Second, when being back home again, no homesickness could be established, thus suggesting a rapid recovery.

It is tempting to speculate that underlying these patterns there are different ontogenic factors. For example, Anticipation Homesickness might be the result of ineffective learning from previous situations. Perhaps people suffering from this type of homesickness have previously had a very intense homesickness experience, resulting in a fear for this type of situations. In spite of some (occasional) positive experiences in similar situations, they nevertheless develop anticipation fear. It might be speculated that these people suffer from fear-of-fear cognitions, a phenomenon well-known from the panic and agoraphobia literature (e.g., Thorpe & Burns, 1983). In agoraphobic patients anticipation anxiety is, among others, directed at fear of losing control and fear of being unable to get home, two cognitions which may be associated with the homesickness syndrome.

In the case of Holiday Homesickness several origins can be hypothesized. In the present study, all subjects went on a holiday together with their families; thus, missing close persons is probably not a predominant factor in the development of homesickness. Strong attachment to their physical home environment is more likely to cause homesickness. In addition, difficulties in

acquiring control over the new situation, a rigid personality, and difficulties in adapting to the new environment may be relevant factors (Fisher, 1989).
In the present study, subjective distress was heightened during periods of homesickness, while there was no clear association with cortisol levels. This can be due to the fact that samples were not taken in a standardized, but in a natural setting. Therefore, it was not possible to rigidly control the time of sampling which is extremely important. For example cortisol levels double within 15 to 30 minutes after awakening. Furthermore, the occurrence of a minor stressful or emotional event, such as a vow with partner or children, just before sampling may have obscured our data. Such effects will be ruled out in large samples of subjects.
The present results once more stress the difficulty of the diagnosis of homesickness. In comparing the occurrence of homesickness, according to the HDT, and the self-reported homesickness on the SHR, it becomes clear that the HDT is more conservative. In general SHR scores increased on days the person was diagnosed as being homesick according to the HDT criteria, although there were some remarkable discrepancies in some cases. Therefore, it can be argued that SHR scores are too unspecific, because the individual has to determine whether or not (s)he suffers from homesickness. The considerable interindividual differences in the way homesickness is defined may be responsible for this observation. For example, psychological states like nostalgia or missing deceased persons are often considered as equivalent to homesickness (Thijs, 1992). Still, self-reported intensity of homesickness feelings can be a valuable supplement to a more objective measure of homesickness.
Although it appears that the HDT possess satisfactory validity given the Fontijn (1990) data and the here presented findings, the present version nevertheless may be significantly improved by making the following modifications. In order to obtain information about the intensity of the homesickness feelings a likert-type scale should be used instead of the current No/Yes answer format. Moreover, one item focuses upon an intense desire to go home or to think a lot about home. Endorsement of this item does not necessarily imply intrusive home imagery. For, Fisher (1989) showed that the non-homesick also think a lot about home, but these thoughts are concerned with problems at home instead of the intrusive home imagery characteristic for the homesick. This is a qualitative difference which is not reflected in the current version of the HDT.
In conclusion, the results from this multiple case study indicate that homesickness is a label for different psychological states which may differ in origin, onset, and course among individuals. More research is needed to investigate the prevalence, causes and consequences of the different types of

homesickness and how they relate to concepts like separation anxiety and agoraphobia. Also, the validity of self-reported intensity of feelings of homesickness has to be determined in order to estimate the magnitude of the homesickness feelings. Furthermore, more research is needed into the homesickness syndrome during *short* stays away from home. It would be valuable to make direct comparisons with more permanent homesickness situations, like migrations. Placement of these research efforts within a theoretical framework is a sine qua non.

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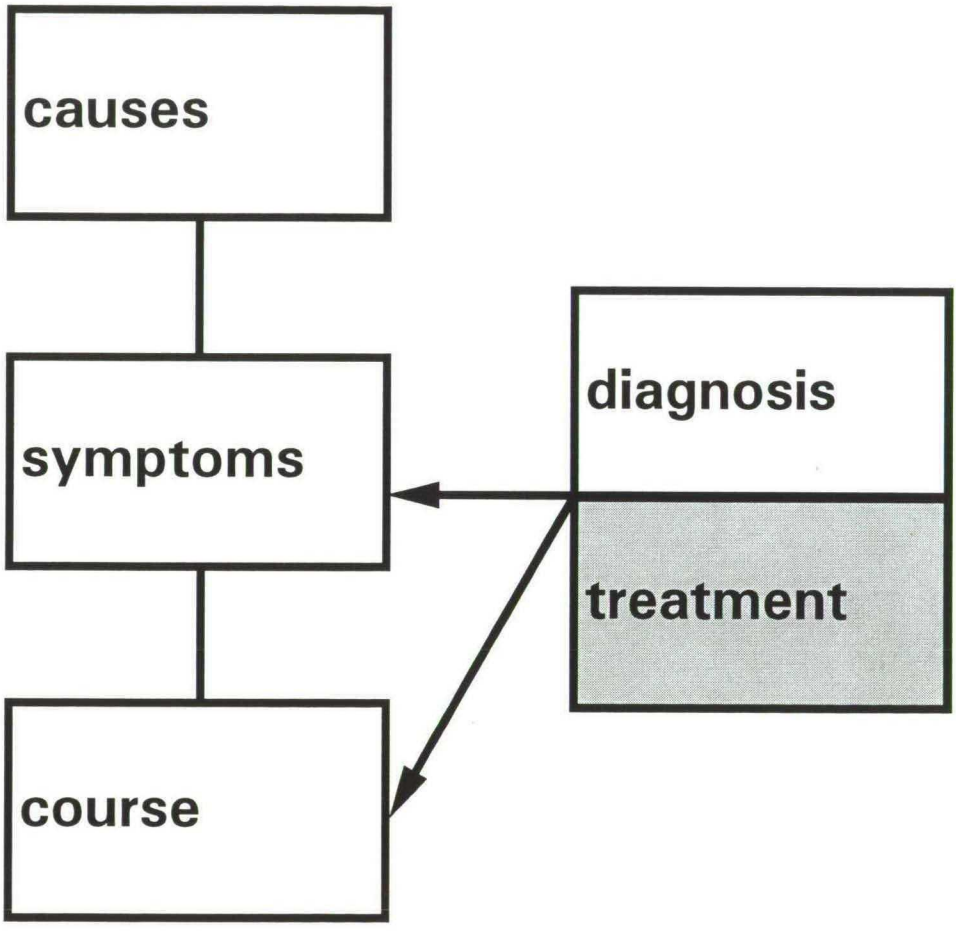
PART III



10 Coping with homesickness: The construction of the Adult Homesickness Coping Questionnaire (AHCQ)

Miranda A.L. Van Tilburg, Ad J.J.M. Vingerhoets, and Guus L. Van Heck

Abstract

This study examined coping with homesickness in a sample of homesick adult women. For this purpose, the Adult Homesickness Coping Questionnaire (AHCQ) was constructed. Analysis of the structure of the AHCQ revealed four factors: Social Support, Positive Thinking/Distraction, Turning to Religion, and Mental Escape. The psychometric properties of the AHCQ appeared adequate. Results indicated that ways of coping with homesickness are related to diverse aspects of the homesickness experience, like length of stay in the homesickness situation, causal attributions, and intensity levels homesickness feelings. It is emphasized that future prospective studies should focus specifically on the (in)effectiveness of coping strategies in order to design adequate interventions for homesick individuals.

Introduction

Over the years homesickness has been a phenomenon which has gained remarkably little attention from behaviourial scientists. At present, however, it has received increasing theoretical and empirical attention. Homesickness is generally described as a depression-like reaction to a move, accompanied by ruminative thoughts about home, the desire to return home, and somatic complaints (Baier & Welch, 1992; Eurelings-Bontekoe, Vingerhoets, & Fontijn, 1994; Fisher, 1989). Recent studies have focused mainly on personality and situational factors associated with homesickness (for an overview see Van Tilburg, Vingerhoets, & Van Heck, 1996a).

Very little is known about the specific ways people deal with their feelings of homesickness. Knowledge about coping strategies of the homesick, however, is important because information on effective and ineffective coping efforts may have important implications for the development of interventions. Some authors have proposed strategies which are supposed to be effective ways of dealing with homesickness, such as expression of feelings of homesickness (Fisher, 1989; Hamdi, 1974; Taylor, 1986), contact with family members (Ellis, 1957; Hamdi, 1974; Taylor, 1986), writing about experienced homesickness (Pennebaker, Colder, & Sharp, 1990), and participating in active

tasks instead of passive and mental tasks (Fisher, 1989). Unfortunately most of these strategies have not been tested empirically.

