HOMESICKNESS:

A LITERATURE REVIEW AND THE EFFECT OF NARRATIVE THERAPY

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Abstract

Homesickness is a relatively common experience, yet there has been little exploration or acknowledgement of the topic within the contemporary literature. Motivated by the longstanding oversight of the phenomenon the first part of this thesis attempts to review and augment the current body of research, and a comprehensive psychological model of homesickness is put forward. The second part of this thesis provides an investigation of the effect of narrative therapy on levels of homesickness. It is recognised that there is a need for a treatment for homesickness that ameliorates psychological well-being, advances intellectual capacity and promotes physical health. Narrative therapy is an approach to treatment that has been shown to have a positive influence on both physical and mental health, and academic performance. In light of the benefits of narrative therapy, it should follow that there will be a reduction in levels of homesickness for students who participate in an emotional writing exercise. To test this hypothesis a total of 60 3rd and 4th form boarding pupils participated in a writing exercise over three consecutive nights. Participants were randomly assigned to two groups; the control group wrote descriptively about non-emotional topics, where as pupils in the experimental group constructed an emotional narrative that contemplated their transition to boarding school. Data concerning the pupil's homesickness scores, average grade, and school attendance was analyzed. Despite the absence of statistically significant change, trends indicated that narrative therapy may have a beneficial effect on levels of homesickness, particularly for homesick females.

CHAPTER ONE: INTRODUCTION AND LITERATURE REVIEW

1.1 HOMESICKNESS - AN OVERVIEW

Homesickness is the distress or impairment caused by an actual or anticipated separation from home. It is a relatively common phenomenon, and there is considerable consensus on its key features. Homesickness is characterized by a depressed mood, persistent thoughts about home, the desire to return to a familiar environment and a variety of vague somatic complaints (Fisher, 1989; Vingerhoets, 1997; Peacock, 1988; Van Tilburg, Vingerhoets, and Van Heck, 1996). Homesick individuals have been found to experience acute longing for home, and are believed to be preoccupied with thoughts about home and attachment objects (Fisher, 1989; Thurber, 1999; Vingerhoets, 1997; Peacock, 1988; Van Tilburg et al., 1996).

There are few references to homesickness in the current scientific literature. More common are references to *acculturation stress* or *culture shock.* Acculturation stress refers to the psychological and physical discomfort experienced as the result of adjusting to a new cultural environment (Hannigan, 1997). Culture shock, on the other hand, is primarily an emotional reaction. The concept implies that the experience of visiting or living in a new culture is an unpleasant surprise or shock (Furnham, 1997). Homesickness, however, is a phenomenon that is often experienced by people who move *within*, rather than *between* cultures or countries.

Studies indicate that here is an intuitive understanding about homesickness and its symptoms (van Tilburg, 1997), however a precise definition is difficult to obtain. *The Oxford Dictionary* defines homesickness as 'depression as a result of absence from home', this definition does not, however, delineate the symptoms that may be associated with the experience. Homesickness is a reaction to leaving one's home or house, and refers to the commonly experienced state of distress among those who find themselves in a new environment (Van Tilburg et al., 1996). Generally, it is understood that homesick individuals miss their family and friends, their familiar surroundings and home comforts, and experience a desire to return to the previous environment (Fisher, 1989; Furnham, 1997; Stroebe, van Vliet, Hewstone, & Willis, 2002).

The experience of homesickness is both ancient and widespread. The longing for the familiar has plagued artists and musicians, and has provided inspiration for myth and poetry. The Greek author Homer, for example, gives eloquent voice to this human phenomenon, the hero Ulysses is described to be weeping and rolling on the floor whilst thinking of home (cited in Werman, 1977). Homesickness is a concept familiar to most people and nearly universally experienced. Mention of homesickness often evokes spontaneous reminiscing of events and feelings attached to the original experience (Baier and Welch, 1992).

Despite the universality of homesickness, contemporary scientific literature has paid limited attention to the phenomenon. This is surprising. Modern day scholastic and professional requirements place increasing demands on adaptational capacities (Vingerhoets, 1997), and residential moves can be a highly stressful experience -particularly for young people (Brewen, Furnham, & Howes, 1989; Fisher, 1989). Fisher (1989) reports that as many as 50-75% of the population have experienced homesickness at least once in their life, and that 10-15% of the homesick have experienced the phenomenon to such an extent that it interferes with their daily living.

Early research into homesickness was scattered, a definition was not agreed on, and the concepts were operationalized in many ways. One of the first to provide insight into the phenomenon was the Swiss investigator Hofer (1678). Hofer regarded homesickness as a cerebral disease of essentially demonic cause. Homesickness was thought to be an illness of young adults who were socially isolated in strange countries and the adverse experience was referred to as "maladie du pays". Hofer proposed that a number of factors including customs, habits, and food, combined to produce strong thoughts about returning home. Thus Hofer attended to the cognitive and motivational dimensions of the phenomenon.

Hofer (1678) subsequently introduced the word "nostalgia". Nostalgia was forwarded as a literal translation into Greek of the German word "heimwech", which means a painful yearning for home or country. While it may appear difficult to differentiate nostalgia, in a broader sense, from homesickness, the latter generally follows separation from the home environment, is associated with sadness and somatic symptoms and is usually resolved quickly by returning home. Where as nostalgia, on the other hand, consists of memories of a given place, at a specific time, and the affect associated with the memories is characterized as 'bittersweet' (Werman, 1977).

Physicians of the seventeenth and eighteenth centuries devoted many studies to homesickness. Bachet (1950) provides a comprehensive review of the early studies. Research focused on observations of both soldiers and hospitalized patients, and organic pathology was stressed as an important cause of homesickness. This view was not eroded until the late nineteenth century when developments in medicine led to a better understanding of the homesickness phenomenon. In the early 1900s homesickness was primarily described among maids, child minders and emigrants and was thought to lead to criminal behavior. Throughout this period psychoanalytical ideas such as regression and infantile bonding became apparent in the homesickness literature (Van Tiburg et al., 1996).

During the first and second World Wars there was an escalation of interest in homesickness, and the phenomenon was identified as a significant motivating factor leading to war desertion. This view was illustrated by Tausk (1969), a physician and psychoanalyst of the Imperial Australian Army, who reported that:

> ...The heavy, homesick, depression that precedes desertion in many cases makes me believe that it is sometimes merely an unconscious flight from a threatening mental illness...Escape to home, where one is never solitary, might perhaps represent salvation from the impending madness (Tausk, 1917, 1969, p.354).

Following World War II the interest in homesickness receded, and there was a dearth of research until the 1980s.

Researcher Shirley Fisher has emerged as a contemporary leader in the field of homesickness. Fisher's (1989) model of homesickness emphasizes the interaction between personality characteristics of the individual and facets of the new environment. The model predicts that the intensity of homesickness experienced is a function of both personality and behavioural features of the individual, and aspects of the new environment. Fisher's work has not only increased insight into the phenomenon but has also stimulated further research.

In 1995 a symposium on 'Homesickness and Acculturation Stress' was held at the 13th World Congress of the International College of Psychosomatic Medicine in Israel. Papers that were presented at the symposium have been compiled into a comprehensive book edited by van Tilburg and Vingerhoets (1997). The collection of papers illustrates the diverse lines of research that surround the homesickness phenomenon, including group research that includes migrants and refugees, individual differences and personality disorders, health issues, and psychopathology in international tourists.

1.2 THE RATIONAL FOR STUDYING HOMESICKNESS

Motivated by the longstanding oversight of homesickness, this thesis attempts to augment the current body of research. The field of study has to some extent been mapped out, the basic issues identified, and tools of the investigation developed. Yet the assortment of homesickness literature remains manageable, and the topic fresh enough for the investigator to make an impact. Many arguments for studying homesickness could be articulated, one of the simplest is that homesickness is so widespread. As previously mentioned, as many as 50-75% of the population have been reported to have experienced homesickness at some time (Fisher, 1989).

Geographical moves are part of modern life. Professionals and their families, diplomats, missionary workers, athletes, the military and students sojourn in foreign countries. Educational, professional, recreational, political, and social demands require people to leave home. From refugees escaping an unsafe environment to children affected by marriage break-ups, the reasons for leaving ones home are diverse (Fisher, 1989; van Tilburg & Vingerhoets, 1997).

Various scales developed to investigate stress, such as the Social Readjustment Rating Scale (Holmes and Rahe, 1967), include change of residence as a major life stressor, and there are strong indications that short or long term residential moves can have a dramatic impact on both physical (Fisher, Frazer, & Murray, 1986) and psychological (Van Tilburg, Vingerhoets, & Van Heck, 1996) health. Thus homesickness can impact not only every segment of society, but also every stage of a person's life and it is a misconception to believe that life becomes easier as one becomes older, that coping skills undoubtedly improve with age, that advancing years magically confer psychological immunity, or to deny that phenomena such as homesickness are a reality of existence for the older adult as well as for the young (Taylor, 1986).

In order to clarify, define and distinguish homesickness it is essential to subject the phenomenon to concept analysis. An extensive literature review is necessary in order to identify areas of interest and to form a basis for the development of strategies and interventions for homesickness that may give rise to real improvements in the quality of life of those separated from their home.. The present research into homesickness may stimulate further investigation and theorizing, contributing to a better understanding of the phenomenon. Finally, studying homesickness may also provide new insights into related research areas such as stress and coping, emotion, and attachment.

1.3 THE PSYCHOLOGICAL CONTEXT OF HOMESICKNESS

Although homesickness has been considered a normative developmental experience for most people (Lifshitz & Sakoda, 1952; Vingerhoets, 1997), more recent research suggests that severe homesickness can cause acute distress, social withdrawal, behavior problems, and severe symptoms of depression and anxiety (Thurber, 1999, Thurber and Sigman, 1998). Insight into the psychological context of homesickness is useful in clarifying and distinguishing homesickness from other related concepts such as separation anxiety, school phobia, loneliness, grief, nostalgia, depression, adjustment disorder and agoraphobia.

Separation Anxiety

Conceptually, homesickness is most congruent to separation anxiety. Separation anxiety is a youth disorder in which the child feels "excessive anxiety concerning separation from home or from those to whom the person is attached" (American Psychiatric Association, 1994, p.110). Homesickness and separation anxiety are similar in that in both conditions the individual becomes distressed when parted from an attachment object and may also present physical complaints. In addition, both homesickness and separation anxiety are classified in the DSM-IV (American Psychiatric Association, 1994) under Axis I, and categorised as disorders that are usually first diagnosed in infancy, childhood or adolescence.

Incongruity in preoccupying thoughts is the most significant difference between the two concepts. The preoccupying thoughts that are the hallmark of homesickness can be about home or attachment objects, not just people as occurs in separation anxiety Whereas in homesickness an individual suffers persistent thoughts mostly about *home* or *attachment objects*, in separation anxiety the individual pines for a *person*. Obtaining a differential diagnosis in a child can be difficult in that separation from home, and separation from an attachment figure often occur together (Van Tilburg, 1997).

School Phobia

School phobia is an extreme separation anxiety disorder of children characterised by a persistent irrational fear and avoidance of going to school or being in a school-like atmosphere (Mosby, 1994). Such children are usually shy, timid, nervous and emotionally immature with pervasive feelings of inadequacy. In order to cope with their fears the children may become overly dependant on others, especially their parents. It has been suggested that homesickness is comparable in many ways with school phobia (Chartoff, 1975). Children experiencing school phobia may manifest physical signs of illness such as vomiting, diarrhea, headache, or abdominal pain (Pillitteri, 1987), similar physical symptoms have been found to be present in homesick children (Van Tiburg et al., 1996; Winland-Brown and Maheady, 1990).

Although there is difficulty in distinguishing between the two conditions, a differential diagnosis can be obtained on the basis of the kind of separation that evokes the fear and avoidance. Where as the child who is suffering from school phobia is fearful of and avoids school alone, the homesick child displays fear and avoidance of situations related to separation from home (Van Tilburg, 1997). Additionally, Baier and Welch (1992) state that school phobia is distinct from homesickness in that school phobia is an emotionally paralysing condition whereas homesickness is usually not.

Loneliness

Although it is difficult to find references to homesickness in the psychological literature, references to loneliness are more frequent. Social transitions are part of living in modern society, and so too is loneliness (Peplau and Perlman, 1982). Yet loneliness is too broad a term. Its causes are many, not specifically the result of relocation (Hannigan, 1997). Loneliness however, has been found to be one of the symptoms of homesickness (Van Tilburg et al., 1996).

Grief

Homesickness and grief are similar in that they are both manifestations of stress associated with a known loss. Homesickness has been considered a type of 'mini-grief' viewed from the theoretical perspectives of loss and bereavement (Stroebe, van Vliet, Hewstone, & Willis, 2002; Van Tilburg, 1997; Fisher, 1989). Both homesickness and grief are related to attachment and loss. Bowlby (1980) suggested that there are four stages that an individual passes through following the loss of an attachment figure. The second, which involves 'yearning and searching' for the lost person, corresponds with homesickness, particularly the cognitive and motivational dimensions of the phenomenon.

However, grief is often associated with the loss of a singular entity such as a loved person or relationship, where as homesickness is associated with multiple losses (e.g. home, friends, and places of emotional significance) that are secondary to a residential move. In homesickness, the 'problem' is partly the conflict between the distress of leaving home and the need to remain in the new environment to fulfill an ambition. Thus homesickness is a self-created problem in the way that bereavement is not (Fisher, 1989).