One of the reasons for the lack of systematic research on coping with homesickness is the absence of a specific questionnaire for coping with homesickness. Only Thurber (1997) has developed a Ways of Coping with Homesickness Questionnaire. However, this measure assess coping strategies in children only. For this target group Thurber identified the following five coping strategies as the most frequently employed: (i) doing something fun in order to forget about being homesick, (ii) thinking positively, (iii) changing feelings, (iv) reframing time, and (v) renewing connection with home. The least effective coping mechanisms were emoting and ruminating. The most effective strategies were doing something in order to forget about homesickness and seeking social support. So, in Thurber's sample of children, both inhibition and approach were effective. However, inhibition appeared to be the more favourite coping strategy.

We feel that for homesickness the distinction between avoidant and confrontative coping might be of special importance. Homesick individuals tend to ruminate a lot. Furthermore, available evidence suggests that suppression of unwanted thoughts and feelings fuel the emotions one tries to avoid (Gold & Wegner, 1995). Thus, avoiding feelings of homesickness and purposefully trying to deny them might lead eventually to more severe homesickness complaints.

This article describes a study that was designed to investigate the coping efforts of adult women who are in permanent or transitional homesickness situations. The primary aim was to construct a homesickness coping questionnaire for adults. In addition, it was examined (i) whether different coping strategies were used in short- and long-term homesick situations, (ii) whether attribution of homesickness to either separation from the old environment or difficulties to adapt to the new environment influenced preferences for particular coping strategies, and (iii) whether specific coping strategies were mediated by homesickness intensity.

Method

Subjects

Subjects were recruited through women's magazines and newspaper announcements in which volunteers were asked to participate in a study on homesickness. A total of 314 subjects completed the questionnaire, of which 231 were suited for further analysis. Due to one of the following reasons, the other 83 questionnaires were left out: (i) subjects were not above 18 years of

age; (ii) they described other phenomena than homesickness; or (iii) they had suffered from homesickness in the past but had recovered a long time ago. Moreover, because the final sample included only eight men, males were left out of the analyses.

Thus, a total of 223 females participated. Age varied from 18 to 79 years ($M=41.1$, $SD=13.3$). Eighty percent of the respondents were married or had a stable relationship. Approximately 75% of the sample had the minimum of a high school education, the remaining fourth part had followed only basic education.

Two groups were distinguished: (i) a subsample of 81 persons who were at the time of the study in a long-lasting, *chronic homesickness* situation, for instance, due to a permanent move, and (ii) a subsample of 142 *homesick-prone* persons who all felt comfortable in their present living situation, but had previously suffered from homesickness experiences. Members of the latter group expected to develop acute homesickness when they should leave their house due to a holiday or a move. In the chronic homesick group, 85 percent of the respondents reported that their homesickness-eliciting life circumstances continued for an indeterminate period of time. In contrast, the majority of the homesick-prone reported a duration of a few days to a few weeks (72.2%).

Measures

The Adult Homesickness Coping Questionnaire (AHCQ) was developed, based on the COPE (Carver, Scheier, & Weintraub, 1989) and the Ways of Coping Checklist (Folkman & Lazarus, 1980, 1985), two questionnaires assessing cognitive and behavioral strategies for dealing with stressful encounters. Items were selected based on their expected applicability in homesickness situations. In addition, a few items were added based on the psychological literature and the authors personal contacts with homesickness individuals (e.g., "You fantasized about being in your old environment"). The final list consisted of 71 items. Subjects rated items on a scale of 1 (*Not at all*) to 4 (*A lot*), indicating to what extent particular ways of coping had been applied in the last homesickness situation they encountered.

In addition, subjects answered nine questions on attributions of homesickness (see *Table 10.1*), and indicated their homesickness intensity on a 10-point scale (subjective homesickness rating), ranging from 1 (*Not at all homesick*) to 10 (*Very homesick*).

Table 10.1. Attributions of homesickness feelings (percentages)

	Chronic homesickness		Homesick-prone		
	not at all or a little bit	fairly or extremely	not at all or a little bit	faitly or extremely	Chi^2 sign.
- Missing the environment	18.5	81.4	25.8	74.2	n.s.
- Missing persons	17.3	82.7	29.2	70.8	n.s.
- Giving up old habits	66.6	33.3	65.9	34.1	n.s.
- Changing the way of living one's life	37.1	62.9	37.0	63.0	n.s
- Dislike of current (work) activities	81.3	18.8	76.4	23.6	n.s.
- Dislike of the new environment	51.3	48.8	53.9	46.1	n.s.
- Insufficient amount of friends in the new environment	58.0	42.0	59.0	41.0	n.s.
- Having no grip on the environment	56.8	43.2	34.1	65.8	a
- Missing the atmosphere of the old environment	12.3	87.7	14.2	75.8	n.s.

a $p \leq .05$.

Results

Structure of the AHCQ

The 71 items were factor analyzed using a principal-components analysis with oblique simple structure rotation[1]. This analysis yielded a four-factor solution based on the scree plot of eigenvalues (Cattell, 1966; Cattell & Vogelman, 1977). These factors could be labelled as follows: (i) Social Support, (ii) Positive Thinking/Distraction, (iii) Turning to Religion, and (iv) Mental Escape. The variance accounted for by the four factors was 36.9%. After removal of (i) items with factor loadings greater than .35 on more than one factor, and (ii) items which loaded less than .35 on all factors[2], 17 items could be included in the Social Support scale, 19 in the Positive Thinking/Distraction scale, 4 in the Turning to Religion scale, and 12 in the Mental Escape scale. Table 10.2 presents the loadings, after oblique rotation, for this four-factor solution. As can be seen from *Table 10.2*, the four rotated factors are clearly defined.

Although the size of the successive eigenvalues suggested four dimensions, we also extracted and rotated three factors. The reason for extracting a more parsimonious number of factors was a suggestion by Zwick and Velicer (1986) to examine routinely one or two components below the estimate given by the scree test in order to check for a possible slight tendency toward overestimation. In addition to factors reflecting Social Support and Positive Thinking/Distraction, the three-factor solution merged the Turning to Religion items with the Mental Escape items into a rather difficult to label third factor. The adequacy of the four-factor solution was clearly suggested by its interpretability which was judged superior to the interpretability of the three-factor solution. Consequently, we refrained from further attempts to determine the correct number of components, for instance, by conducting parallel analysis (Zwick & Velicer, 1986), a procedure which is somewhat superior to the more traditional criteria (see, e.g., Digman & Shmelyov, 1996).

For each of the four AHCQ subscales, Cronbach alpha's were computed. All internal consistency coefficients were above .79. Subsequently, in the case of the Social Support subscale two items, and for the Mental Escape subscale one item were deleted in order to increase the internal consistency. Finally, scales were scanned for items which were both highly correlated and almost

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1 The intercorrelation matrix and the final version of the AHCQ are available to readers from Miranda A.L. Van Tilburg.

2 Using .35 as a cutting point is, of course, somewhat arbitrary, but used quite regularly (see, e.g., Almagor, Tellegen, & Waller, 1995).

Table 10.2. Pattern matrix for oblique rotated factors of the ACHQ

Item	Factors			
	SS	PT/D	TR	ME
You talk to someone about how you feel	**.77**	.15	.10	.04
You let your feelings out	**.70**	-.01	.08	-.04
You talk to someone who could do something concrete about the problem	**.69**	.10	.12	.04
You clearly show that you think something has to be done about the situation	**.66**	-.04	-.15	.25
You talk to someone to find out more about the situation	**.65**	.28	.09	-.08
You try to get emotional support from friends or relatives	**.60**	.26	.09	.06
You go on as if nothing happened	**-.64**	.10	-.06	.22
You upset and let your emotions out	**.63**	-.07	.12	.01
You keep others from knowing how bad things are	**-.61**	.07	.04	.17
You try to get advice from someone about what to do	**.60**	.13	.08	.02
You feel a lot of emotional distress and you find yourself expressing those feelings a lot	**.59**	-.32	.10	.10
You get sympathy and understanding from someone	**.50**	.22	.16	.12
You think hard about what steps to take	**.49**	.18	-.08	.24
You accept that this has happened and that it can't be changed	**-.48**	.28	.28	-.08
You ask people who have had similar experiences what they did	**.45**	.25	.15	.08
You go along with fate	**-.39**	-.03	.22	.32
You get upset and you are really aware of it	**.37**	-.28	.05	.34
You look for something good in what is happening	-.08	**.70**	.13	-.19
You try to feel better somehow or other	.10	**.68**	-.05	.14
You learn something from the experience	.11	**.65**	.07	-.13
You make light of the situation; You refuse to get too serious about it	-.10	**.64**	-.07	-.04

(Table 10.2 continued on next page)

Table 10.2. (continued)