Nostalgia

Authors have interchangeably used the terms nostalgia and homesickness, however the terms are in fact conceptually different. In the early twentieth century Nostalgia was defined simply as *homesickness* (Oxford, 1924), etymologically homesickness is traced to the Greek *nostos* meaning to return home, and *algos* meaning pain. However, "nostalgia" began to take on an additional broader meaning during the nineteenth century, and in contemporary times nostalgia is defined as a "*wistful or excessively sentimental yearning for something past or irrecoverable*" (Longman, 1991, p.1092). Homesickness, on the other hand, is presently defined as *"longing for home or family while absent from them"* (Longman, 1991, p. 756)

Nostalgia and homesickness also differ in their cognitive peculiarities - the nostalgic individual pines for a time that is in the past, where as the homesick person longs for a reunion that is at least potentially possible. Contrasts between the two states emerge in relation to mood: where nostalgia on the one hand, may be a bittersweet experience of both joy and sadness (Werman, 1977); homesickness, on the other hand, is associated mostly with negative mood (Van Tilberg, 1997). Experts have long been critical of those who equate homesickness and nostalgia. Werman (1977) proposed that by considering the two concepts as homologous researchers were reducing these phenomena to a single underlying configuration and thereby excluding much of their richness and variability.

Depression

Homesickness has been conceptualized as a type of 'reactive depression' (Fisher, 1989; Van Tilberg, 1997; Baier and Welch, 1992) secondary to leaving the home environment. Both homesickness and depression may be expressed in wide spectrum of affective, physiologic, cognitive, and behavioral manifestations. Many symptoms of depression such as depressed mood, loss of interest in activities, change of appetite, altered sleep patterns, fatigue, somatic complaints, feelings of worthlessness or guilt, and decreased ability to concentrate, have also been observed in homesick individuals (Fisher, 1989; Van Tilburg et al., 1996; Burt, Strongman, and Costanzo, 1998; Winland-Brown & Maheady, 1990).

However, if homesickness is simply a manifestation of depression, then one would expect to see comparable symptoms before, during and after separation. In examining the differences between homesickness and depression attention is drawn to the cognitive symptomatology. The homesick individual specifically experiences obsessional thoughts about home, negative thoughts about the new environment and especially misses home (Van Tiburg et al., 1996). In short, homesickness can be differentiated from depression firstly by the separation from the home environment, and secondly by the individuals ruminative cognitions about home.

Adjustment Disorder

An adjustment disorder refers to the development of emotional or behavioral symptoms following a major life stressor (Davison and Neale, 1997), and as such, homesickness may be considered to be an adjustment disorder. However, the DSM-IV (American Psychiatric Association, 1994) states that the reaction must be in excess of a normal and expectable reaction to the stressor, and that school or work performances and social relationships must be impaired. If the homesickness is not severe enough to retard performance and relationships, then, according to the DSM-IV, homesickness should be viewed as a normal reaction to leaving home (Van Tilburg, 1997).

In addition to this, it is interesting to note that homesickness may be considered either an acute or chronic adjustment disorder. If the homesick feelings remit within six months, the disorder may be considered to be acute, alternatively if the symptoms continue for over six months the homesickness may be considered to be chronic (Van Tilburg et al, 1996).

Agoraphobia

Van Tilburg (1997) suggests that while homesickness shares some common ground with agoraphobia, the syndromes are in fact conceptually distinct. A fundamental difference between homesickness and agoraphobia is that depressive symptoms usually accompany homesickness, where as phobias in general are characterised by increased anxiety and panic (Vingerhoets, 1997). Agoraphobia, classified in the the DSM-IV (American Psychiatric Association, 1994) as an anxiety disorder, is characterised by a fear of leaving familiar surroundings, and is often accompanied by panic attacks (Davison and Neale, 1997).

Avoidance behaviors such as fear of being away from or leaving home have been observed in both agoraphobic and homesick (Fisher, 1989; Van Tilburg et al., 1996) individuals. Like homesickness, agoraphobia is often exacerbated by travelling, or by being away from home. However, where individuals suffering from agoraphobia may fear debilitating panic attacks, homesick individuals fear the actual homesickness itself (Van Tilburg et al., 1996).

1.4 THE CHARACTERISTICS OF HOMESICKNESS

Incidence and Prevalence

Homesickness is considered to be a relatively common, short-lived experience that affects both genders. Nevertheless, providing estimations of the incidence of homesickness is rather problematical. Prevalence rates are limited to specific contexts such as schools or hospitals, and the phenomena is subject to reporting bias such as social desirability and labelling problems.

Homesickness experiences are generally episodic, and only in severe cases are the feelings are continuous (Van Tilburg, et al, 1996). Periods of homesickness are most often reported in the early morning and late evening, and homesick feelings have been found to occur more frequently when performing mental tasks rather than partaking in physical activities (Fisher, 1989). There is also evidence that suggests only intense homesickness experiences are reported spontaneously. In a study by Fisher, Frazer and Murray (1984) the spontaneously reported incidence of homesickness was found to be only 18%, on deeper exploration 60%-70% of the students reported experiencing homesickness to some degree.

Self reported homesickness rates during a stay away from home vary from 39% (Brewin, Furnham, and Howes, 1989) to between 50% and 96% (Fisher, 1989; Thurber, 1995). Furthermore, 10-15% of the homesick have experienced the phenomenon to such an extent that it interferes with their daily living (Fisher, 1989), and about 7% of individuals experience high levels of homesickness associated with severe depressive and anxious symptoms (Thurber, 1995).

The dynamic nature of the phenomenon was first attended to by Woulff (1975) who found that although a greater proportion of females (28%) than males (19%) reported high homesickness three weeks into the first semester, the rate of decline was more rapid for females. On follow-up after eleven weeks of the semester, the proportion of students experiencing homesickness was 15% for females and 17% for males.

Homesickness has been documented in individuals at boarding schools (Fisher, 1989), in hospitals (Mitchell, 1967), away at camps (Thurber, 1995), attending universities (Burt, 1993), in prisons (Ireland and Archer, 2000), entering the armed forces (Tausk, 1917), as well as in refugee populations (Eisenbruch, 1990), immigrants and employees of multinational companies (Eurelings-Bontekoke, Brouwers, and Verschuur, 2000).

Ethnic and Cultural Ubiquity

In the seventeenth and eighteenth centuries homesickness was considered to be a disease of certain ethnic groups, predominantly the Swiss. These considerations may be tempered, however, when taking into account that much of the early work on homesickness was completed by Swiss investigators (Van Tilburg et al., 1996). In recent times there has been limited systematic research that focuses on cultural differences. Stroebe et al. (2002) conducted two studies, one in the Netherlands and one in the United Kingdom (UK). The research provided the first cross-cultural examination of homesickness in both male and female students in their own countries. Homesickness was found to be a common though differentially prevalent phenomenon among recent intake students. Approximately 80% of UK students were found to be suffering from homesickness compared to 50% in the Netherlands. Stroebe et al. (2002) speculated that homesickness in the Netherlands sample was mitigated by going home at weekends, which students in the Netherlands, in contrast their counterparts in the UK, were found to frequently do.

Eurelings-Bontekoke et al. (2000) examined homesickness among foreign employees of a multinational company in the Netherlands. Those coming from a culture and environment that differs considerably from the culture they actually have to work in were found to be far more at risk for developing homesickness than those coming from rather similar cultures.

A local study by Ward and Kennedy (1993) examined homesickness among New Zealand American Field Service (AFS) students who were residing in 23 different cultures. The research revealed that psychological well-being was predicted by life changes, locus of control, homesickness and socio-cultural adaptation. As hypothesized, AFS students experienced greater socio-cultural adjustment difficulties than did a comparable home based sample. Ward and Kennedy (1993) continue with an in-depth examination of the magnitude of the relationship between psychological and socio-cultural adaptation, and although engaging, their research has more pertinence to culture shock than homesickness per se.

Studies such as those by Hojat and Herman (1985) and Caden and Feicht (1991) have found contrasting results. An exploration of the prevalence of homesickness amongst Iranian and Fillipino physicians working in the United States of America found no differences in levels of homesickness (Hojat and Herman, 1985). Where as Caden and Feicht (1991), who investigated homesickness among female Turkish and American students in their own countries, found homesickness to be more prevalent among the Turkish students than among American students. There are of course a number of factors influencing the different results, from the operationalization and measurement of homesickness to sample selection. The studies nonetheless contribute to the body of knowledge surrounding homesickness.

Lu (1990) published an interesting paper that examined the adaptation of Chinese students who had relocated to the UK. The cultural differences between the long-isolated China and the West were attended to, and the Chinese students were anticipated to have various problems associated with cultural adjustment. Results revealed that homesickness is a common psychological reaction amongst the Asian students who were studying in Britain, indeed every subject in the sample reported homesickness. Of note, no differences were found between the more homesick and less homesick groups in terms of personality or perceived demands, thus homesickness was concluded to be a widespread problem for Chinese students studying abroad. Another interesting finding was that relocation causes a prolonged homesickness syndrome, but does not affect mental health, homesickness was found to be distinct from mental ill-health.

Given that the present study is based in New Zealand, it would be remiss not to attend to the unique cultural milieu of the country. According to the population estimates released by Statistics New Zealand in December 2003 the population reached the four million milestone last year. The principal ethnic element of New Zealand's population (about 82 percent) is of European origin (mostly British); Maori (the indigenous Polynesian inhabitants) constitute about 9 percent, while Pacific Islanders, and Asians constitute the remainder. The estimated population growth in 2003 remained high and, fifty-five percent of the growth in the December 2003 year was due to a net migration gain, including permanent and long-term arrivals (Pink, 2003).

In light of the finding that over half of New Zealand's population growth was secondary to immigration - that is over 34,000 individuals leaving their home environment in order to relocate to New Zealand within one year alone, it becomes apparent that it is critically important for New Zealand investigators to undertake research into the homesickness phenomenon. Transition to a foreign country, compounded by cultural relocation and being away from the familiarity of the home environment and support systems is going to be stressful. Recognising and understanding the migrants' emotional suffering and various adaptational problems are no doubt the first steps to facilitate helping efforts and to alleviate homesickness.

In addition to New Zealand's migrant population, there is also a transient student and tourist population. For instance, since the early 1980s, the number of Asian students attending western universities and schools has increased dramatically (Lu, 1990). It is currently popular for young Asians to study in cities such as Christchurch, and institutions and schools that actively court Asian students should attend to Lu's (1990) findings and make provision for homesick students.

As the tängata whenua, the indigenous population, Mäori people occupy a unique place in New Zealand society. Homesickness has been recognised to exist within the Mäori population. Early accounts emerged in the late 1950s, when a large group of young Mäori men from the East Coast of the North Island moved to Christchurch to do trade courses. It has been reported that the young Mäori males experienced culture shock, racism and homesickness. In an attempt to alleviate homesickness and to improve their feelings of self worth, 'Te Kotahitanga' was set up to provide education about cultural roots would be. Established in 1961, 'Te Kotahitanga', or 'Unity', was reported to be a successful intervention that assisted rural Mäori to make the adjustment from tribal lands to the "Pakeha cities" (http://www.embassy.org.nz/poverty/skotahi.htm).

More recently, an account forwarded by The Venerable Turi Hollis, University Chaplain at the University of Canterbury, highlighted homesickness as one of the problems experienced by Mäori undertaking tertiary study. Hollis (1999) reported that in order to attend university a high proportion of Mäori students have to leave whanau, hapu and Iwi, with whom there is usually a strong sense of identity and powerful emotional bonds. Homesickness researchers have found that greater reliance on others, and strong emotional ties to parents and family have been are predictive of homesickness (Carden & Feicht, 1991; Brewin et al., 1989; Eurelings-Bontekoke et al., 1994) thus it may follow that Mäori students with deep emotional bonds to whanau have a particular vulnerability to developing homesickness.

Hollis (1999, 2004) believed that although the environment of a university can be daunting for anyone, it is even more so for Mäori, because for most, there are strong doubts that they should be there in the first place. Low self-esteem and confidence are considered to be a significant factor in Mäori students leaving universities in their first year. Low self confidence characterized by lack of self esteem and sub-assertiveness have been identified as antecedents to homesickness (Eurelings-Bontekoke et al., 1994).

Hollis (1999) also attended to the problem that Mäori students arrive at the gate of the university with extra "luggage" which the non-Mäori students do not have to bear. Hollis (1999) maintains that "*the Mäori student has to carry the expectations of whanau, hapu and iwi... and university education is seen as elitist and expensive*" (http://www.nzine.co.nz/features/maori_education_2.html). Furthermore, Hollis (1999, 2004) believes that Mäori students are increasingly being torn between their own aspirations and ambitions, and the expectations, obligations and interests of their whanau, hapu and Iwi. Increasing numbers of Mäori are understood to be pursuing their own self-interest, and it is proposed that although Mäori feel the 'pull' of their whanau, hapu and Iwi they are torn, because the Western education system has ingrained an individualistic philosophy in them which pulls them in the other direction (Hollis, 1999).

The concept of conflict forms the basis of a theoretical model of homesickness put forward by Fisher (1989), who proposes that homesickness creates a protracted experience of distress in some individuals secondary to conflict that is experienced when an individual is torn between approach and avoidance tendencies towards the new environment.

In light of the problems identified by Hollis (1999, 2004) it is not surprising that the phenomenon of homesickness is recognized within Mäori culture. There is even a word for the phenomenon –'manatu', which means *"homesick for the land of my forbears"* (Ngata, 2003). For New Zealand to grow as a nation, and for Mäori to develop as a people it is crucial for barriers to success and achievement, such as homesickness, to be recognized, researched, and overcome.

1.5 ANTECEDENTS OF HOMESICKNESS

Research on the predispositional factors, risk factors and mediators of homesickness has had a fairly narrow focus. Attention has been given to both characteristics of the environment that are associated with greater intensities of homesickness and to personality characteristics that predispose an individual to become homesick. The issue of whether the environment is the important factor, or whether vulnerable personality traits are the trigger continues to be addressed by contemporary researchers. On the one hand, some powerful forms of environmental influence have been identified, on the other, evidence has been found to suggest that individuals who are vulnerable to homesickness differ from their non-homesick counterparts prior to leaving home (Fisher, 1989).

Sex Differences

Against the informally held beliefs of laypersons that females are more likely to feel homesick, much of the research focusing on gender differences have found little distinction between men and women. Fisher (1989) has found few clear direct sex differences in relation to homesickness reporting. By the same token, Brewin et al. (1989) reported that homesickness was equally probable in men and women. Gender differences were found, however, in the subject's reactions to homesickness. In particular, homesick women were much more likely to discuss their feelings, which may have an impact on the lay-perception alluded to above.

Age

On the whole, homesickness is thought of as being more common in children than adults. Although much of the research has focused on homesickness in children at camps and college freshmen (Fisher, 1989; Brewin et al., 1989, Thurber, 1995, Mitchell, 1967) there is significant evidence that adults also suffer from the phenomenon (Van Tiburg, Eurlelings-Bontekokoe, Vingerhoets, and Van Heck, 1999; Ireland and Archer, 2000; Vormbrock, 1993). Unfortunately there is a lack of data that examines the difference of incidence between children and adults. Any age related differences in homesickness reporting that have been found may actually be secondary to lifestyle differences associated with age, such as control over the decision to leave home.

Past Experiences, Home Background and Life History

Fisher (1989) outlines that there is *no* evidence to suggest that birth order, number of siblings, already having a sibling established at a school, parental harmony, parental loss, or negative life events are antecedents to homesickness. However, there is some evidence that suggests that homesick individuals may be 'tied' to there parental home from an early age. Eurelings-Bontekoke, Vingerhoets and Fontijn (1994) reported that homesick subjects were found to have spent fewer childhood vacations without parents or alone, to have disliked school excursions, to have stayed home more frequently, to have evaluated visiting friends as less pleasant than the non-homesick subjects and to have suffered from homesickness from an early age.

It is interesting to note that individuals who report high levels of homesickness have a tendency to view their home environments in a positive light (Fisher and Hood, 1987). Fisher and Hood (1987) believe that positive past experiences may make it more difficult for an individual to leave their home behind. However, findings that are gained from retrospective studies need to be considered with caution, -particularly in the light of affect distortion research that indicates that homesick individuals appear to actually idealize the home environment (Burt, Strongman, and Costanzo, 1998).

Current research (Verschuur, Eurlelings-Bontekokoe, Spinhoven, and Duijsens, 2003) suggests that previous homesickness experiences are the strongest predictor of the severity of homesickness. Other general or homesickness-specific personality factors have been found to have less predictive power. It appears that the more severe the present feelings of homesickness, the greater the chance that the individual experienced homesickness feelings earlier in life.

Verschuur et al., (2003) suggest that as in depression, the sensitivity in developing episodes, as well as the severity of the clinical picture increases as the number of episodes increases. In other words, the more homesickness an individual has experienced in the past, the more severe the present homesickness feelings are likely to be.

Social Relationships

Homesickness usually occurs when an individual has left behind a social support network and has subsequent difficulty adapting to the new environment. Social support is a factor that has been shown to buffer the stressfulness of a variety of problematic situations (Alloway and Bebbington, 1987). It would follow that the availability of social support should be associated with less homesickness, however the evidence is conflicting. Eurelings-Bontekoke et al. (1994) reported that seeking social support is a preferred coping strategy for homesick individuals - although they may lack the social skills to acquire it.

Conversely, several studies have shown that social support might have a negative influence. Homesick students have been found to associate with others who have similar experiences, and it has been suggested that homesickness may actually be intensified through modeling and positive reinforcement (Porritt and Taylor, 1981; Fisher, 1989, Van Tilburg et al., 1986).

Gruijters (1992, cited in Van Tilburg, Vingerhoets, and Van Heck, 1996) undertook an interesting study in which hypothetical situations were presented to participants. The subjects were subsequently asked to indicate the intensity of their (hypothetical) homesickness it they were to find themselves in such a situation. As one may expect the situation 'nearby, short, with trusted persons' was found to indicate the least homesick feelings, where as 'long, far away, and alone' revealed the most homesick feelings. Of note the 'type of companionship' available

emerged as one of the factors most influential over levels of homesickness. Thus the risk of becoming homesick may increase if there are no trusted persons, or worse, no companions at all in the new situation.

In contrast to Gruijters (1992) findings, Burt (1993) failed to find differences in the intensity of homesickness between first year students who relocated alone and those who came with a friend. Further studies are needed before any definite conclusions can be drawn about the availability of social support and the onset of homesickness.

Attachment

Attachment issues are considered to play a role in the development of homesickness. As previously discussed the DSM-IV (American Psychiatric Association, 1994) incorporates homesickness as a youth disorder related to attachment problems. Styles of attachment behavior learnt in infancy, in combination with experiences of separation and loss form the basis of adult emotional relationships (Bowlby, 1977). Theoretically, homesickness should be most common in those who are anxiously attached. It has been suggested that individuals who are concerned about the possibility of their affectional bonds weakening or dissolving, and individuals who perceive themselves as highly reliant on others may be more susceptible to homesickness (Brewin et al., 1989). However, the exact relation between insecure attachment and homesickness remains unclear.

Early work on homesickness emphasized the loss of healthy and intimate family relationships as precursor to the onset of homesickness. Woulff (1986) defined homesickness as a need for psychological intimacy and found that intimacy with parents was the variable most closely related to a predisposition to homesickness. It was recognized that *homesick* college freshmen reported significantly greater levels of verbal disclosure with their parents than *non-homesick* freshmen (Woulff, 1986).

More recent research has highlighted the relationship between homesickness and dependency. A longitudinal by study by Brewin, Furnham, and Howes (1989) found support for the hypothesis that 'dependency on others', anxious attachment, and greater reliance on others, could be considered antecedent of homesickness. Garden and Feicht (1991) reported that dependence on family and parents, in particular, was characteristic of homesick students. Similarly, support has been found for the hypothesis that a strong emotional bond to parents is predictive of homesickness (Eurelings-Bontekoe et al., 1994). Furthermore, Kazantzis and Flett (1998) identified that family cohesion (emotional bonding or dependency between family members) was a significant predictor ($r = -.28$, $p < .01$) of homesickness in first year university students. Thus strong empirical support has been found for the link between homesickness and separation anxiety.

Geographical Factors and Length of Stay

Although geographical distance is thought to influence levels of homesickness reporting, opposing results have been found. Where as Fisher (1985) found homesick *university students* had a significantly higher average distance from home compared to their non-homesick peers, Brewin et al (1989) found geographic variables were unrelated to homesickness. In a study of *boarding school children* no links were found between distance from home and homesickness (Fisher et al., 1986).

Fisher (1989) proposes that geographical distance from home affects the probability of home visits because of financial costs and the time involved. Of note, no difference has been found in relation to actual visits home for homesick and non-homesick students; therefore any effect may be due to perceived isolation rather than the amelioration produced by actual home visits by the non-homesick. The existence of desire, but the lack of attempt to accomplish the desire, may represent important features in homesickness.

Gruijters (1992, cited in Van Tilburg, et al., 1996) observed that although going 'far away' from home as opposed to being 'near by' home was indicated as arousing homesick feelings, the length of stay was actually found to be of more importance than the distance. In other words, the risk of becoming homesick greatly increases if the length of stay away from home increases. A later study (Eurelings-Bontekoe et al., 2000) investigated employees of a multinational

company in the Netherlands and found a significant relationship between homesickness and duration of stay. However, the results differed from Gruijters (1992, cited in Van Tilburg, et al., 1996), in that the association between homesickness and time spent in the novel environment was not linear. Homesickness was found to be most prevalent among the group who had lived in the Netherlands for 6 to 8 years, and somewhat less prevalent for those staying from 0 to 5 years. Prevalence of homesickness was found to be lowest for those who had lived in the Netherlands for considerably longer, from 9 to 18 years.

No evidence has been found to suggest that coming from either rural or urban locations influences homesickness reporting (Fisher et al., 1985). The role that geographical factors play in the onset of homesickness remain unclear, and factors which may be operative for one population, are not necessarily operative for another.

Environmental Demands

It has been recognized that an individual may be more susceptible to homesickness in an environment that places high demands on personal resources. Physicians of the eighteenth and nineteenth centuries devoted many studies to this problem based on observations of soldiers in the armies of the wars of the French Revolution and later of those in Napoleon's Imperial Army (Peacock, 1988). Rosen (1975) alludes to the observations of a military doctor in the seventeenth century, who noted that cases of homesickness increased significantly as soon as

the French armies suffered reverses and were no longer victorious. However, not all individuals develop homesickness even when exposed to the same situational demands. The general theory of stress and its effects on behaviour may be useful in accounting for this specific phenomena associated with homesickness.

Decisional Control, Demands, and Expectation

From among the many theoretical approaches to homesickness, expectancy theory and control theory emerge as two separate but related bodies of knowledge that are of particular interest.

Work on perception of control as a moderating variable in stress suggests that having control over an event often lessens the threatening nature of the experience (Fisher, 1984). Increasingly, definitions of stress have emphasized the importance of the interaction of the individual with the environment. Stress is not 'external' or 'out there' in the world but is in part created 'internally' through an individuals cognitive or thought properties (Fisher, 1989).

An individual's 'perception of the demands' and 'perception of control over the demands' have been shown to have a significant influence over the onset of homesickness. An individual may not become committed to the new environment if their expectancies create incongruence. For instance, poor residential features, difficult psychosocial environments, and lack of money may all contribute to a

feeling of lack of well-being, which may in turn delay or prevent commitment to the new environment.

Freedom of choice has been recognized to influence the onset of homesickness. Fisher (1989) reports that for university students if the decision to leave home was made entirely by the individual, then less homesickness was experienced as compared with persons who were obliged to leave home. Perceived control regarding the decision to relocate has also been found to be a significant predictor for the intensity of homesickness in university students (Burt, 1993). Interestingly, an earlier study by Fisher (1989) found no such effect for boarding school pupils. A possible explanation is that school children do not have the expectation of control over decisions affecting their lives because they are used to parental authority.

The pervasive influence of individual expectations in shaping perception, emotion and behavior is well established. In light of expectancy theory Brewin et al., (1989) predict that prior expectations of homesickness may reflect the actual frequency of homesickness. Perceiving homesickness in advance to be highly probable, may lead to individuals away from home giving any distress they experience the specific label of homesickness. In turn, their thoughts may be directed to sources of support who are no longer available to them.

Van Tilburg et al. (1996) surmise that 'freedom of choice' suggests the situation is within ones control. Where as if an individual is compelled to leave home, feelings of helplessness develop, which may lead to the onset of homesickness. However, even if an individual is 'free to choose' whether or not they remain in the new environment, the homesick person may be locked into conflict due to the opportunities for the future that are made available by remaining in the new environment.

It is important that studies that investigate homesickness in relation to control and expectancy theory are considered with caution. There is the potential for a selection bias to occur. Individuals who anticipate that they will easily develop homesickness may actually be less inclined to move, which may in turn lead to the selection bias in research samples.

Personality and Behavioral Characteristics

Until recently, little was known about the personality and behavioural antecedents of people at a high risk for developing homesickness. Fisher (1989) identified that homesickness is a function of a combination of both peculiarities of the new environment and personality characteristics. There is now substantial literature that examines the role of personal factors like personality and temperament in homesickness.

As previously discussed, high levels of dependency, greater reliance on others, and strong emotional ties to parents have been found to be predictive of homesickness (Carden & Feicht, 1991; Brewin et al., 1989; Eurelings-Bontekoke et al., 1994). It may be possible that when parted from those on whom they usually rely, the anxiously attached individual experiences a more acute sense of loss than would be experienced by individuals who are more securely attached. Brewin et al. (1989) proposed that certain patterns of attachment may actually predispose an individual to feel more keenly the loss of attachment figures. However, if homesickness was simply a reflection of attachment, then there should be few, if any, symptoms prior to an actual or anticipated separation.

Dependency is not the only personality characteristic that has received attention from homesickness researchers. Several pathogenic models support the possibility that homesickness reflects both attachment and a number of personality features, emotional vulnerabilities and cognitive variables. In particular, considerable links between obsession, depression, and introversion on the one hand, and homesickness on the other hand, have been found (Fisher and Hood, 1987; Fisher, 1989; Fisher, Murray, and Frazer, 1989; Beck, Taylor, and Robbins, 2003; Thurber, 1999; Eurelings-Bontekoke et al., 1994).

Fisher and Hood (1988, 1989) investigated the association between homesickness and certain personality characteristics. Students who exhibited signs of insecurity and poor social skills prior to entering university life were found to be more likely to develop homesickness after relocation. Furthermore, data obtained from students two months prior to leaving home for university showed that psychoneurotic symptoms specifically depression, somatic symptoms and obsession were already elevated in those who became homesick. Results lead to speculation of the existence of a possible 'homesickness vulnerability factor' (Fisher and Hood, 1988, 1989).

Although differentiation of homesick and non-homesick prior to transition might provide signs of vulnerability to homesickness, the personality factors that indicate vulnerability are not actually the same factors that interact with the relocation. Fisher and Hood (1987) report that depression, for instance, distinguishes the two groups prior to the relocation but does not interact with the relocation. Post-transition, on the other hand, personality factors can play a part. Levels of anxiety, for example, do not distinguish between the homesick and non-homesick at home, however after relocation the increase in anxiety in the homesick group clearly distinguishes them from the non-homesick group.

A study by Eurelings-Bontekoke et al. (1994) concentrated on identifying personality characteristics and behavioural features that are specific to homesickness but not to depression. Homesick military conscripts were compared with both normal controls and depressed psychiatric patients. A number of personality factors appeared to be characteristic of homesickness in particular. High rigidity was demonstrated to be most predictive of homesickness. In addition, homesick conscripts were found to adhere to old habits, to avoid new situations, and to be strongly attached to a regular life. Other antecedent factors for homesickness that were reported include introversion; a high need for social support combined with a lack of social skills; and low levels of dominance and low self esteem (Eurelings-Bontekoke et al., 1994).