Item	Factors			
	SS	PT/D	TR	ME
You look at the silver lining, so to speak; tried to look on the bright side of things	-.09	**.64** ⊨	.17	-.16
You seek cheerful company	.08	**.60**	.11	.19
You try to relax	-.01	**.60**	.06	-.12
You try to take your mind of things	.09	**.60**	-.13	.08
You joke about it	-.01	**.59** ⊨	-.11	-.01
You get away from it for a while; trying to rest or take a vacation	.11	**.55**	-.15	.18
You think about how you might best handle the problem	.23	**.54**	.07	.01
You turn to work or substitute activity to take your mind off things	-.12	**.52**	-.01	.07
You feel unable to do something	.02	**-.50**	.16	.26
You learn to live with it	-.31	**.50**	.26	-.15
You seek diversion in sports and games	.11	**.46**	.04	.14
You avoid being with people in general	-.08	**-.46**	.08	.15
You go over the problem again and again in your mind	.21	**.42**	.20	.05
You tell yourself things that help you feel better	-.05	**.40**	.14	.28
You learn something from the situation	.08	**.38** ⊨	.01	-.20
You put your trust in God	.05	.04	**.87**	-.14
You try to find comfort in your religion	.05	.02	**.87**	-.10
You seek God's help	.06	.02	**.87**	-.14
You pray more than usual	.12	-.05	**.76**	.01
You daydream about or imagine better times	-.21	-.07	-.04	**.71**
You fantasize being back in your old environment	-.11	-.23	-.10	**.64**

(Table 10.2 continued on next page)

Table 10.2. (continues)

Item	Factors			
	SS	PT/D	TR	ME
You think about how great things are in the place you long for	.00	-.06	.05	**.60**
You think about fantastic or unreal things that make you feel better	-.13	.16	-.02	**.54**
You have fantasies or wishes about how things might turn out	.09	.16	.00	**.55**
You think about things that are left behind	.01	-.01	.23	**.51**
You become recalcitrant and stubborn	.02	-.16	-.15	**.45**
You get mad at the people that caused the problem	.02	-.16	-.06	**.43**
You become rebellious	.16	-.28	-.00	**.43** ⊨
You make a promise to yourself that things will be different next time	.12	-.21	.15	**.42**
You refuse to adapt to your new environment	.19	-.33	-.06	**.40**
You try to make yourself feel better by drinking or smoking	-.14	.12	-.12	**.36**+

Note. For each item, subjects *(N=223)* were asked to indicate, using 4-point scales, to what extent that particular way of coping was used in the last homesickness situation they encountered. SS= Social Support; PT/D= Positive Thinking/Distraction; TR = Turning to Religion; ME= Mental Escape. + = items which were left out of the AHCQ subscales in order to increase Cronbach alpha's; ⊨ = items which were left out of the AHCQ subscales because of high intercorrelation with other items and their being almost identical in terms of content.

identical in terms of content. In these cases, the item with the lowest factor loading was deleted. This resulted in a homesickness coping questionnaire consisting of four subscales: (i) Social Support (14 items; α = .89), (ii) Positive Thinking/Distraction (16 items; α = .86), (iii) Mental Escape (10 items; α = .79), and (iv) Turning to Religion (4 items; α = .95) (see *Table 10.2*). In order to assess the degree of scale independence, the total scores for each subscale were intercorrelated. As can been seen from *Table 10.3*, correlations were low, indicating reasonable independence of the scales.

Further analyses

In order to test whether different coping strategies were used in long- versus short-term homesickness situations, *t*-tests were performed comparing the 'homesick-prone' with the 'chronic homesick'. Mean scores of the chronic homesick group were 33.7 for Social support, 42.5 for Positive Thinking/ Distraction, 7.6 for Turning to Religion, and 22.9 for Mental Escape. For the homesick-prone group these scores were 32.6, 37.9, 6.9, and 23.0, respectively. The twc groups differed only significantly ($p \leq .0001$) on Positive Thinking/Distraction which was more frequently employed by chronic homesick persons, who have to deal with a long-term homesickness situation.

To test whether some coping strategies were more effective in reducing homesickness than others, correlations between self-reported homesickness intensity and coping strategies were computed. All AHCQ subscales were positively correlated with homesickness intensity except for Positive Thinking/Distraction which was negatively related. Although significant, the correlations were quite low (range= -.15 to .27). In addition, a stepwise regression analysis was undertaken with homesickness intensity as the dependent variable and coping strategies as independent variables. Positive Thinking/Distraction (β = -.20; $p \leq .05$), Turning to Religion (β = .15; $p \leq .05$), and Social Support (β = .28; $p \leq .05$) entered the regression equation (total R^2 = .13).

To investigate whether preferences for coping styles are mediated by intensity of homesickness feelings, attributions of homesickness feelings, and time period (short- *versus* long-term homesickness situations), additional stepwise regression analyses were performed with coping strategies as the dependent and self-reported intensity, attributions of homesickness, and type of homesickness (chronic versus prone) as independent variables. Social Support was predicted by homesickness intensity (β = .25; $p \leq .05$), giving up old habits, and missing the atmosphere of the old environment (resp. β = -.22; β = .21; all $p_s \leq .05$; total R^2 = .15). Type of homesickness (more chronic than prone; β = -.30; $p \geq .0001$), dislike of the new environment,

Table 10.3. Correlations among the AHCQ subscales

	SS	PT/D	TR	ME
Social Support (SS)				
Positive Thinking/Distraction (PT/D)	.11			
Turning to Religion (TR)	.11	.12		
Mental Escape (ME)	.28 a	-.22 b	.03	

a= $p \leq .000$; b= $p \leq .001$.

dislike of current (work) activities, and missing the old environment (resp. β = -.20, -.17, .15; all $p_s \leq .05$; total R^2 = .20) predicted Positive Thinking/Distraction. Four self-attributed causes of homesickness entered the equation of Mental Escape (R^2 = .34), namely having no grip on the new environment (β = .22; $p \leq .05$), missing the atmosphere of the old environment (β = .22; $p \leq .05$), dislike of current (work) activities (β = .18; $p \leq .05$), and dislike of the new environment (β = .17; $p \leq .05$). Finally, self-reported intensity stepped into the regression equation of Turning to Religion (β = .19; $p \leq .05$; R^2 = .19).

Discussion

The current lack of an instrument to assess coping with homesickness led us to the development of the Adult Homesickness Coping Questionnaire (AHCQ) containing four subscales: Social Support, Positive Thinking/Distraction, Mental Escape, and Turning to Religion. The internal consistency and face validity of the subscales appear to be good. As most of the items were derived from two existing general coping scales with good psychometric properties, the scales should cover the coping domain adequately. However, it might be possible that some coping strategies are specific to homesickness situations. Therefore, the questionnaire might not be completely exhaustive.

Consequently, more research is needed on the range of coping behaviours in homesickness situations. In future research use could be made of focus groups as a tool to unravel missing facets (Morgan, 1988).

The coping strategies which are used by the homesick are mainly emotion-focused coping strategies. As the homesickness situation generally is uncon-

trollable, because there is no opportunity to return home timely (Van Tilburg, Vingerhoets, & Van Heck, 1996b), problem-focused coping is probably less functional than emotion-focused coping (Auerbach, 1989).

The results of this study indicate some moderate to low relation between coping strategies and perceived causes, felt intensity of homesickness, and duration of separation from home. Social support was predominantly sought when feelings of homesickness were attributed to missing the old environment. Scores on Turning to Religion and Social Support were positively related to high intensities of homesickness feelings. This result is contrary to the negative association generally found between social support and distress (for an overview, see Barrera, 1986). Our findings thus lend support for the hypothesis that feelings of homesickness are difficult to avoid, resulting in increased attempts to seek support in order to solve the problematic situation. On the other hand, it can be speculated that this relation is rather spurious, due to substantial links of both homesickness intensity and seeking social support to stress. Finally, it might be that low levels of social support increase the likelihood that events will be perceived as highly stressful, as there is evidence for a combination of a lack of social skills and a strong need for social support in the homesick (Eurelings-Bontekoe *et al.*, 1994).

Positive thinking/Distraction was more frequently applied by persons in long-lasting or chronic homesickness situations compared with persons in short-term or more acute situations. Thus, when the situation is perceived as rather unchangeable, individuals try to cope by forgetting the old environment or thinking about positive aspects of the new environment, resulting in lower intensities of homesickness feelings.

Mental escape, on the other hand, was more often found in short-term homesickness situations. People in these situations return home soon. So, there is a solution for their problems in the near future and consequently confrontative coping is not necessary. In addition, as home is very salient, attention will be focused on the old environment resulting in ruminations about home, a dislike for the new environment, and intense feelings of missing the old environment. In fact, when homesickness feelings were attributed to missing the old environment and disliking the new environment, mental escape was significantly employed more often. However, contrary to the observation of Gold and Wegner (1995) that rumination leads to fuel the emotions, mental escape was not related to the reported intensity of homesickness feelings.