Low self confidence characterized by lack of self esteem and sub-assertiveness have been suggested to underlie the strong tendency for homesick individuals to avoid social contacts (Eurelings-Bontekoke et al., 1997). There is however a paradoxical nature to the relationship between homesickness and social withdrawal. Although the greatly depressed and anxious homesick students have been found to socially withdraw, homesick students with less severe symptoms of depression and anxiety have been reported to have a need for social affiliation (Brewin et al., 1989).

The less severely homesick students desire for affiliation is suggested to be restricted to other people who have similar or relevant experiences, and does not extent to a need to affiliate with people in general. Rather, it appears that fellow students are confided in and valued for the light they can shed on the homesickness experience, and for their ability to reduce anxiety (Brewin et al., 1989).

Attention needs to be drawn, however, to the divergent results surrounding the matter of self-esteem. The finding of low levels of self esteem among homesick individuals Eurelings-Bontekoke et al. (1994) is contradictory to earlier research by Fisher (1989) that found no differences in levels of self esteem between homesick and non-homesick pupils. It has been suggested that such differences may reflect cultural differences between the populations, or possibly research differences in the operationalization of homesickness and self esteem (Van Heck, Vingerhoets, Voolstra, Gruijters, Thijs, and Van Tilburg, 1997).

The finding (Eurelings-Bontekoke et al., 1994) that homesick adults reported to suffer from homesickness from homesickness from an early age onwards led Eurelings-Bontekoke et al. (1996) to examine whether a proneness to develop homesickness was associated with certain personality disorders. Results revealed homesickness is associated with traits of the anankastic/obsessive-compulsive, dependent, and avoidant/anxious personality disorders. The findings were consistent with earlier research that identified the tendency for homesick

individuals to have high levels of rigidity, sub-assertiveness, and introversion and low levels of dominance. That is to say that homesick individuals tend to experience a need for personal control, a need for support from familiar persons, and to experience high levels of social anxiety.

Van Heck et al. (1997) related the five-factor model of personality to homesickness. The five global factors included (I) Extraversion, (II) Agreeableness, (III) Concientiousness, (IV) Emotional Stability, and (V) Openness to Experience. Similar to earlier findings (e.g. Eurelings-Bontekoke et al., 1994), homesick individuals were found to be relatively introverted, emotionally unstable, and closed to new experiences. These characteristics may lead to feelings of distress and difficulties in functioning in, and adapting to a new environment, particularly with unfamiliar persons.

An interesting study by Beck, Taylor and Robins (2003) used Aaron Beck's (1983) dimensions of sociotropy and autonomy to predict homesickness in first year university students. Sociotropic individuals who are considered to have heightened interpersonal needs for dependency, were found to display the classic symptoms of homesickness in that they were more likely to be preoccupied about home and display depressive symptoms after the transition to university. By contrast, autonomous individuals, who focus on goal-related achievement and personal independence were reported to be less attached to home. Although individuals possessing autonomous traits were not immune to the effects of the

relocation, autonomic persons clearly differed to sociotropic individuals in the facet of the homesickness that was manifested. Sociotropy was associated with grief-related symptoms, where as autonomy was associated with themes of restlessness and anger or blame.

Beck et al (2003) suggest that sociotropic homesickness is driven by separation anxiety and attachment grief, where as autonomous homesickness may be due to the strain of attempting to master a new environment. Although Beck et al. (2003) suggest that the constructs of sociotropy and autonomy have predictive validity for emotional disturbance such as homesickness, the study was limited in that it was not longitudinal in design. Assessments of personality style prior to relocation would have gone somewhat further towards future utilization of the dimensions of sociotropy and autonomy to predict homesickness.

Inspired by the suggestions (e.g. Eurelings-Bontekoke et al., 1997; Fisher, Murray and Frazer, 1985) that homesickness involves certain vulnerable personality characteristics Verschuur et al. (2003) investigated the relationship between severe feelings of homesickness and general temperament and character dimensions. Homesickness was found to be characterized by high scores on Harm Avoidance and Reward Dependence, and low scores on Self Directedness (as measured on the Dutch version of the Temperament and Character Inventory).

Research concerning the features that may predispose an individual to homesickness has yielded interesting findings. However, for definitive statements about the nature of associations to be made, further research utilizing a prospective design is needed.

1.6 THE SYMPTOMATOLOGY OF HOMESICKNESS

Homesickness is a complex state that is associated with a range of emotional, behavioural, cognitive, and physical symptoms.

Emotional characteristics

The emotional characteristics of homesickness that have been reported include depressed mood, feelings of insecurity, loss of control, nervousness and loneliness (Van Tilburg, Vingerhoets & Van Heck, 1996), low perceived control (Thurber and Sigman, 1998), continued longing, hopelessness, anger (Porritt and Taylor, 1981), anxiety, obsessional symptoms, depression (Fisher and Hood, 1987), high levels of stress (Burt, 1998) and low self esteem (Eurelings-Bontekoke et al., 1994).

Stroebe et al., (2002) believe that homesickness is associated with, or even a causal factor in distress and depression. Path analysis suggested that that homesickness precedes depression, rather than depression and homesickness occurring simultaneously, for example. Stroebe et al. (2002), postulate that relocation is antecedent to both loss (of family and home) and change (adjustment to the new situation) which themselves are associated with emotional distress such as depression rather than vice versa. Thus homesickness appears to play a mediating role between the stressor (relocation) and the outcome (adaptation).

Behavioural Manifestations

Homesick children have been reported to exhibit more internalising and externalising behavioural problems than their homesick peers (Thurber, 1995). Listlessness, apathy, lack of initiative, little interest in the new environment (Van Tilburg et al., 1996), generalised distress symptoms (Porritt and Taylor, 1981), and difficulty making and keeping friends (Thurber et al., 1999) represent some of the behavioural manifestations of homesickness. Winland-Brown & Maheady (1990) report that frequently talking about home, not wanting to eat, withdrawal, crying, unwilling to participate in activities, attention seeking behaviour and acting out have been observed at school camps. One study (Burt, 1993) has even found that homesick first year university students were three times more likely to drop out of university than their peers who were not homesick.

Cognitive Symptoms

Homesickness is a psychological state that is centered on a preoccupation with the home environment (Van Tilburg et al., 1996). The cognitive symptoms may include negative thoughts about the new environment, absent-mindedness, obsessional thoughts about home (Van Tiburg et al., 1996; Burt, 1993); suicidal ideation (Baier and Welch, 1992); missing home cooking, television or pets (Thurber, 1995); and a strong desire to return home (Fisher, 1989; Furnham, 1997). It has even been observed that one can even miss an entire country or culture (Eisenbruch, 1997; Furnham, 1997).

However, it is important to note that reflective activity is not primarily directed at problems at home, but rather at idealizing the home environment. Fisher (1989) forwards that psychological escape into the pleasure of home life carries penalties because the distress of separation and loss are more likely to be perpetuated in the long term. The short-term gains from 'escapism' are counterbalanced by long-term repercussions such as lack of adaptation and adjustment, and interminable homesickness. The affective distortion associated with homesickness could be considered to be a coping strategy with adverse consequences.

It is interesting to note that the affective distortion of memories applies not only to private events such as home life, but to public events also. Burt, Strongman, and Costanzo (1998) examined memorial distortions following relocation to university. Homesick pupils were found to rate 'unpleasant' public events that had occurred both before and after they had relocated to university as 'less unpleasant' compared to control subjects ratings. Like Fisher (1989), Burt et al. (1998) believe that homesick students may avoid coping with the demands of the university environment by mentally escaping to the home environment.

Two potential explanations for the affective distortion memory problem are put forward. The first explanation provided is that home experiences may be distorted as pleasurable in order to justify the 'escapism'. The second proposal is that the homesick individual may be attempting to overcome negative effect by increasing positive effect. Burt et al. (1998) concede that the second explanation is unlikely given that positive and negative effect are thought to be independent, that is an increase in positive effect does not appear to decrease negative affect. An alternative explanation for consideration is that by distorting the memories of home as pleasurable, the homesick individual may actually be increasing the immediate 'reward' gained from the mental escape to home.

Finally, research suggests that homesickness may exercise a considerable influence on academic performance, at least over the short term. An association between homesickness reporting and an increase in cognitive failures, handing work in late and decrements in work quality have been found (Fisher, Murray & Frazer, 1985; Fisher & Hood, 1987; Burt, 1993). Academic difficulties may be secondary to other symptoms such as obsessional thoughts about home, absentmindedness, sleep difficulties, apathy, and physical complaints.

The theoretical underpinnings of the academic and attentional difficulties associated with homesickness were attended to by Fisher (1989) who proposed two models of attentional demands. The first of these, the 'demand strength model', postulates that the intensity of homesickness will influence attentional ability. The second model the 'competing demands model', suggests that an individual's degree of commitment to the new environment will positively related to attentional ability. Burt (1993) found some support for both models, although the evidence for the later model, that commitment enhances academic functioning, was stronger than the support for the former.

Physical Health

The powerful state labeled 'homesickness' has also been linked to far-reaching negative effects on health status. Early medical interest in the topic centered on homesickness as a factor in health and well-being. The 17th century physician Hofer (1678), for instance, described the case of a youngster who was "lying on his death bed" when homesickness was diagnosed. His condition improved immediately when he was sent home.

Contemporary literature provides evidence of a variety of health factors adversely affected by the phenomenon. Gastric and intestinal complaints, nausea, anorexia, headache, fatigue, sleep disturbances, impaired immune system, sore throat, and a range of vague complaints and minor aches and pains are frequently reported (Van Tiburg et al., 1996; Hamessley, 1987; Winland-Brown and Maheady, 1990). There is even data that has suggested an association between 'leaving home' and the onset of leukaemia (Jacobs and Charles, 1980).

Fisher, Frazer, & Murray (1986) found that there were more days absent from school for non-traumatic illness for the homesick group of boarding pupils as compared with the non-homesick group, and that equally the homesick group had seen a doctor more times. A similar finding (Zimmerman & Bijur, 1995) occurred within the context of a summer camp for children aged 8-12 years. Two of the three measures of homesickness were significantly associated with multiple visits to the infirmary – indicating that multiple visits to the camp infirmary might be a warning signal of lack of adjustment to the camp environment.

1.7 'NORMAL' vs 'PATHOLOGICAL' HOMESICKNESS

A distinction between normal and pathological homesickness is emerging. Bergsma (1963, as cited in Vingerhoets, 1997) considers homesickness to be a normal phenomenon, which can become pathological when it cannot be conquered. Vingerhoets (1997) postulates that homesickness is a 'normal' and 'healthy' reaction to leaving ones safe home environment in much the same way that grief is a 'normal' and healthy reaction to losing a friend, or that depression is a 'normal' and logical reaction to being diagnosed with a terminal illness.

Although discerning, Vingerhoet's (1997) argument that homesickness secondary to relocation is directly comparable to either grief following the death of a companion, or depression following a terminal diagnosis, could be criticized in that the analogies are unduly simplified. The Social Readjustment Rating Scale (SRHS) (Holmes and Rahe, 1967), for example, recognizes the loss of a loved one or partner to be the most highly stressful experience, as evidenced by its stress value of 100. Change of residence, on the other hand, is rated as a significantly less stressful experience than bereavement, reflected by its SRHS rating of 20. In addition, bereavement and relocation differ in 'permanence', the death of one's companion can be conceived of as an irreversible event, where as it is reasonable to consider relocation to be a reversible situation.

Nonetheless, while 'normal' homesickness may not be rated as highly stressful, the distinction between this and 'pathological' homesickness is one that most certainly deserves further attention. Pathological homesickness may be able to be distinguished from 'normal' homesickness in that the individual's reaction to relocation is unduly severe, and that normal functioning is impaired. The emotional, cognitive, behavioral and physical reactions of homesickness may be amplified. For example, the individual who is suffering from pathological homesickness may experience distressing anxiety, depression, persistent thoughts about home, excessive withdrawal, and relentless headaches. Furthermore, it is reasonable to predict that an individual who has experienced 'pathological' homesickness in the past may become anxious and avoidant of future separations from home (Vingerhoets, 1997).

'Normal' homesickness, on the other hand, may present as the individual struggles to adjust to the new environment. The individual experiencing 'normal' homesickness may experience mild, transient, symptoms, whilst continuing to participate and function in the new environment. Vingerhoets (1997) proposes that for 'normal' homesickness to become 'pathological', there will be undue prolongation and no reduction in the symptoms and disturbances. This proposal may, in actuality, more accurately describe a state of 'chronic' homesickness rather than 'pathological' homesickness.

The author of the present thesis hypothesizes that for some individuals a state of 'Chronic Homesickness' may emerge. It is proposed that an individual who has coping mechanisms that are sufficient to ensure adequate day to day functioning and fulfillment of roles and obligations may nonetheless be functioning at a sub-optimal level. Sub-optimal functioning may be due mild but persistent feelings of homesickness that are just below the surface. Coping mechanisms, such as attentional manipulations, may be employed to keep homesickness feelings in check, but the individual is possibly managing the homesickness with a symptomatic approach, without ever achieving comprehensive cognitive assimilation and complete resolution of the phenomenon.

1.8 THERAPEUTIC INTERVENTIONS AND COPING

Care-givers and counselors in universities, schools, camps and other institutions are faced with the problem of how to help homesick individuals. Although a number of papers (e.g. Eurelings-Bontekoke et al., 2000) allude to the need for counseling for homesickness, in actuality there is a paucity of systematic scientific research that examines therapeutic interventions. This is surprising given the frequency and impact of homesickness.

The most striking feature in the meager body of literature is that relief from homesickness is often only gained by returning to the home environment (Van Tilburg et al., 1987). Nonetheless, even though the homesick person may be able to 'cure' the problem by simply returning home the cost may be substantial. Returning to the home environment may result in loss of opportunity for advancement, reduced sense of competence and control, over-dependence, and feelings of guilt or failure. On the other hand, there are potential risks of forcing continued separation including aversion to future separation and attachment problems with care givers (Fisher, 1989; Thurber, 1995).

Care-givers must give significant consideration to the dilemma of whether the homesick individual should remain in the new environment or whether they should return home. The risks of forced separation versus the risks of returning home earlier than planned, need to be weighed up against the obvious benefits of separation (for example, independence, enhanced sense of competence and control, and reduced risk for future homesickness) (Thurber, 1999).

Individuals have different levels of tolerance to change and have developed unique ways of coping with new situations. When away from home, individuals are away from their usual sources of support, and their usual methods of coping are challenged. Ethics insist that caregivers help the homesick to find relief from their symptoms. Generally, the distress produced by most traumatic experiences is responsive to intervention, and irrespective of the cause of distress, its expression is important (Thurber, 1999; Fisher, 1989).

Early research by Chartoff (1975) utilized Ellis's (1973) Rational Emotive Therapy (RET) as a treatment for homesickness. RET is a cognitive restructuring behavior therapy based on the assumption that distress is rooted in the absolutistic demands that an individual places on themselves (Ellis, 1973). RET was found have some use in ameliorating homesickness.

Chartoff (1975) later investigated the efficacy of allowing homesick children to have regular telephone calls with family at home. The children's parents had been instructed to convey understanding throughout the five minute phone call, but to refuse any requests to come home. The regular telephone contact with home was found to be an even more effective intervention than RET. The daily telephone calls could be considered to provide an opportunity for the homesick children to have regular contact with a known support person with whom they could express their feelings.

Porritt and Taylor (1981) investigated homesickness in student nurses and suggested that the need to cling to home attachments may be able to be reduced by supporting the homesick whist they explored their problems. Techniques such thought stopping, 'time-out' for worry, and even fantasized conversations with support figures were suggested to be useful in reducing homesickness.

Taylor (1986) studied homesickness in visually impaired individuals, and found a number of strategies to be useful to combat homesickness and forestall its consequences. The most crucial intervention was reported to be encouragement of verbalization of distress. It was suggested that this may take the form of empathic listening, a willingness to hear with the "third ear", or requesting elaboration upon a comment offered as a flippant aside.

The second strategy was that of labeling, and encouraging clients to recognize the signs of their homesickness. Furthermore, it was recommended that staff provide reassurance to the homesick, it was suggested that knowing that others have experienced, endured, and conquered the effects of separation from home is comforting to the homesick. The fourth intervention was that of ego enhancement, that is, recognition and praise for realistic accomplishment and effort aimed at building self-confidence and projecting towards the future with positive expectations (Taylor, 1986).

Taylor's (1986) fifth suggestion was to help clients to identify and use strategies that are alternatives to termination. For example, staff may facilitate brief periodic visits home, visits from family members, and regular routine contact by telephone and mail. It was also recommended that staff should be encouraged to respond to minor complaints, not in the sense of over reacting to the trivial, but of being sensitive to the possibility that the voicing of, for example, concern with delay in receipt of mail, may signal the presence of much more deep-seated and pervasive anxiety or discouragement. The final strategy that was put forward was that of the need for positive attitudes of staff members. It was proposed that while staff should not overly identify with the anxious, depressed, or homesick client, they should remain sensitive, stay focused on the task at hand, which – given persistence, diligence, and mastery – should alleviate psychological concerns.

Taylor (1986) provides a number of practical strategies that have been found useful in the amelioration of homesickness. Even though Taylor (1986) centered his research on residential institutions for the visually impaired, the research findings and recommended interventions in particular, may prove useful for many settings where homesickness is prevalent, not only other rehabilitation centers, nursing homes and hospitals but also boarding schools, university hostels, and summer camps.

Fisher (1989) believes that the most significant factor contributing to homesickness is a failure to cognitively assimilate the new experience. That is, rather than focusing on the new environment, the individual spends an inordinate amount of time thinking about their home. According to Fisher's (1989) approach to homesickness the therapist should encourage the homesick individual to express and acknowledge their feelings, and to explore the conflict between remaining in the new environment and returning home.

Fisher (1989) also recommends striving to rationalize and normalize the homesickness experience. For example, by utilizing a problem-orientated approach the therapist might allude to the data that at least half to three-quarters of most people who leave home have been found to experience homesickness at some stage.

Encouraging commitment to the new environment is considered an important management principal. By encouraging the homesick to participate in social, leisure and sporting activities the punishing ruminations associated with homesickness may be attenuated by the competing information. Additional benefits of participating in sports and leisure activities may include the increased social interactions which might in turn, not only help to dispel loneliness but also provide confiding relationships (Fisher, 1989).

Hannigan (1997) proposes a number of suggestions to assist the international student who is suffering from homesickness. It is recommended that the student be provided with accurate and up to date information before they depart for the new location. Upon arrival, workshops that offer more detailed information are proposed in order to facilitate a sense of orientation and group identity among the newly arrived students. It is also recommended that each new should individually meet with helping professionals. Additional suggestions, such as increasing the relocated student's self-reliance (e.g. making a list of places to go or things to do, or exchanging phone numbers with other students), ensuring the student is aware of hobbies and interests that can be pursued in the new culture, and exploring opportunities for continued commitment to religious beliefs have been put forward.

Although not empirically tested, many of Hannigan's (1997) suggestions appear practical and consistent with work (e.g. Fisher, 1989) that advocates active participation within group activities. Activities associated with home that are also available in the new environment, may be of transitional value in that they acquire a significance that is symbolic of lost relationships. Providing both individual and group support covers the different needs of students, regardless of their communication preferences and cultural values. Limited resources, however, may restrict the feasibility of individual counseling for each of the relocated students. Although Hannigan (1997) intended the interventions be applied to international students in a foreign culture, similar tools may prove useful when assisting an individual to adapt to a diverse array of novel environments.

Pennebaker, Colder, and Sharp (1990) attended to Fishers (1989) theory that the most significant correlate of failure to adjust to a new environment is an individuals failure to cognitively assimilate the new experience. Pennebaker et al. (1990) studied college freshman, and believed that by addressing fundamental psychological problems, students would recognize and assimilate any problems into their evolving sense of college-student self. Pennebaker et al. (1990) found that new college students' adjustment to college could be facilitated and coping abilities enhanced by a confrontational writing technique.

In his treatise on children's coping with homesickness Thurber (1995, 1999) believed that understanding how individuals cope with homesickness deserved careful attention in that this information would be helpful in guiding future interventions. Thurber and Weisz (1997) proposed that the etiologic theories developed for depression and anxiety, both of which are common in homesick children, could complement interventions for homesickness. Theories concerned with learned helplessness and control beliefs were also considered to be useful when shaping interventions for homesickness.

Thurber (1997) emphasized the finding that children's methods for coping with homesickness appeared to be determined, in part, by the controllability (perceived and objective) of the stressful circumstance. Coping was found to vary by both age and gender. Older children reported less homesickness, and less frequent more effective coping than young children. Boys reported more aggressive methods of coping than girls, girls turned to more social support type coping. Certain coping strategies were found to be more effective than others. For example, relinquishing control by emoting or anxiously ruminating was found to be futile in overcoming homesickness, whereas secondary control coping (i.e., adjusting oneself to fit objective conditions fit oneself) was found to be the most potent method of coping. It is noteworthy that the most frequent and effective manner of secondary coping that was observed was for the homesick individual to participate in distracting physical activity (Thurber, 1999).

In an interesting discussion Thurber (1997) proposed that by enhancing the new environment in ways that make it easy for children to experience control, one may be able to minimize the severity of homesickness without actually diluting its value as a growth experience. Thurber (1997) believes that it should be possible to structure the environment in a manner that significantly reduces the distress associated with homesickness, yet still provides children with meaningful growth experiences. Thurber's (1997) technique appears masterly in that it progresses beyond prevention and symptom relief by addressing the phenomenon of homesickness from an environmental perspective, *in situ*.

Van Tilburg et al. (1997, 1999) examined coping behaviour in homesick adults. Several ways of coping with homesickness were initially identified. The coping strategies included seeking social support, positive thinking, distraction, mental escape, and turning to religion (Van Tilburg et al., 1997). Further investigation (Van Tilburg, 1999) into the role of coping strategies, basic personality traits and homesickness was consistent with earlier research (e.g., Thurber, 1995) and revealed that mental escape is a relatively ineffective coping strategy. Moreover, day dreaming and fantasizing about home, and wishful thinking were found to be associated with homesickness chronicity.

Recovery from homesickness was mainly attributed to actively confronting the problem by seeking social support and making friends. It was argued that new friends promoted adaptation to the new environment, and curtailed feelings of homesickness and the tendency to daydream about home (Van Tilburg et al., 1999).

In their review of the homesickness literature researchers Van Tilburg et al. (1996) emphasized a number of factors that could be utilized to alleviate the intensity of homesickness. Firstly, it was suggested that it is important to create acceptance of the feelings associated with homesickness. The second recommendation was to stimulate exploration, and to create involvement and commitment to the new environment. Active and physical activities like sports and museum visits were proposed in order to occupy the homesick mind. Fourthly, it was advised that homesick individuals and their carers anticipate critical moments where inactivity is unavoidable, such as going to sleep. The importance of learning new social skills and training in assertive behavior was emphasized due to the homesick individual's high need for social support. Finally, the value in scrutinizing the cause of the homesickness experience was proposed, because different causes of homesickness require different interventions.

Although the interventions proposed by Van Tilburg et al. (1996) have not been subjected to rigorous empirical testing, they are, however, consistent with earlier research (e.g. Fisher, 1989), eclectic in their approach (for example both humanistic and behavioral techniques are suggested) and astute in that the uniqueness of the individuals experience is emphasized.

Descriptive studies concerning nursing interventions for homesickness have emerged in the medical literature. Winland-Brown and Maheady (1990) reported a number of interventions utilized by camp nurses. The interventions included giving the camper extra attention, encouraging the camper to cry, giving hugs, providing support, displaying a positive attitude, acknowledging and validating the campers feelings, not letting the camper withdraw, letting the camper lie down for a specified period, being open and straight forward such as saying "yes, you are homesick; it's ok to be homesick", encouraging the camper to socialize with others, and practicing relaxation and visualization with the camper. A number of Winland-Brown and Maheady's (1990) interventions were consistent with those recommended in the psychological literature. For example encouraging the camper to cry, acknowledging and validating the campers feelings, not letting the camper withdraw and being open and straight forward were congruent with Fisher's (1989) recommendations to encourage the homesick to express and acknowledge their feelings, to participate in social interactions, and to rationalize and normalize the experience.

However, allowing the camper to lie down (Winland-Brown and Maheady's, 1990) is incongruent with Fisher's (1989) recommendation that the homesick individual should be kept busy in order for the competing information to attenuate the ruminations that drive homesickness. Perhaps the nursing approach of "allowing the camper to lie down" is based on the universal nursing practice of implementing 'bed-rest' in the 'unwell'.

Fisher's (1989) concept of attentional manipulations provides a strong argument against encouraging the homesick to "lie down". A critic may, however, consider Fisher's (1989) notion of 'attentional manipulation' to be a 'distraction' that is merely a symptomatic treatment of the homesickness phenomenon. Moreover, there may actually be benefits in giving permission to lie down. This 'time out' may provide time for the homesick to reflect about being away from home and to assimilate the homesick experience – perhaps even actually ameliorating the homesickness.

Nonetheless, research (Thurber, 1996; Van Tilburg et al., 1997; Van Tilburg et al., 1999) suggests that even though some homesick individuals are able to give detailed explanations about why they are homesick and what they think they should do to overcome it – they are, however, somehow paralyzed from acting. Instead of engaging in coping strategies, the homesick person withdraws, ruminates, and emotes.

In addition to the interventions suggested in the scientific literature, a number of 'self-help' websites have emerged on the internet. In light of the research (e.g., Fisher, 1984) that suggests that there may be a personal bias against reporting the experience of homesickness, the 'virtual' self-help counseling pages may indeed provide a useful service for those reluctant to seek professional help.

The American Psychological Association's (APA) on-line help center dedicates a web-page to helping children cope with "summer camp blues" (www://helping.apa.org/family/camp.html). Homesickness experts Christopher Thurber and John Weisz appear to have been consulted, and the web-page offers useful suggestions, presented in reader friendly text, substantiated by scientific research (e.g., Thurber and Weisz, 1997).

The APA website proposes that parents can play a major role in helping their children overcome homesickness. Talking with children about the ways they can cope with homesickness before camp actually begins is suggested as the first step to beating homesickness. It is advised that children practice shorter separations before they go to camp to identify and develop useful coping methods. Parents are urged to help their children understand which aspects of the separation they can control (e.g., letter writing and participation in activities) and which aspects they cannot control (e.g., the routines of the new environment, and the duration of the stay).

The APA website advice is in accordance with Thurber and Weisz's (1997) finding that the least homesick children are those who change what they can about the situation and adjust to what they cannot. Furthermore, the suggestions that parents aim to normalize the experience of homesickness, encourage their children to participate in physical activity and to make new friends to distract themselves from feelings of homesickness are consistent with Fisher's (1997) work.

There are a variety of additional self-help websites for homesickness, many of which are affiliated with university counseling centers (e.g., the University of Liverpool website - www.liv.ac.uk/counserv/homesickness.htm). Nonetheless, web-pages on homesickness must be considered with caution, as the information may lack validity, and few of the strategies that are proposed have been examined empirically.

1.9 HOMESICKNESS DURING ADOLESCENCE

Adolescence is a particularly significant stage of life for examining homesickness. The adolescent years are synonymous with extensive physical, psychological, emotional and personality changes, and relocation to a new environment during this developmental period creates an additional set of demands for the adolescent. Yet research on homesickness in the adolescent period remains sparse.