In summary, homesickness experiences may be dominated by diverse personal and situational aspects, which contribute significantly to the way subjects cope with homesickness. Length of stay was related to the kind of

coping efforts; mental escape was more often found in short-term periods, and positive thinking and distraction more frequently in long-term periods, but only if the homesickness was not attributed to the unpleasantness of the new situation. Furthermore, if attributions of the cause of homesickness were made to the old environment, seeking social support was more frequently employed. If, on the other hand, feelings of homesickness were attributed to perceived unpleasantness of the new situation, then, this resulted in more mental escape and rumination. Finally, seeking support and turning to religion were positively and positive thinking/distraction negatively related to intensity of feelings of homesickness. However, the variance accounted for by these variables was moderate to low. Therefore, future studies need to focus on another set of variables which might explain more effectively the application the four coping strategies.

A major drawback of this study is its exclusive focus on coping with homesickness in women. Therefore, the results cannot be generalized to a more general population. Thus, research among homesick men, for example military conscripts, is needed.

Unfortunately, in this study no data were collected which could test the hypothesis that certain coping strategies are more beneficial than others. This information, however, is of utmost importance for designing effective interventions for homesick persons. Therefore, future studies should specifically focus on the quality of the different coping efforts.

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11 Determinants of homesickness chronicity: Coping and personality

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Abstract

The aim of the present study was to examine the impact of coping strategies and basic personality styles on the one hand and timely recovery of homesickness on the other hand in female students. In order tot study whether certain coping strategies and personality styles were associated with chronicity of homesickness, a sample of homesick female students was split up in those who were chronic homesick (N = 29) and those who were not (N = 30). Logistic regression analyses revealed that Mental Escape (coping style) and Neuroticism (personality trait) predicted homesickness chronicity. It is concluded that Mental Escape is a relatively ineffective way of coping with homesickness. Daydreaming and fantasizing about home, and wishful thinking are associated with homesickness chronicity. As the impact of Neuroticism on the timely recovery of homesickness was greater than the effect of any coping style, personality seems to be more important than coping style. Recovery from homesickness was mainly attributed to making new friends. It is argued that new friends promote the adaptation process, keeping feelings of homesickness and the tendency to daydream and fantasize about home, at bay.

Introduction

Each year many students leave home in order to enter university. As a consequence, they are confronted with the many opportunities, challenges and stressors that inevitably accompany such a transition. For instance, they have to deal with sudden breaks with routines, loss of friends and family, and the necessity to adjust to a new environment. Following such a move, many students develop homesickness, a complex cognitive-motivational-emotional state which is associated with ruminations about home, an intense desire to return home, depressed mood, and somatic symptoms (Fisher, 1989). In two studies among British university students, Fisher and co-workers reported that 60% to 70% of those who move to take up residency at university develop homesickness (Fisher & Hood, 1987; Fisher, Murray, & Frazer, 1985). Furthermore, Burt (1993) found in a group of Australian first-year students that all of them had experienced some degree of homesickness. A similar finding was obtained by Lu (1990) in Chinese

students who moved to universities in the United Kingdom. Finally, incidence rates of 18.7% for American students and 76.8% for Turkish students were reported by Carden and Feicht (1991). Thus, homesickness can be considered a world-wide problem among students.

Until now, longitudinal studies on homesickness phenomena, covering a long time-span have not been conducted. Therefore, little is known about the natural course of homesickness. It is also unknown why some students will eventually overcome it, while others will not be successful in his respect. Knowledge on what constitutes effective ways of dealing with homesickness in students is important, because homesickness has been associated with raised psychological disturbance and absent-mindedness (see, e.g., Fisher & Hood, 1987; Van Tilburg, Vingerhoets, Van Heck, & Kirschbaum, 1997), which might lead to academic difficulties. Successfully dealing with feelings of homesickness might help students to regain their previous level of psychological functioning. Studies among children at summer camps (e.g., Thurber, 1997) indicate that the most endorsed effective ways of coping with homesickness are: (1) doing something fun in order to forget about being homesick; (2) thinking positively in order to feel better; (3) simply changing feelings in order to be happy; (4) reframing time; and (5) renewing a connection with home (e.g., writing to parents) in order to feel closer to home. Relinquishing control by simply emoting or anxiously ruminating is often futile (Thurber, 1997).

It also has to be taken into consideration that personality variables might influence the course of homesickness. Several investigators have found strong associations between personality and homesickness (for overviews, see Eurelings-Bontekoe, 1997; Van Tilburg, Vingerhoets, & Van Heck, 1996). Characteristic features of the homesick, in contrast to the non-homesick, are high levels of rigidity and dependency, and low levels of extraversion, dominance, and assertiveness. Until now, no studies have focussed on the role of personality and coping in processes determining the duration of homesickness. Therefore, the main aim of the present study was to examine the (in)effectiveness of coping with homesickness. In addition, the role of basic personality traits in the development of chronic homesickness was scrutinized.

Method

Study participants

Subjects were recruited by announcements in university papers calling for university students who had experienced homesickness after their move away from home. A total of 84 students participated. Because of the low proportion of men (7.1%), it was decided to leave them out of the analyses. Thus, the results pertain to data from 78 female students. Their age ranged from 17 to 31 years (M = 21.94; SD = 2.67). Only 29.5% of these women were actually homesick at the moment of completing the questionnaires. The others reported to be recovered.

Measures

To assess coping strategies, the Adult Homesickness Coping Questionnaire (AHCQ; Van Tilburg, Vingerhoets, & Van Heck, 1997) was administered. The 44-item AHCQ consists of four subscales: (1) Social Support, (2) Positive Thinking/Distraction, (3) Turning to Religion, and (4) Mental Escape. The psychometric properties of the AHCQ appear to be adequate (Van Tilburg *et al.*, 1997).

Basic personality traits were measured using the Five-Factor Personality Inventory (FFPI; Hendriks, 1997), which has been constructed to cover the five-dimensional trait space of the Abridged Big-Five Dimensional Circumplex (AB5C; Hofstee & De Raad, 1991; Hofstee, De Raad, & Goldberg, 1992). These five broad dimensions are: (1) Extraversion, (2) Agreeableness, (3) Conscientiousness, (4) Emotional Stability, and (5) Autonomy[1]. The FFPI possesses high internal consistencies, substantial stabilities, and good construct validity (Hendriks, 1997).

In addition, students filled in a questionnaire concerning feelings and experiences when homesick (e.g., "How lonely did you feel"; "Did you miss your old home environment?"; "Did you have difficulties adapting to your new living environment?", etc.), homesickness intensity, and previous homesickness experiences. Finally, the following two open-ended questions were included: (1) "Why were you homesick?"; and (2) "What happened or what did you do that caused the homesickness to fade away?" (only in case the subject was recovered from homesickness).

1 Usually the fifth dimension, here called Autonomy, is labelled differently, namely Openness to Experience or Intellect.

Results

Our first focus was on deciding who was homesick for a 'normal' period of time and who should be considered as 'chronic' homesick. With respect to homesickness until now nothing is known concerning its natural course. However, we felt that it is valid to make a parallel with grief. After the death of a loved one a certain time period is generally thought of as needed to 'recover' (see for overviews Parkes, 1996; Stroebe, Stroebe, & Hansson, 1993). Grieving after a year is seen as a serious, although not sufficient, indicator of maladaptive grieving (see, e.g., Bowlby, 1980; Byrne & Raphael, 1994; Middleton, Burnett, Raphael, & Martinek, 1996).

Approximately 50% of both the currently homesick and the recovered were homesick for 1-6 months; the range of homesickness duration being 1 to 48 and 1 to 36 months, respectively. Therefore, it was decided to consider those who were 1-6 months homesick as *not* chronically homesick; in contrast, those who were longer than 6 months homesick were conceived of as chronic homesick (respectively $N = 39$ and $N = 29$; missing data for 10 participants). Six of the non-chronic homesick individuals were not recovered yet. They were less than 6 months homesick, but indicated that they probably would feel homesick for a long while. So, it has to be taken into account that some of them will eventually develop a state of chronic homesickness. For that reason, they were not included in the analyses. Furthermore, it was checked whether recovery was due to a move back home. It appeared that in the non-chronic group three persons moved back home or closer to one's old house. These persons were also left out of the analyses. Thus, the data of 30 non-chronic homesick and 29 chronic homesick were analyzed.