Developmental features of early adolescence must surely impact on relocation at this age, a good example being relocation to boarding school. During adolescence, a complex set of developmental changes appears to increase one's sense of isolation and need for affiliation, to introduce a sense of ambiguity regarding future directions, and to disrupt the sense of personal identity. These processes are primarily related to separation from parents, separation from the preadolescent identity, the concomitant struggle for autonomy, individuation, and belonging (Brennan, 1982; Erikson, 1982). For some, relocation to boarding school may facilitate the adolescent's search for a unique identity, for others, a more familiar environment may be necessary before the search is initiated. The adolescent's ability to cognitively assimilate the transition to boarding school may be critical in determining his or her adaptation, psychological well-being, and academic success.

It is interesting to note that behavioral expressions of homesickness such as withdrawal or lack of engagement in the new environment (Van Tilburg et al., 1996), are actually considered normative developmental changes among 12 to 14 year olds (McDermott, 1996). It has been suggested that the stresses of relocation may actually intensify both the expression of these behaviors and feelings of isolation and self consciousness (Vernberg and Randall, 1997).

The socio-cognitive advances of early adolescence must also be considered. Lapsley, Milstead, Quintana, Flannery and & Buss (1986) report that increased capacity for social comparison and social perspective-taking may lead unpleasant social experiences to seem particularly grim when experienced during the early adolescent stage. In addition, it is understood that close friendships often increase in intimacy in early adolescence. Thus the sense of loss for missed friends may de exceptionally acute for the individual who relocates during adolescence (Vernberg & Randall, 1997).

Relocation in early adolescence is a major life transition during a particularly sensitive developmental period, yet consignment to boarding school remains most common during this developmental stage. Thus strong justification is gained not only for studying homesickness in adolescence, but also for investigating the potential of a therapeutic intervention.

1.10 THEORETICAL MODELS OF HOMESICKNESS

Several separate but related theoretic approaches appear to be potentially useful in accounting for the specific phenomena related to homesickness. Current formulations of homesickness draw from the theoretical fields of attachment, grief and loss, expectancy, interruption, control, social affiliation, role change, and conflict (Brewin, et al., 1989; Fisher, 1989; Thurber, 1999; Stroebe et al., 2002). The analysis of Fisher (1989) remains the most comprehensive exploration of the theoretical underpinnings of the homesickness phenomena. Fisher (1989) identifies five main theoretical models that provide a basis for understanding the distress that may be experienced on relocation. Fisher's (1989) models will provide the framework for this section.

Attachment, Grief and Loss

The theoretical format of attachment and loss could be considered to provide the most useful model for understanding the effects of relocation. Homesickness has been likened to separation anxiety (Van Tilburg, 1997), the term given to distress and searching behavior displayed by infants separated from their mother. It is believed that styles of attachment behavior and expectation of attachment figures learnt in infancy, combined with experiences of separation and loss, form the basis of adult emotional relationships. The significance of attachment in the development of homesickness is emphasized in the literature (Bowlby, 1973; Porritt & Taylor, 1981; Fisher, 1989; Brewin et al., 1989; Van Tilburg, 1996).

Support has been found for the hypothesis that anxious attachment and greater reliance on others would predict homesickness (Brewin et al., 1989). It is believed that individuals who are anxiously attached, or highly reliant on others, more keenly feel the absence of those on whom they rely. Furthermore, those who score highly on measures of sociotropy or dependency are thought to be more inclined to attribute any transient distress to significant others in their life, and it may follow, that the initial disconcertion or discomfort associated with relocation may be labeled as 'homesickness' (Brewin et al., 1989).

On relocation, an individual is separated not only from family, friends and acquaintances, but also from pets, possessions, and places of emotional significance. The pervasive separation and permeating sense of loss may predispose the individual to a grief type reaction. Bowlby (1980) identified four phases of loss. The first was a phase of numbing, the second is a 'yearning' or searching phase, followed by a phase of disorganization and despair, and finally, a phase of attempted reorganization. The relocated individual may react with anxiety, distress, anger and searching behavior, and perhaps even experience apathy and helplessness at a later stage before finally becoming accustomed to the new environment (Fisher, 1989; Fisher, 1996; Van Tilburg et al., 1996).

Throughout this thesis the theoretical formulations of grief and loss have frequently emerged as a useful perspective from which the phenomenon of homesickness can be examined. Although an argument has been formulated against drawing a direct comparison between homesickness and grief *per se*, there is, nonetheless, a strong case for the conceptualization of homesickness as a form of *reversible* bereavement. Change of location is reversible, home usually still exists, and the individual may be able to contact, visit or even return to the home environment (Fisher, 1989; Fisher, 1996; Van Tilburg et al., 1996; Van Tilberg, 1997).

Insofar as homesickness is understood as the emotional reaction to temporary and reversible loss, then it would be reasonable to expect some, perhaps less extreme, parallels with reactions to grief. Stoebe at al. (2002) put forward a cogent argument for applying a recent bereavement-specific model, the Dual Process Model of Coping with Bereavement (DPM, Stroebe & Schut, 1999), to homesickness. The DPM is germane in that it provides a framework for integrating the central propositions of both cognitive stress (Lazarus and Folkman, 1984) and attachment Bowlby (1980).

The DPM recognizes two tasks that are necessary for successful adaptation following a death, namely, *loss orientation* (which involves contemplation of, and coping with the loss experience alone), and *restoration orientation* (which refers to efforts to adjust to the altered and challenging situation). The DPM identifies the necessity of 'oscillation' between the two tasks, thus recognizing the need both to come to terms with the loss, and to adapt to the changed environment. In the case of homesickness, loss-orientation would include missing absent family, friends, and pets. Those whose attachment is less secure may experience greater homesickness. Restoration-orientation following relocation, on the other hand, would include developing a new identity and new roles in the new environment (e.g. becoming a 'high school' or 'university' student, adjusting to hostel life, and becoming a member of new social or academic groups) (Stoebe at al., 2002).

The DPM predicts that individuals experiencing relocation (stressor) who lack the resources (e.g. support from home) may be unable to cope with the demands of the new environment, and would be at risk of developing homesickness. Thus the DPM provides a basis for introducing two different factors (missing absent support persons and adjustment difficulties in the new environment) into a structural equation model for the theoretical and empirical examination of homesickness (Stoebe at al., 2002).

Interruption

One basis for an explanation of homesickness is the assumption that relocation creates interruption of lifestyle. The interruption and discontinuity model adheres to Mandler's (1975) principle that interruption of routines and daily life may lead to feelings of anxiety, distress, and fear. When away from home, these negative emotions may be categorized as homesickness. Fisher and Hood (1987) believe that laboratory research that examines the effects of interpretation on memory and task performance has offered a basis for understanding the changes in cognitive activity and mood that are manifest in the homesickness response. It is understood that interruption of ongoing laboratory tasks causes the disruption of planned activity and persistence towards completion of the interrupted sequence, in turn tension is created and release manifest in elevated levels of arousal or anxiety (Mandler, 1975, Mandler and Watson, 1966).

Fisher (1989) proposes that after relocation, plans from the old home environment which previously dominated behavior may continue to dominate, and to drive inappropriate thoughts or activities in the new environment. Habits, routines, and coping mechanisms from home may be inappropriate or futile in the new location, one is unable to fall back on them, and may be unable to cope after relocation (Fisher, 1989; Van Tilburg et al., 1996).

The ruminative activity that is characteristic of homesickness may be produced by the capacity of earlier plans to dominate attention, and may create an inefficient state of mental functioning in the new environment, perhaps manifest in poor concentration or decrements of academic work quality. Furthermore, the perseverance of plans and memories from the home environment could also play a part in maintaining the sense of separation and loss that is associated with homesickness (Fisher, 1989).

Control

Fisher (1989) believes that control theory makes different predictions than theories based on separation and loss, and interruption. The control model focuses on reduced personal control or mastery over the environment, and an explanation of homesickness can be provided on the assumption that relocation modifies the level of control that is accessible to the individual. Following a move, new aspects of life need to be learned and new skills must be acquired. Fisher (1989) attends to the notion that when control is achievable because of instrumentality or skill, subsequent events become less threatening. Control is thought to gradually return, as new skills, behaviors and knowledge are required. From this perspective, homesickness is not a reaction to the new environment *per se*, but a reaction to a lack of control over it (Burt, 1993).

Results from several studies offer support for the control hypothesis. A study by Peacock (1988) that investigated Australian boarding school students found that students who reported never feeling homesick since relocating were more likely to feel in balance regarding the control they felt they had over school life relative to the control they would prefer. Where as the majority of students who reported frequent feelings of homesickness felt a "control" incongruence, that is, the students felt they had less control over school life than they would have preferred. Similar findings were reported in relation to perceived demand, every student who acknowledged being frequently homesick reported that the demand made by the school exceeded the demand that would have been preferred. Congruent with Peacock's (1988) findings, Fisher (1989) found that homesick first year university students differed from their non-homesick peers in terms of both the perceived demands of university life and lower control over these requirements and threats. Lu (1990) examined Chinese students who had moved to the England to study, and found that perceived high social demands was a significant predictor of homesickness. Further support for the control hypothesis was provided by the results of a study by Thurber and Weisz (1997). Low perceived control was found to be associated with more severe homesickness and lower overall ratings of satisfaction in the new environment Thurber and Weisz (1997). Given the empirical support that has been found for the control hypothesis, it is reasonable to concede that homesickness can be conceived of as function of reduced personal control or mastery over the environment.

Role Change

The focus of the fourth model is role change. Fisher (1989) reasons that relocation to a new environment results in a change in perceived role; one's previous commitments may end, and a new set is initiated. As a consequence of assuming on a new role, self-concept or self-image needs to be changed, a period of adjustment is required which may lead to a rise in anxiety. A similar view is taken by Stroebe et al. (2002), who, as previously discussed, proposed the Dual Process Model of Coping with Bereavement (DPM). Although intended to be applied to grief, the DPM recognized that two tasks that are necessary for successful adaptation, namely, *loss orientation* (which involves coping with the loss experience), and *restoration orientation* (which refers to efforts to adjust to the altered and challenging situation – such as assuming a new role or identity).

Following relocation there may be a period of strain in reaction to adjustment to new roles. An individual's role is reinforced by others, who respect and interact meaningfully with it, and in a new environment, a role may become threatened if this reciprocity is not maintained. For instance, the lofty role offered by popularity among peers could possibly be partially or entirely lost following a move. The individual once known to associates as the dependable 'best friend' may not be able to acquire sufficient levels of intimacy and companionship in friendships following relocation to return to comfortable levels of intimacy and support.

It is likely that some individuals will experience significant changes in their friendship experiences after moving. The role confusion resulting from this discrepancy may be expressed as homesickness for a known and relatively static niche within a peer network (Fisher, 1989; Vernberg and Randall, 1997).

The confusion can be compounded because relocation offers the opportunity to assume new roles (such as, 'drinking buddy' to new friends or independent university student), whilst at the same time, contact with home may be maintained. reinforcing an individual's former role (e.g., dependable 'best friend' or reliant child). Consequently, conflict between the previous and the new roles may propose threats to 'self hood'. It would be reasonable to predict that throughout this time a relocated individual may experience distress due to the conflict that is experienced, the distress may be apparent in symptoms of homesickness such as raised anxiety and self-preoccupation (Fisher, 1989).

Conflict

The possibility that homesickness creates a protracted experience of distress in some individuals due to conflict between approach and avoidance tendencies towards the new environment (Fischer, 1989) forms the basis of the final model. In order to obtain new experiences or vocational improvement, an individual may need to give up the security and comfort of home. This means the individual may become locked into a situation (of their own creation) in which the severance of contact with home although reversible, is in effect perceived as irreversible

because of the costs attached to reversing it. On relocation there is a period of low control and uncertainty at a time of high demand. It is hypothesized that individuals who are experiencing conflict may be mentally preoccupied with the conflicting decisions, manifested in cognitive symptoms such as poor concentration and raised absentmindedness. The conflict may create anxiety, and if periods of anxiety are prolonged, homesickness may occur (Fisher, 1989; Van Tilburg et al., 1996).

Fisher (1989) forwards a persuasive argument that distress on relocation can be assumed to originate, at least in part, from conflict in which the security of home is compared to the opportunities provided in the new environment. Although the conflict that is experienced on relocation may primarily comprise approach-avoidance tendencies towards the new environment in particular, the model could be expanded to encompass further conflict, such as that arising from inconsistencies surrounding role change and 'sense of self', futurity, and friendship development.

A relocated individual may not only experience conflict between new and old roles, such as 'independent university student' versus 'reliant child', but also in regards to futurity. Platt and Taylor (1967) presented a theory of homesickness that identified that homesick young adults had a tendency towards a lack of futurity. That is, the homesick had been observed to have a considerable discrepancy between conceptions of present and future goals. Such individuals

were found to project an 'ideal self' into the future, an ideal that was beyond attainment by any realistic means, and that differed greatly from the individual's current self image. Thus there is the potential for conflict between the individual's perception of 'current self' and desired 'ideal self'.

A study by Fisher et al. (1985) found that homesick students reported lower levels of satisfaction in the new environment – partly because they anticipated having better relationships in the future than in the present. Accordingly some support, albeit circuitous, has been found for Platt and Taylor's (1967) futurity theory.

Following relocation, an approach-avoidance conflict may also emerge with regard to friendship development, particularly for adolescents. Vernberg and Randall (1997) draw attention to the natural propensity of adolescents to form intimate and companionate relationships with peers, and the expectation of those who move to immediately pursue new friendships. However, recently relocated individuals may be incapacitated to do so because of real and perceived social obstacles. Such an approach-avoidance conflict may precipitate homesickness. Obstacles to friendship development may include language difficulties or peer rejection experiences such as bullying.