Non-chronic homesick individuals were expected to cope more effectively with homesickness, while chronic homesick persons were conceived of as coping less effectively. Therefore, coping strategies were compared across these two groups. It appeared that none of the students used Turning to Religion as a coping strategy. Consequently, this scale was left out of the analyses. A logistic regression analysis was performed on chronicity of homesickness as the outcome variable and Social Support, Positive Thinking/Distraction, and Mental Escape as predictors. The goodness of fit statistic was significant ($Chi^2 = 9.5$; $df = 3$; $p \leq .05$). Of the non-chronic homesick 72.4%, and of the chronic homesick 69.0% were correctly classified. So, overall, 70.7% were correctly classified. The Wald statistic was significant for Mental Escape only ($z = 7.2$; $p \leq .01$). Furthermore, a test of the full model in a logistic regression analysis, from which Mental Escape was excluded, against a constant-only model was not statistically significant (Chi^2

= 6.02; $df = 3$; $p > .05$). Thus, only Mental Escape predicted homesickness chronicity. The odds ratio of Mental Escape was .86.

Next, the role of personality in homesickness chronicity was investigated. A logistic regression analysis, with homesickness chronicity as outcome and Extraversion, Agreeableness, Conscientiousness, Emotional Stability, and Autonomy as predictors, yielded the following results. A test of the full model with the five personality dimensions against a constant-only model was statistically significant ($Chi^2 = 17.3$; $df = 5$; $p \leq .01$). Thus, the five personality dimensions clearly distinguish between the non-chronic and chronic homesick. Prediction success was 75.9% for the chronic homesick and 73.3% for the non-chronic homesick with an overall success rate of 74.6%. Wald statistics were computed for each predictor. According to this criterion, only Emotional Stability predicted homesickness chronicity ($z = 10.3$, $p \leq .01$). A model run with Emotional Stability omitted was not better than a constant-only model. This confirms the finding that Emotional Stability is the only reliable predictor of homesickness with an odds ratio of 3.6. Finally, Emotional Stability and thereafter Mental Escape were entered as predictors into a logistic regression analysis with chronicity of homesickness as outcome. The goodness of fit was significant for both Emotional Stability ($Chi^2 = 15.5$; $df = 1$; $p \leq .0001$), and Mental Escape ($Chi^2 = 5.1$; $df = 1$; $p \leq .05$). The Wald statistic was also significant for both Emotional Stability ($z = 8.9$; $p \leq .01$), and Mental Escape ($z = 4.6$; $p = .05$). Emotional Stability had an odds ratio of 3.1 and Mental Escape only an unimpressive .89.

Since six months is quite a short time period, we decided to repeat these analyses after splitting up the group in those who are less and those who are more than 12 months homesick ($N = 45$ and $N = 14$, respectively). These results will not be reported here, but were mainly similar. In addition, correlations were calculated between duration of homesickness and personality and coping style. It was found that all correlations were low ($.23 > r > -.01$; *ns*), except for Emotional Stability ($r = -.46$; $p \leq .001$). This confirms the finding that Emotional Stability is related negatively to duration of homesickness. The correlation between Mental Escape and duration of homesickness was .23 (*ns*).

Differences between the non-chronic and chronic homesick in feelings/experiences when homesick, homesick intensities, and previous homesickness experiences were calculated using *t*-tests (see *Table 11.1*). It was found that the chronic homesick reported significantly higher homesickness intensities, more missing of the old house and the atmosphere of the old environment, less happiness, more difficulties leaving the parental home, and more fear of small rooms, than the non-chronic homesick.

Table 11.1 Differences between non-chronic and chronic homesick on feelings and experiences when homesick, homesickness intensity, and previous homesickness experiences

	Non-chronic homesick *M*	Chronic homesick *M*	*T*-test
How intense was your homesickness? (10-point scale)	6.63	7.93	b
Did you expect to become homesick? (4-point scale)	1.83	2.21	n.s.
Did you miss... (4-point scales)			
▪ your old home environment?	2.80	3.17	n.c.
▪ your home?	2.63	3.38	c
▪ persons who were left behind?	3.43	3.69	n.s.
▪ things and objects which were left behind?	2.80	2.35	n.s.
▪ pets?	3.47	3.41	n.s.
▪ the atmosphere of the home environment?	3.07	3.52	a
Did you have difficulties adapting to your new living environment? (4-point scale)	2.33	2.73	n.s.
Did you have a good relationship with your parents? (4-point scale)	3.83	3.86	n.s.
How happy were you? (4-point scale)	4.97	3.45	b
How lonely did you feel (10-point scale)	5.47	6.69	n.s.
Did you regret moving? (4-point scale)	1.87	2.18	n.s.
Did you have enough friends in your new living environment? (4-point scale)	2.57	2.45	n.s.
How was the contact with room mates? (10-point scale)	5.77	5.69	n.s.
Did you like your study? (10-point scale)	6.90	5.97	n.s.
Did you feel your study was demanding? (4-point scale)	2.47	2.45	n.s.
How difficult was it to leave your parental home? (4-point scale)	2.37	3.14	b
Are you afraid of small rooms? (4-point scale)	1.30	1.69	a

Note. All questions had to be answered referring to the time one was homesick. Scales ranged from 'not at all' to 'very' on 4- or 10-point scales. a= $p \leq .05$, *b*= $\leq .01$, c= $p \leq .001$.

Furthermore, it appeared from the open answer questions that homesickness was attributed to[2]: (1) negative feelings towards the new environment (34.9%); (2) having no (good) friends in the new environment (34.9%); (3) missing family, parents, partner (28.9%); (4) feelings of loneliness and insecurity (26.5%); (5) missing the company, attention, warmth, security, love etc. of home (25.3%); (6) having to take care of everything by yourself (14.5%); and (7) a rest category including problems at home, missing the home environment or house, distance from home, and missing of friends (36.0%). Recovery from homesickness was attributed to making new friends (61.0%), visiting home (12.0%), and moving back home (8.0%). Eight percent did nothing, and a rest category of 11.0% acted in various ways like going into therapy, writing a diary, etc.

Discussion

The present study focussed on why some people recover from their homesickness in a relatively short time period, whereas others develop a chronic state of homesickness. The role of coping strategies, basic personality traits, and attributions on homesickness were examined. It was found that Mental Escape was a relatively ineffective way of coping with homesickness. Daydreaming about home, fantasizing about home and being at home, and wishing one was home obviously does not enhance adjustment. On the contrary, it may even interfere with it. The focus of chronic homesick persons remains directed on the old environment, preventing the development of a genuine interest into the new environment, and sustaining homesickness. It is surprising that seeking Social Support failed to emerge as a significant predictor of adjustment. For, it has generally be found that seeking social support buffers stress (e.g., Barrera, 1986). However, Eurelings-Bontekoe, Vingerhoets, and Fontijn (1994) found that homesick conscripts have a strong need for social support, but lack social skills. Thus, it could be speculated that homesick persons are actually seeking social support, but that their efforts fail and often are in vain. Furthermore, Positive Thinking about the new situation and Distracting oneself also failed to prevent homesickness to become chronic. It might be argued that thinking positively about the new environment does not imply real cognitive changes related to adjustment to new situations. Thus, it could be speculated that

2 Percentages of students giving each answer. More reasons could be given by one person; therefore, percentages do not add up to 100%.

being positive about the new environment and distracting oneself gives some breathing-space, but does in the end not facilitate the adjustment process. In conclusion, it can be said that a good advise for homesick people is to refrain from fantasizing and daydreaming about home and bygone days. However, this might be an impossible task for a severely homesick persons. Therefore, they are more helped by distraction from their thoughts and worries and the accompanying need to escape from the bad situation mentally. Fisher (1989) found that episodes of homesickness thoughts are more likely to occur during passive tasks and mental activity. Active tasks and physical activity, thus, can keep homesickness at bay, thereby preventing fantasizing and daydreaming about the old environment.

Most students who were recovered attributed this to making new friends in their new environment. New friends are able to provide support to the homesick, who are torn away from their social network. This study shows that seeking social support is not associated with the duration of homesickness. However, new friends facilitate the adaptation process of the homesick individual. Homesick people can learn much about their new environment and the local habits and norms from friends ('informational and instrumental support'). Moreover, active and fun activities are typically undertaken with friends, thereby distracting the homesick from his/her thoughts and feelings ('emotional support').

The relation between Mental Escape and homesickness chronicity could be a spurious one. Increases in both could be caused by homesickness intensities. Higher homesickness intensities may lead to both longer duration of homesickness and more use of mental escape as a coping strategy. However, in a previous study, it was found that Seeking Social Support and Positive Thinking/Distraction predicted homesickness intensity (Van Tilburg *et al.*, 1997). These results thus contradict the hypothesis that the relationship between Mental Escape and homesickness chronicity is spurious. However, longitudinal studies are needed.

Of the five personality dimensions, only Emotional Stability was related to timely recovery from homesickness. This is in congruence with other research linking homesickness to neuroticism (Gasselsberger, 1982; Eurelings-Bontekoe *et al.*, 1994; Rümke, 1940; Voolstra, 1992). Thus, neuroticism is not only related to a greater vulnerability to develop homesickness, but it also interferes with recovery. The impact of Emotional Stability on the timely recovery was greater than that of coping. Although, personality seems to be more important than coping, coping did have a separate effect on homesickness chronicity. Furthermore, it was found that those who run the risk of becoming chronically homesick, also report more extreme reactions to leaving home, as evidenced by higher homesickness

intensities, more missing of what is left behind, and fears of leaving home. The chronic homesick did not report more difficulties in the new environment than the non-chronic homesick. This confirms the previous finding of Van Tilburg (1997) that inability to cope with the high demands of a new environment might not be a major cause or sufficient condition for the development of serious homesickness. The results of the present study thus seem to indicate that difficulties in the new environment are neither leading to prolonged homesickness, although as much as 35% of the students in this study attributed their homesickness to these difficulties.

In conclusion, this study has yielded some interesting findings which might have important practical implications for those suffering from homesickness and professionals working with the homesick. As far as we know, it is the first study which focusses upon (in)effectiveness of coping with homesickness. Meanwhile, there is need of more studies using a prospective design and larger samples over a wide variety of groups.

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12 General discussion

The idea for this thesis grew out of the scarce literature on homesickness and the outcry of many of our research participants support, when at the same time we were unable to offer them any help because we knew so little about this phenomenon. When reviewing the literature it appeared that the few studies which have been reported were mainly directed at manifestations of homesickness, and personality and environmental factors which are related to the onset of homesickness (cf. Van Tilburg, Vingerhoets, & Van Heck, 1996). Although homesickness might be a normal reaction to leaving home, it was helpful to hold the current literature of homesickness against a model of a medical disorder (see *Figure 1.1* in Chapter 1). By doing so it was found that vital information on causes, symptoms, diagnosis and treatment of homesickness was largely lacking.

First, it is not clear yet how homesickness must be defined and diagnosed. The lack of a well agreed upon definition and diagnostic rules is the most important gap in the current literature on homesickness. Important in this aspect is to know whether homesickness is really different from related syndromes like separation anxiety, or might be a form of one of these syndromes. In Chapter 3, a review of the literature revealed that homesickness could be conceptually distinguished from related syndromes. Homesickness has much in common with other concepts, especially nostalgia, grief and separation anxiety. In fact, there is evidence that homesickness is easily mixed up with these concepts (e.g., Thijs, 1992). However, there is one quality of the homesickness concept that seems to distinguish it from all the other related concepts, namely their cognitions are different. Homesick people long for home when being separated from home. They do not long in particular, although this might be a part of their longings, for bygone days (nostalgia), for loved ones lost by death (grief), or for attachment figures from which one is separated (separation anxiety). They long for the atmosphere of home, the persons left behind, the house and city left behind, their old neighborhood, the feelings of security and warmth etc. All these things constitute 'home'.

Even when it is clear what is not part of a homesickness experience, this does not mean that we exactly know what homesickness is. Therefore, in Chapter 4, a community study is reported directed at the common beliefs about homesickness. It appeared that there is general consensus on how to define homesickness among lay people. According to the results of this study, homesickness can best be defined as: *Longing for home and aspects of home, due to a transition from home, accompanied by negative affect (sorrow, loneliness, depression, and tension) and possibly by physical*

complaints (mostly gastric/intestinal complaints and headaches). As in Chapter 3, it appeared that the cognitions of the homesick were most important for the definition of homesickness by lay persons. Other manifestations, like emotions, had supportive value for the definition. Future studies should focus on the potential of the above mentioned aspects of the definitions to distinguish the following groups: (i) the homesick and the non-homesick, (ii) the 'normal' and 'pathological' homesick, and (iii) the homesick and people suffering from related syndromes like separation anxiety.

The study reported in Chapter 4, showed a large consensus on the personal meanings of homesickness. Lay people did not distinguish different 'types' of homesickness. In contrast, several authors (e.g., Bergsma, 1960; Rümke, 1940) proposed that homesickness is not a singular syndrome, but multifaceted with subtypes which differ in etiology. Although these typologies of homesickness were based on their extensive contact with homesick individuals, no empirical test had been done to test the validity of these subtypes of homesickness. In Chapter 5, a study is reported in which 31 individuals with severe cases of homesickness were interviewed. From this study it appeared that three subtypes of homesickness could be distinguished. The first type of homesickness, *recovered homesickness*, seems to be a reaction to adjustment problems when making a residential move to another culture or environment. Most people eventually overcome this type of homesickness as they adjust to their new living environments. Second, there is a type of *recurrent homesickness* associated with deeply rooted anxieties. Individuals suffering from this type of homesickness are unable to 'let go' and deal with a loss of home even if it is only temporarily. They will become homesick every time they have to leave their homes. Because of the associations with agoraphobia, separation anxiety, and adverse attachment experiences, it is hypothesized that this is a pathological type of homesickness. Very tentatively a type of homesickness may be distinguished. *Holiday homesickness* is associated with a rigid personality style, featuring difficulties in breaking with old routines. Homesickness strikes especially during holiday, when changes daily routines and schedules cannot be avoided. Vingerhoets (1997) discussed the relationship between homesickness and adjustment suggesting three possible theoretical links: (i) homesickness is a result of poor adjustment; (ii). poor adjustment is a result of homesickness, and (iii) homesickness is equivalent to poor adjustment. Vingerhoets proposes to define homesickness in a very strict way: homesickness reflects problems with leaving home and interferes with adjustment. In the recurrent homesick, this seems to be the case. In contrast, distress caused by adjustment problems should not be labeled homesickness. However, recovered homesickness seems to be caused rather by adjustment

problems in the new environment than by difficulties with separation from the old environment.

The major drawback of the study reported in Chapter 5 is the small sample size and the reliance on interview data. Therefore, the study in Chapter 6 was designed to test the existence of the three subtypes of homesickness in a large community sample. This study failed to replicate the results of the interview study. Although there seems to be empirical support for distinguishing three subtypes, the determinants associated with these subtypes were not clear. For future studies it is of utmost importance to include better designed measurements of homesickness determinants. For now, the data gives us reason to believe that there are several subtypes of homesickness that might differ in etiology. This observation has far-reaching consequences for research and therapy. Especially therapists might find the results of great value in determining the most appropriate therapeutic approach. For researchers it is important to be able to distinguish types of homesickness by self-report questionnaires. Therefore, after validation of the three subtypes, the next step should be to develop well-designed homesickness questionnaires.

The second major part of this dissertation focuses on the symptoms and course of homesickness. Although a lot is known about homesickness symptoms from Fisher's work (e.g., Fisher, 1989), due to its reliance on students and boarding school children the generalizability to other populations was greatly reduced. Therefore, Chapters 7 to 9 are mainly replication studies among a larger population, consisting of homesick women. Homesick men were not excluded on purpose from these studies, but were rather reluctant to participate. Therefore, replication studies in men are still needed. It appeared that the results of Fisher's studies could largely be replicated. The main symptoms of homesickness seem to be quite universal, not varying to a large degree among ages, sexes, or homesickness situations. However, on the basis of the current results, the causal role of characteristics of the *new* environment in homesickness, as proposed in Fisher multi-causal theory, was questioned. The data indicated that it was more likely that homesickness is caused by the separation from the *old* environment. In Chapters 5 and 6, provided evidence for the existence of subtypes of homesickness, one of which is related to difficulties in the new environment and another to difficulties with leaving home, exactly the two processes that cause homesickness, according to Fisher. The samples used in Chapters 7-9 consisted of mostly severely and recurrent homesick women. Therefore, the pathological type of homesickness might have been over-represented leading to an underestimation of the role of the new environment in the development of homesickness.

An addition to replicating Fisher's and others work on homesickness manifestations (e.g., Fisher, 1989), the studies reported in Chapters 7-9 also focused upon the course of homesickness. In Chapter 7 this was done retrospectively by asking about the onset and cure of homesickness. In Chapter 8, a three-year follow-up is presented. In Chapter 9, a longitudinal multiple case study is reported among homesick-prone women who went on a holiday. It appeared that homesickness usually develops directly after a separation from home. However, sometimes the onset can be delayed and triggered by life-events like the death of a left-behind loved one. In addition, some participants also reported homesick-like symptoms before leaving home. This anticipation homesickness was not necessarily followed by a period of homesickness after leaving home. This is remarkable as it was found that most persons do not expect to become homesick, even when having had homesickness experiences before. The anticipation homesick women, on the other hand, seem to develop anticipation fear, much alike the fear-of-fear cognitions well described in agoraphobia (e.g., Thorpe & Burns, 1983).