Social anxiety may also create an approach-avoidant conflict that impacts on friendship development following relocation. Urani, Miller, Johnson and Petzel (2003) found a significant positive relationship between social anxiety and homesickness in first year university students at the beginning of the semester. Interestingly, the tendency for the socially anxious to withdraw (Miller et al., 2003) has been found to have paradoxical functions following relocation. Data (Vernberg, Abwender, Ewell, and Beery, 1992) indicates that on the one hand, social anxiety and withdrawal may actually provide a protective function for the recently relocated adolescent by restricting exposure to the peer rejection that may be experienced after moving to a new community. On the other hand, social anxiety and withdrawal reduce the probability of establishing the very type of intimate friendships which may be emotionally and developmentally valuable to the adolescent (Vernberg et al., 1992).

It is a reality that the recently relocated individual may find themselves in a dilemma due to real and perceived threats to establishing friendships in a new community. Is it better to put one's self at risk and to approach a new group of peers, or is it better to avoid social contacts in order to avoid rejection? (Vernberg and Randall, 1996).

Thus there is the potential for an individual to experience an array of dilemmas and ensuing conflict following relocation, and the 'conflict model' should be expanded beyond Fisher's (1989) original focus of conflict surrounding the decision of whether to remain in the new environment for the opportunities or to return home for the comfort. It is possible that, following a move, an individual may be homesick for the home environment not only for the comfort and security, but also for the stability of social role, constancy of 'sense of self', and permanence of social contacts, and for the reason that such difficult approach-avoidance dilemmas did not have to be faced.

1.11 MULTI-CAUSAL MODELS OF HOMESICKNESS

It has been established that homesickness is a complex state with multifarious psychological processes. The common denominators may indeed be separation and loss, interruption, reduced control, role change, and conflict, but it is clear that a multi-causal model is needed.

Fisher and Hood's (1987) 'Job Strain' Model of Homesickness

Fisher and Hood (1987) 'Job Strain' model (see Figure 1.) attends to the belief that following relocation an individual experiences a computational process which involves weighing up the benefits and threats created by the new environment against the benefits and securities of home. Disparity between what is desired and what is obtained in reality is thought to create the preconditions for homesickness. The individual is considered to be able to adapt to the stress of separation from home if the new environment has positive elements and is not objectionable or overly demanding. It is hypothesized that the experience of homesickness can be created or exacerbated by features of the new environment, and the individual is predicted to increasingly miss home when it is discovered how hard life away from home can be.

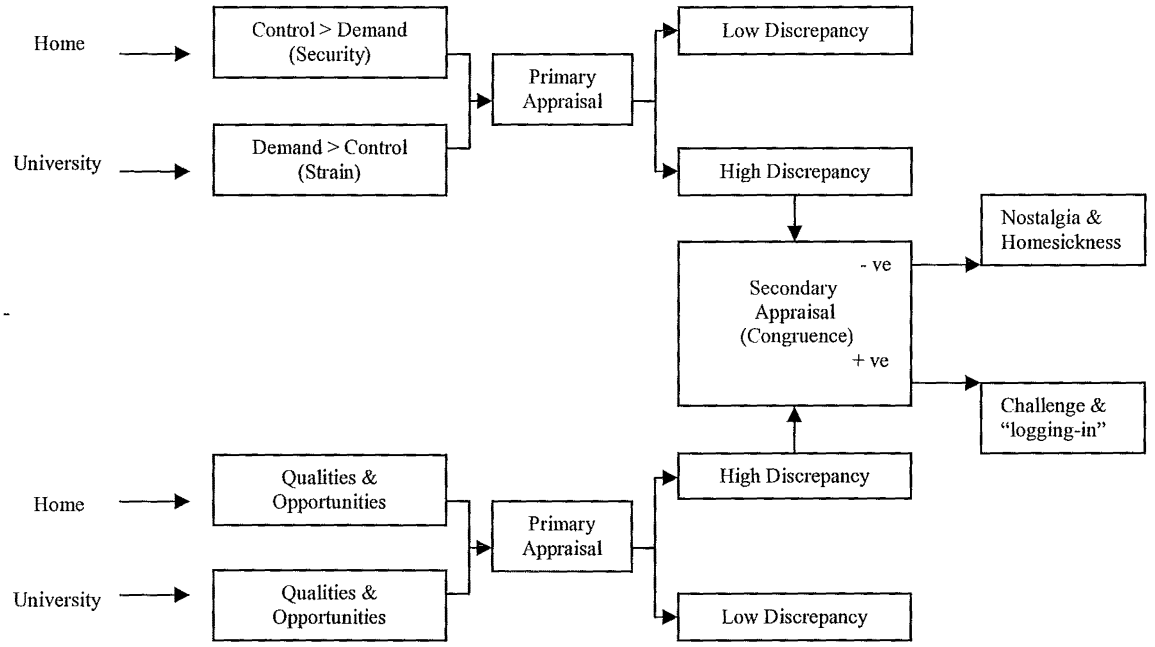

Figure 1. Computational 'job strain' model of homesickness (Fisher and Hood, 1987).

Fisher and Hood's (1987) model predicts that following relocation there is a period of cognitive appraisal of new conditions relative to the situation at home. The model suggests that an individual will 'weigh-up' firstly the qualities of home as compared to the new environment, and secondly the demands and levels of control that are presented by the new environment. The 'weighing up' or appraisal is believed to be the 'computation' that determines whether or not 'job strain' is perceived.

The model suggests that homesickness may be a response to perceived strain. However, it remains unclear whether homesick students find the new environment a greater strain by cause or consequence. Being unhappy and homesick may have self-fulfilling characteristics that drive ruminative activity, in which attentional resources are competed for. Subsequently, a psychological state may be produced that is not conducive to establishing new friendships, exploring, or learning in the new environment (Fisher & Hood, 1987, Fisher, 1989).

The job strain model appears similar to both the separation and interruption models in that it may be useful for explaining the finding (Fisher & Hood, 1987) that although levels of depression may be greater in homesick subjects prior to relocation, it is symptoms of anxiety and obsessionality that differentially interact with the transition. That is to say, the job strain model predicts that individuals who experience homesickness following relocation are responding to strains of the new environment in particular, and as a result raised levels of anxiety and obsessionality would be expected (Fisher & Hood, 1987, Fisher, 1989). There are however, several areas in which the job strain model appears to be deficient. Personal factors that have been found to predispose an individual to homesickness have not been included in the model, for example personality characteristics, factors of the home environment, and previous lifestyle experiences are not included. Thus it would be reasonable to evaluate the job strain model as a useful, but not comprehensive model from which the phenomenon of homesickness can be investigated.

Fisher's (1989) Composite Model of Homesickness

Fisher (1989) responded to the need of a multi-causal formulation of homesickness by providing descriptive composite model (See Figure 2). The model reflects a two-part challenge and also illustrates two roles of the environment. The two-part challenge involves both separation from the home setting, and the entrance into the new environment. Separation from home is portrayed to be associated with loss, interruption of plans, and withdrawal, which may lead to psychological disruption and cognitive ruminations about home. The individuals attentional resources are subsequently affected, the negative effect of which may be homesickness (Fisher, 1989; Van Tilburg et al., 1996).

Simultaneously, the entrance into the new environment may bring about feelings of strain, dissatisfaction, or commitment. Strain and dissatisfaction may give rise to a desire to return home, which may lead to compulsive thoughts of home, and homesickness, whereas commitment to the new environment enables the individual to feel challenged and open to new experiences. Commitment may interfere with the psychological disruption that may be experienced when one leaves home and competes with homesick thoughts facilitating successful adjustment and adaptation to the new environment (Fisher, 1989; Van Tilburg et al., 1996).

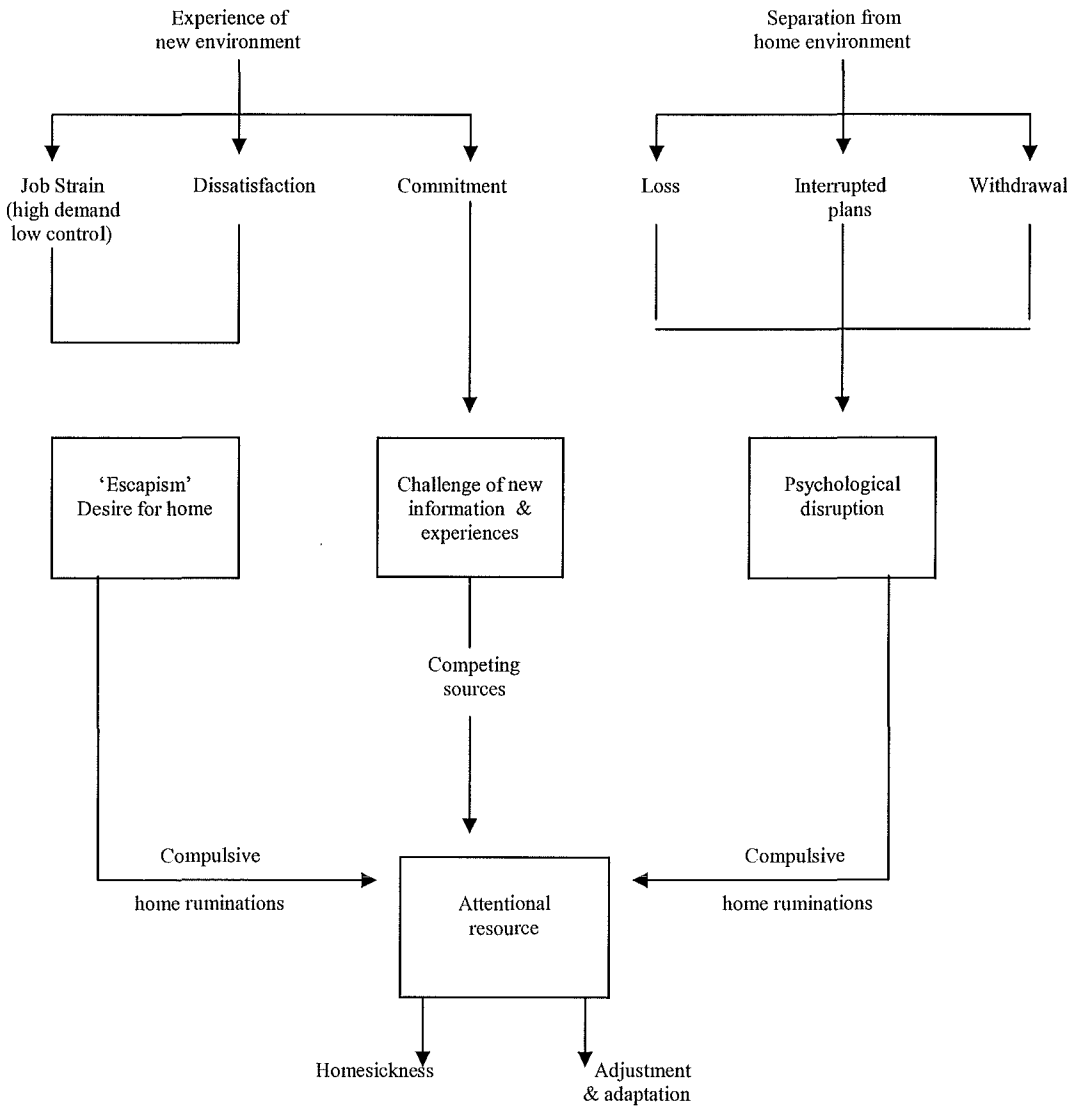

Figure 2. A Composite model of homesickness (Fisher, 1989).

Thus the first role the environment is assumed to have, is that it may moderate the homesickness created by loss, separation, interruption, reduced control, or role change, because it offers competing sources of information. Secondly, there is the possibility that the environment may actually be responsible for producing homesickness, especially when it is not compatible with the individual's expectations or when strain is perceived (Fisher, 1989; Van Tilburg et al., 1996).

The model attends to the key factors that have been identified as being influential to the onset and preservation of the homesickness experience. It has been recognized (Van Tilburg et al., 1996) however, that factors that determine the intensity of the feelings associated with both the new and the home environment are lacking. Furthermore, neither elements of the previous environment that contribute to the distress, nor the personality features of individuals that have been found more likely to become homesick have been identified (Fisher, 1989; Van Tilburg et al., 1996).

Peacock's (1988) Cognitive Model of the Etiology of Homesickness

Peacock (1988) drew form the work of Fisher et al. (1985) in formulating the 'Cognitive Model of the Etiology of Homesickness'. Peacock (1988) believed that a comprehensive model of homesickness in boarding school children would incorporate several dimensions. Elements that were considered to be important included cognitive characteristics such as control and demand, adjustment to the previous environment, expectations about the new environment, adjustment to the new environment, and comparison of the new environment with expectations of the previous environment. Such a cognitive model of the etiology of homesickness is illustrated below (see Figure 3).

The 'cognitive model of the etiology of homesickness' Peacock (1988) was developed to be applied specifically to a Year 9 population at Timbertop Boarding School, which is part of Geelong Grammar in Victoria, Australia. The model is useful in that it recognizes that the personality, cognitions, and coping skills of an individual are shaped by genetic disposition, family dynamics, early school life and peer group experiences, and the mass media. The model acknowledges that the pupils early secondary school experience (Year 7 and 8) may be as a day student or boarder, at Geelong Grammar School or at an alternative school.

A strength of the model (Peacock, 1988) is that it predicts that the pupils perceived adjustment to life at school and home prior to Year 9, in combination with expectations about boarding school life, will affect the cognitive interpretation of events and experiences at boarding school. Furthermore, the model is compelling in that it illustrates the potential for a comparison of the cognitive interpretation of experiences at boarding school with the pupil's prior expectations, memories of the previous home and school environment that may lead to either a favorable or unfavorable assessment of life at boarding school. The model predicts that individuals who make a 'very favorable' or 'quite favorable' assessment will never or rarely experience homesickness. On the other hand, pupils who make an unfavorable assessment are hypothesized to be at risk of experiencing homesickness. A final advantage of the model is that it identifies that that the pupils adaptiveness (or otherwise) of coping strategies will determine whether homesickness, if experienced, will be attenuated or become chronic. Although useful in that it provides an uncomplicated framework of homesickness in boarding school pupils, the models downfall is that it is so definite in the subject group that it targets, specifically the Year 9 population at Timbertop Boarding School, Geelong Grammar, Australia. There is however, great potential to adapt and expand the model in an endeavor to make it applicable to diverse populations.