Thus, onset of homesickness occurs mainly during the first few days after separation from home. After onset, only the severely homesick will be homesick all day, otherwise it strikes at variable times during the day, mainly in the evenings and during the night. Furthermore, homesickness intensities might decrease, increase or stay the same when time passes. For most people, homesickness will eventually fade away. However, there is no guarantee for cure. In some cases homesickness lasted a lifetime. This is also reflected in the fact that most homesick people feel that they are unable to find a solution for their homesickness besides returning home. Once back in the old environment many of them will try to prevent future homesickness by avoiding homesickness-eliciting situations. This poses a real problem for homesickness research. There is some self-selection bias in all samples, because homesick-prone people will decide not to leave home. Especially when the decision to move was not forced upon the person, people who think they might develop homesickness will stay at home. Exceptions might be samples of asylum seekers, conscripts, and hospitalized patients, because those individuals have less freedom regarding the choice to leave home. It is important to keep this these considerations in mind, when studying people in homesickness-eliciting situations. Especially when one is interested in prevalence rates of homesickness.

The last part of this thesis focuses on one of the major questions for those who are confronted with homesickness: How to deal with it? In the literature interventions have been proposed like expression of feelings through writing (Pennebaker, Colder & Sharp, 1990) and stress-management therapy (Fisher,

1989). Unfortunately many of the proposed interventions are not adequately tested empirically. From the results of our own study, reported in Chapter 7, it appeared that most people believe that only returning to the old environment brings real relief. However, we also found that many of the people who do not return eventually recover from their homesickness. The question is which coping strategies are adequate for dealing with homesickness. As nothing is known about coping behavior in adult homesickness, the first step was to examine which coping strategies are used. In Chapter 10, the development of the Adult Homesickness Coping Questionnaire (AHCQ) is discussed. Factor analysis yielded four subscales: Seeking Social Support, Positive Thinking/ Distraction, Mental Escape, and Turning to Religion. The internal consistency and face validity of the subscales appear to be good. The results of this study indicated that the use of coping strategies is related to perceived cause, felt intensity of homesickness, and duration of the separation from home, although these relations were only moderate at best. These findings were most interesting, but they still did not give us a clue on how effective each coping strategy was. Therefore, a study among female university students was done focusing on the relationship between coping strategies and personality styles, on the one hand, and timely recovery of homesickness, on the other hand (see Chapter 11). Contrary to our expectations based on findings in the literature, seeking social support did not predict homesickness chronicity. Mental escape was positively associated with homesickness chronicity: the more daydreaming and fantasizing was used as a way of coping with feelings of homesickness, the more likely it was that homesickness would become chronic. However, it is almost impossible to refrain oneself from fantasizing and daydreaming about home, when being homesick. It is like saying to a depressed person: do not be depressed anymore. Therefore, it follows from this study that the homesick are helped best by distractions from their thoughts and worries. The most frequently reported factor that contributed to the recovery process in this study was making new friends. From the empirical results it seems that the social support one gets from these new friends probably was not an important factor in the duration of homesickness. It seems more likely that the beneficial effect of making new friends is due to the fact that new friends get the homesick people involved in new activities and make them explore their new environment, leaving less opportunity for daydreaming and fantasizing about the old environment. It is this distraction from their thoughts and the stimulation to get adapted to the new environment that probably influences homesickness duration. The problem is that in this particular study we did not know whether the chronic homesick might as well have made friends, who distracted them, but did not recover anyway. So, recovery might not be due to

making new friends, but to some other less apparent factor. It could also be the case that those who recovered in time were suffering from another type of homesickness than those who developed chronic homesickness (e.g., recovered homesickness versus recurrent homesickness). These and other issues need to be addressed in future research. As we get to know more about the effectiveness of coping styles and how they interact with personality and situational variables, this will stimulate the development of interventions for the homesick. Furthermore, future studies should address the question how (severe) homesickness can be prevented. We have to keep in mind that for the homesick the most important pay-off of all our efforts would be to come up with some sort of a solution for them, because they really do not have a clue how to handle their problem most effectively.

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Summary

Being a topic of scientific interest from the 17th century onwards, it is surprising how little is known about homesickness. As a consequence of the rather scarce and scattered literature there is a lack of information on causes, symptoms, diagnosis and treatment of homesickness. Since the 18th century homesickness has often been found unworthy as an object of scientific study, in spite of the fact that it is a very common phenomenon with possibly devastating consequences for psychological and physical health.

The first part of this thesis focused upon the causes and definition of homesickness. In Chapter 3, a review of the literature revealed that homesickness is conceptually different from related concepts, like nostalgia and grief. Unique for the homesick is an intense longing for home when being separated from home. A community study, reported in Chapter 4, directed at the conceptual analysis of homesickness, supported this finding. Generally, homesickness was defined as: *Longing for home and aspects of home, due to a transition from home, accompanied by negative affect (sorrow, loneliness, depression, and tension) and possibly by physical complaints (mostly gastric/intestinal complaints and headaches)*. In this study, it did not appear that lay people distinguish different types of homesickness. However, the studies in Chapters 5 and 6 revealed that there is reason to believe that homesickness is not a homogeneous concept. Three subtypes of homesickness were distinguished, although more research is needed to determine their validity. The first type, *recovered homesickness* was related to difficulties adjusting oneself to new norms, rules, values, etc., which are held by the people in the new environment. Most people eventually overcome these problems as they integrate into a new culture. Recovered homesickness is most common among those who move or migrate, and generally not found during short-term separations from home like holidays. Second, the *recurrent homesick* always become (severely) homesick as soon as they leave their house. It is essentially the separation from things and persons that affects them; they cannot deal with the loss. Home is perceived as a safe and secure place, and separation from it will lead to great distress even though the person him or herself might not know why (s)he feels distressed. Finally, very tentatively, a third type of homesickness may be distinguished. *Holiday homesickness* is associated with difficulties in breaking with old routines and forming new routines. Rigidity and a lack of flexibility seem the major characteristic features of this group. When plans and daily routines are changed, distress and anxiety are experienced, followed by a longing for the planned and predictable life at home. This type of homesickness is most common during holidays and stay-overs and does not typically occur after a move.

In the second part of this thesis, the focus is on symptoms and course of homesickness. Using a general female adult population, the studies reported in Chapters 7 to 9 replicated to a large extent the symptoms previously observed among children and adolescents. Although replication studies among adult males are needed, it seems that the main symptoms of homesickness are universal, not varying to a large degree among sex, ages, or homesickness situations. It was furhter established that homesickness generally develops within the first day after leaving home. However, homesickness is not only experienced during absence from home, but it may also occur in anticipation to a leave from home. It is hypothesized that anticipation homesickness is a fear of developing homesickness, much alike fear-of-fear cognitions in agoraphobia. Only the severely homesick will be homesick all day, otherwise it strikes at variable times during the day, mainly in the evenings and during the night. Furthermore, homesickness intensity might decrease, increase or stay the same when time passes. For most people, however, homesickness will eventually fade away, although there is no guarantee for curing, because homesickness can last a lifetime. Returning home gives immediate relief from homesickness. Once back in the old environment, many try to prevent future homesickness by avoiding homesickness-eliciting situations.

In the third and last part of this thesis (Chapters 10 and 11), two studies are reported which examine coping behavior in the homesick. An Adult Homesickness Coping Questionnaire was developed, which appears to have good psychometric properties. Homesick people cope by: (1) seeking social support, (2) thinking positively about the new environment or distracting themselves from thoughts and worries, (3) trying to escape from the situation mentally by fantasizing and daydreaming about home, and (4) turning to religion, e.g., praying. Only mental escape was related to homesickness duration. The more daydreaming and fantasizing was used as a way of coping with homesickness, the more likely it was that homesickness would become chronic. However, it is almost impossible to refrain oneself from fantasizing and daydreaming about home, when being homesick. Therefore, it seems that the homesick are most helped by distractions from their thoughts and worries. It is hypothesized that the beneficial effect of making new friends is due to the fact that new friends get the homesick people involved in new activities and make them explore their new environment, leaving less opportunity for daydreaming and fantasizing about the old environment.

More research is needed to unravel many of the questions and doubts raised by the studies reported in this thesis. Most importantly, there is need of studies directed at (1) the development of diagnostic rules for homesickness; (2)

validation of the subtypes of homesickness and development of homesickness questionnaires directed at measuring these subtypes; (3) replication studies in adult homesick males on the symptoms, course and prognosis of homesickness, (4) prospective studies directed at the (in)effectiviness of coping with homesickness, and (5) development and test of interventions for the homesick. Placement of these studies in a theoretical framework is strongly recommended.

Samenvatting

Alhoewel heimwee al sinds de 17de eeuw onderwerp is van wetenschappelijke studie, is er tot op heden opmerkelijk weinig bekend over dit fenomeen. Het gevolg van de schaarse en versnipperde literatuur is een gebrek aan kenis over oorzaken, symptomen, diagnose en behandeling van heimwee. Reeds sinds de 18de eeuw heerst er de opvatting dat heimwee niet de aandacht verdient van wetenschappers. Dit ondanks het feit dat heimwee een veelvoorkomend fenomeen is dat een zeer negatief effect kan hebben op de psychische en lichamelijk gezondheid van de heimweelijder. In het eerste gedeeelte van dit proefschrift worden de oorzaken en definitie van heimwee nader bekeken. N.a.v. de literatuurstudie in hoofdstuk 3, kunnen we concluderen dat heimwee verschilt op conceptueel niveau van gerelateerde concepten zoals nostalgie en rouw. Karakteristiek voor heimwee is het intense verlangen naar huis wannneer men verwijderd is van huis. Een conceptueel bevolkingsonderzoek dat gerapporteerd wordt in hoofdstuk 4 onderschrijft deze bevindingen. In het algemeen wordt heimwee als volgt omschreven: *Verlangen naar thuis en aspecten van thuis,veroorzaakt door een verwijdering van huis,* gepaard gaande met negatieve affecten (verdriet, eenzaamheid, depressie en spanning) en mogelijk ook met lichamelijke klachten (voornamelijk maag/darmklachten en hoofdpijn). Uit dit onderzoek kwam niet naar voren dat leken spontaan verschillende typen van heimwe onderscheiden. Echter, de resultaten van de onderzoeken beschreven in hoofdstuk 5 en 6, geven reden om aan te nemen dat heimwee geen homogeen concept is. Alhoewel meer onderzoek nodig is, lijkt het dat er drie types van heimwee kunnen worden onderscheiden. Het eerste type, *herstelde* heimwee, is gerelateerd aan moeilijkheden om zich aan te passen aan nieuwe normen, waarden, regels etc.. De meeste personen overwinnen deze moeilijkheden als ze zich integreren in de nieuwe cultuur. Herstelde heimwee komt het meeste voor onder migranten en verhuizers, het is minder bekend bij kortdurende afwezigheid van thuis zoals tijdens vakanties. Het tweede type heimwee is de *herhaalde heimwee*. Deze personen lijden aan ernstige heimweeproblematiek elke keer als ze hun huis moeten verlaten. De heimwee wordt veroorzaakt door de scheiding van personen en dingen. Deze personen kunnen niet omgeaan met verlies van enigerlei aard. Thuis is een veilige haven en scheiding ervan veroorzaakt veel pijn en verdriet, alhoewel de persoon zelf niet altijd doorheeft waarom hij of zij zich zo voelt. Onder voorbehoud kan er nog een derde type van heimwee onderscheiden worden. *Vakantieheimwee* wordt gekarakteriseerd door moeilijkheden met het doorbreken van routines. Rigiditeit en een tekort aan flexibiliteit zijn de belangrijkste eigenschappen van deze groep heimweelijders. Het onvermogen terug te vallen op plannen en dagelijkse routines in de nieuwe omgeving veroorzaakt angst en ongemak, waarna men gaat verlangen naar het geplande en voorspelbare leven van

thuis. Dit type heimwee treedt gewoonlijk op tijdens vakanties en logeerpartijen en is eerder uitzondering dan regel na verhuizingen.

Het tweede gedeelte van dit proefschrift is gericht op de symptomen en het verloop van heimwee. De studies, die worden gerapporteerd in hoofdstukken 7 tot en met 9, vonden onder volwassen vrouwen grotendeels dezelfde symptomen van heimwee als eerder geobserveerd was in kinderen en adolescenten. Alhoewel replicatiestudies onder volwassen mannen hard nodig zijn, lijkt het erop dat de symptomen van heimwee universeel zijn. Ze variëren niet sterk naar sekse, leeftijd, of heimweesituatie. Tevens werd geobserveerd dat heimwee zich in het algemeen ontwikkelt binnen de eerste dag na vertrek van thuis. Echter, heimwee bleek niet alleen voor te komen als men weg was van huis. Het kan optreden al enkele dagen voor het naderende vertrek. Men zou kunnen veronderstellen dat deze anticipatieheimwee een angst is om heimwee te ontwikkelen als men thuis moet verlaten, net zoals de angst-voor-angst cognities in agorafobie. Alleen in zeer ernstige gevallen is het gevoel van heimwee continu aanwezig. Dat betekent dat heimwee meestal episodisch van aard is. Voornamelijk de avond en nacht zijn heimweemomenten . Met het verstrijken van de tijd kan de intensiteit van heimwee toenemen, afnemen, of gelijk blijven. In de meest gevallen zal de heimwee uiteindelijk wegebben. Maar er is geen garantie voor een genezing, heimwee kan een leven lang duren. Terugkeren naar huis geeft directe verlichting van heimwee. Eenmaal terug in de oude omgeving proberen veel ex-heimweelijders toekomstige problemen te voorkomen door heimwee-opwekkende situaties te vermijden.

In het derde en laatste deel van dit proefschrift (hoofdstukken 10 en 11), worden twee studies gerapporteerd naar het omgaan met heimwee. Een Volwassenen Heimwee Coping Vragenlijst werd ontwikkeld, welke goede psychometrische eigenschappen lijkt te bezitten. Er wordt omgegaan met de heimwee door: (1) sociale steun te zoeken, (2) positief te denken over de nieuwe omgeving en afleiding te zoeken van gedachten en zorgen, (3) mentaal te ontsnappen uit de situatie door te fantaseren en te dagdromen over thuis, en (4) steun in het geloof te zoeken, zoals bidden. Het bleek dat alleen het gebruik van mentale ontsnappingstechnieken gerelateerd was aan hoe lang men aan heimwee leed. Hoe meer men dagdroomde en/of fantaseerde over de oude omgeving, hoe meer kans er was dat de heimwee een chronisch probleem werd. Het is echter vrijwel onmogelijk om niet over thuis te dromen en te fantaseren als je last hebt van heimwee. Daarom lijkt het erop dat mensen met heimwee het meest geholpen zijn door ze af te leiden van hun gedachten aan thuis. Het zou zo kunnen zijn dat het maken van vrienden zo heilzaam is omdat nieuwe vrienden de heimweelijder enerzijds betrekt in

allerlei activiteiten en anderzijds zijn/haar nieuwe omgeving laat verkennen. Daardoor heeft men minder tijd voor dagdromen en fantaseren over thuis.

De resultaten van de hier gerapporteerde studies, benadrukken de noodzaak voor meer onderzoek naar heimwee. Toekomstige studies zouden zich in ieder geval moeten richten op (1) de ontwikkeling van diagnostische regels voor heimwee; (2) validatie van de subtypen van heimwee en ontwikkeling van heimweevragenlijsten met welke de subtypen vastgesteld kunnen worden; (3) replicatiestudies onder volwassen mannen met heimwee gericht op de symptomen, het verloop en de prognose van heimwee; (4) prospectieve studies naar de effectiviteit van coping met heimwee, en (5) de ontwikkeling en het testen van interventies voor heimwee. Het wordt ten sterkste aangeraden deze studies binnen een theoretisch raamwerk te plaatsen.

Erratum

After printing of this disertation a fault in one of the analysis described in chapter 8 and Table 8.1 was found. It concerns the means on the HSCL-scales in the homesick-prone group. The corrected figures are given in the table below. In contrast to what is described in chapter 8, the overall test revealed significant between-group differences on all HSCL scales. Post hoc tests showed that HSCL total scores of all groups differed significantly from each other, except for the homesick-prone and recovered homesick. Psychological health subscale scores differed significantly between all groups except between the homesick-prone and recovered homesick and between the recovered and non-homesick. Scores on the physical health subscale were significantly higher for the chronic and homesick-prone compared to the non-homesick. The comparison of HSCL scores per group to norm scores in an adult Dutch sample, as reported in chapter 8, was not altered in anyway by these new analyses. The corrected analyses did not affect the general conclusions given in chapter 8 to a large degree.

Means of HSCL scale scores

	Chronic homesick	Homesick prone	Recovered homesick	Non-homesick	F-value
HSCL					
Total	112.11	**96.62**	91.40	75.69	**19.21**[b]
Phys. health	13.35	**12.50**	12.45	10.60	**17.34**[b]
Psychol. health	34.54	**29.06**	26.26	22.78	**5.00**[a]

Note HSCL = Hopkins Sympton Checklist. Corrected figures are bold.
[a] $p \leq .01$: [b] $p \leq .001$