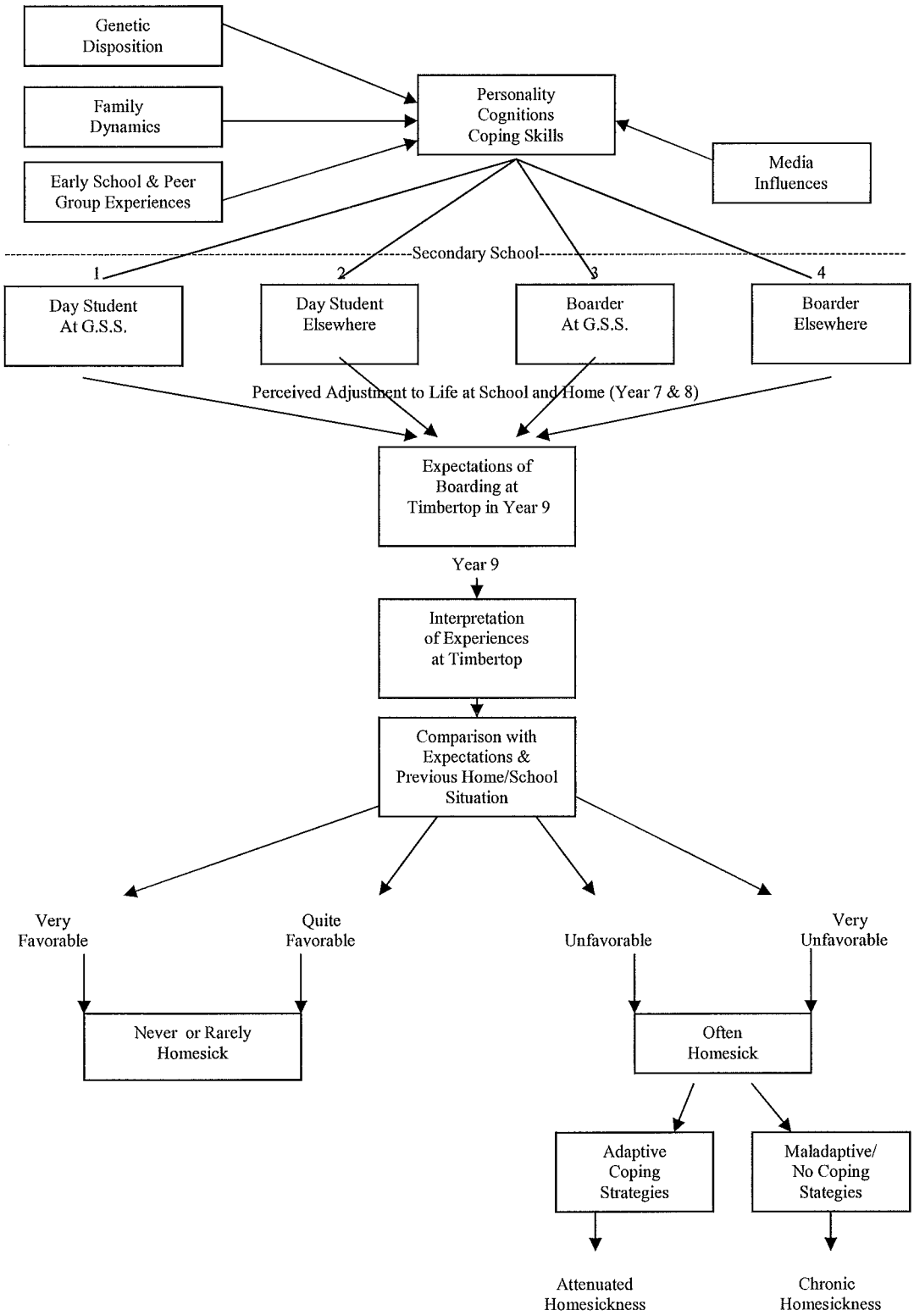

Figure 3. A Cognitive model of the etiology of homesickness (Peacock, 1988).

1.12 CHAPTER SUMMARY
-THE COMPREHENSIVE PSYCHOLOGICAL MODEL OF HOMESICKNESS

In sum, homesickness is characterised by the distress or impairment caused by separation from the home environment, it is a dynamic phenomenon that is both prevalent and varied in intensity. Homesickness is a conceptually distinct manifestation of distress and it is essential to acknowledge it as such. From a clinical perspective homesickness may have interesting implications, and it is essential that psychologists and therapists consider the possibility that recently relocated patients may be homesick and include the possibility of homesickness in their diagnostic assessment, otherwise homesick individuals are at risk of being incorrectly diagnosed or 'labelled'.

Critical antecedents of homesickness include previous homesickness experiences, attachment issues, and high levels of dependency on family and parents. Several pathogenic models support the possibility that homesickness reflects a number of personality features, including obsession, depression, introversion, insecurity, poor social skills, low self esteem, anxiety, rigidity, and avoidance of new situations (Brewin et al., 1989; Thurber, 1999; Eurelings-Bontekoke et al., 1994; Van Heck et al., 1997). Furthermore, considerable links between homesickness and freedom of choice, expectations, and perception of control over environmental demands have been found (e.g., Fisher, 1989).

Homesickness is a complex state associated with a range of emotional, behavioural, cognitive, and physical symptoms. Emotional characteristics of homesickness have been identified to include depressed mood, feelings of insecurity, loss of control, nervousness and loneliness (e.g., Van et al., 1996; Thurber and Sigman, 1998; Fisher and Hood, 1987; Eurelings-Bontekoke et al.,1994; Stroebe et al., 2002). Homesick individuals have been reported to exhibit listlessness, apathy, lack of initiative, little interest in the new environment, generalised distress, frequent talking about home, little desire to eat, and withdrawal(e.g., Thurber, 1995; Van Tilburg et al., 1996). Homesickness is a psychological state centred on a preoccupation with the home environment, and cognitive symptoms may include negative thoughts about the new environment, idealizing the home environment, absent-mindedness, academic difficulties, obsessional thoughts about home, and a strong desire to return home (Fisher, 1989; Burt, 1993; Van Tilburg et al., 1996; Thurber, 1995). There is evidence of a variety of health factors that may be adversely affected by the phenomenon. These include gastric and intestinal complaints, nausea, anorexia, headache, fatigue, sleep disturbances, impaired immune system functioning, and a range of vague aches and pains (Van Tiburg et al., 1996; Hamessley, 1987; Schmitz, 1992; Winland-Brown and Maheady, 1990).

A distinction between 'normal' and 'pathological' homesickness is emerging. Pathological homesickness may be able to be distinguished from 'normal' homesickness in that the individual's reaction to relocation is unduly severe, and that normal functioning is impaired, where as 'normal' homesickness, may present as the individual struggles to adjust to the new environment and experiences mild, transient symptoms, whilst continuing to participate and function in the new environment (Vingerhoets, 1997). It is hypothesized that for some individuals a state of chronic homesickness may emerge. It is proposed that an individual who has coping mechanisms that are sufficient to ensure adequate day to day functioning and fulfillment of roles and obligations, may nonetheless be functioning at a sub-optimal level due to mild but persistent feelings of homesickness that are just below the surface.

Care-givers and therapists are faced with the problem of how to help homesick individuals. It is suggested that the cause of the homesickness experience should be scrutinized, because different causes of homesickness require different interventions. However, in light of the principle that the most significant factor contributing to homesickness is a failure to cognitively assimilate the new experience, it believed that all homesick individuals should be encouraged to express and acknowledge their feelings, and to explore the conflict between remaining in the new environment and returning home (Fisher, 1989).

Additional interventions include aiming to rationalize and normalize the homesickness experience, promoting the recognition of homesickness symptoms, anticipating critical moments, and encouraging commitment to the new environment and participation in social, leisure and sporting activities. Furthermore, regular telephone contact with home, thought stopping, 'time-out' for worry, and fantasized conversations with support figures have been reported to be useful in helping to alleviate homesickness. Recovery from homesickness has been mainly attributed to recognizing and actively confronting the problem, seeking social support and making friends. As a preventative measure, it may be useful for those who are intending to relocate to investigate the new environment prior to relocation. Being aware of opportunities, routines, and cultural and geographical idiosyncrasies of the new environment may go some way towards reducing the likelihood of developing homesickness (Van Tilburg et al., 1996; Hannigan, 1997; Taylor, 1986; Chartoff , 1975).

Several separate but related theoretic approaches appear to be potentially useful in accounting for the specific phenomena related to homesickness. It has been established that homesickness is a complex state with multifarious psychological processes. The common denominators have been recognized to include separation and loss, interruption, reduced control, role change, and conflict, but it is clear that a multi-causal model is needed (Fisher, 1989).

Fisher and Hood (1987) put forward a 'Job Strain' model of homesickness that attends to the belief that following relocation an individual experiences a computational process which involves weighing up the benefits and threats created by the new environment against the benefits and securities of home. Fisher (1989) later proposed a 'Descriptive Composite' model of homesickness in which the environment is assumed to have two roles.

Firstly, it is believed that the environment may moderate homesickness that is created by loss, separation, interruption, reduced control, or role change, because it offers competing sources of information. Secondly, the possibility that the environment may actually be responsible for producing homesickness, especially when it is not compatible with the individual's expectations or when strain is perceived is proposed. Peacock (1988) formulated the 'Cognitive Model of the Etiology of Homesickness', although useful in that it provides an uncomplicated framework of homesickness in boarding school pupils, the models downfall is that it is so definite in the subject group that it targets, specifically the Year 9 population at Timbertop Boarding School, Geelong Grammar, Australia. There is however, great potential to adapt and expand the model in an endeavor to make it applicable to diverse populations. In recognition of the need for a generic, multi-causal, model of homesickness the "Comprehensive Psychological" model is proposed (see Figure 4a & b). The model draws from the existing scientific literature and attempts to augment the current body of knowledge.

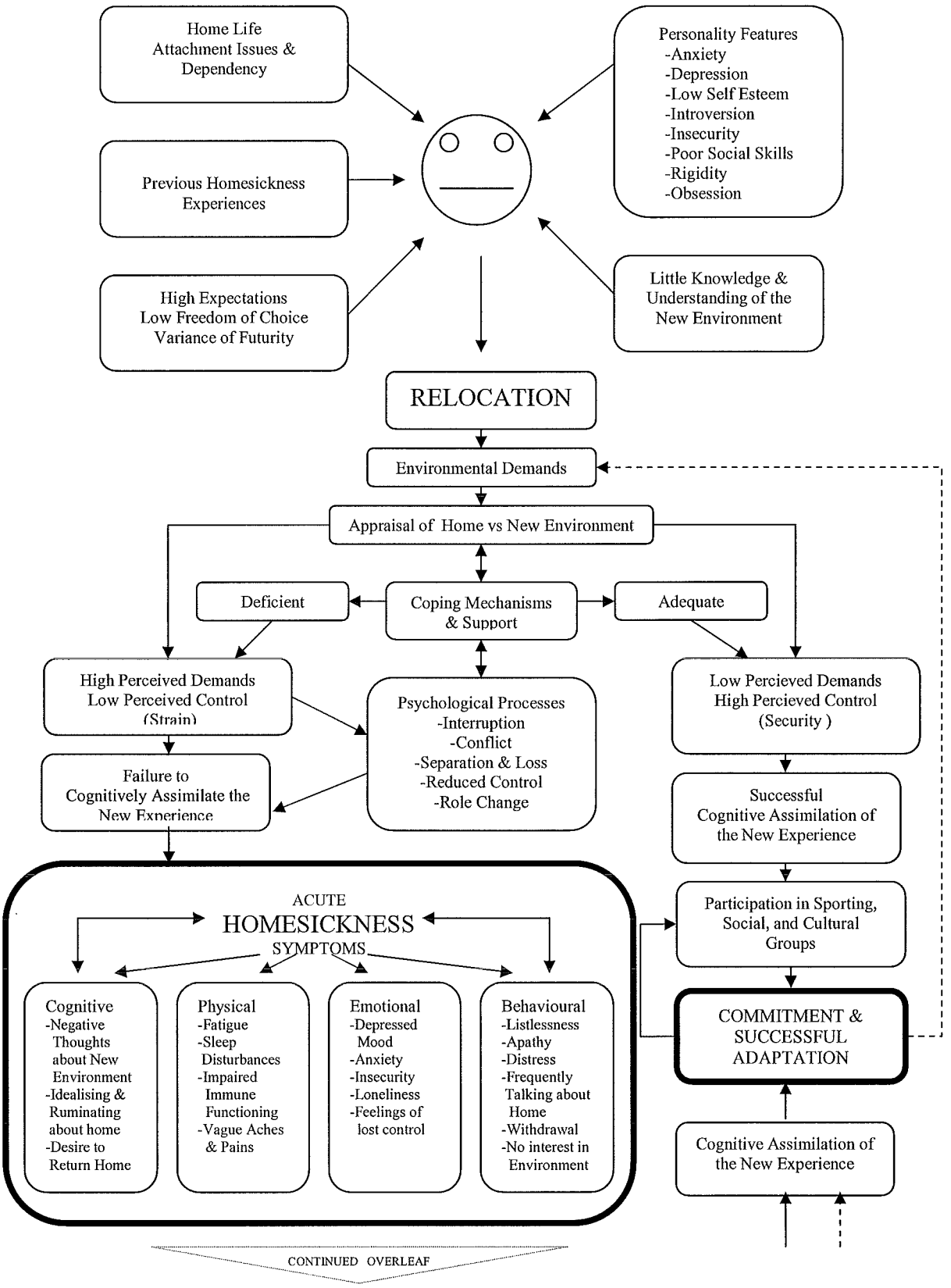

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Figure 4a. Comprehensive Model of homesickness.

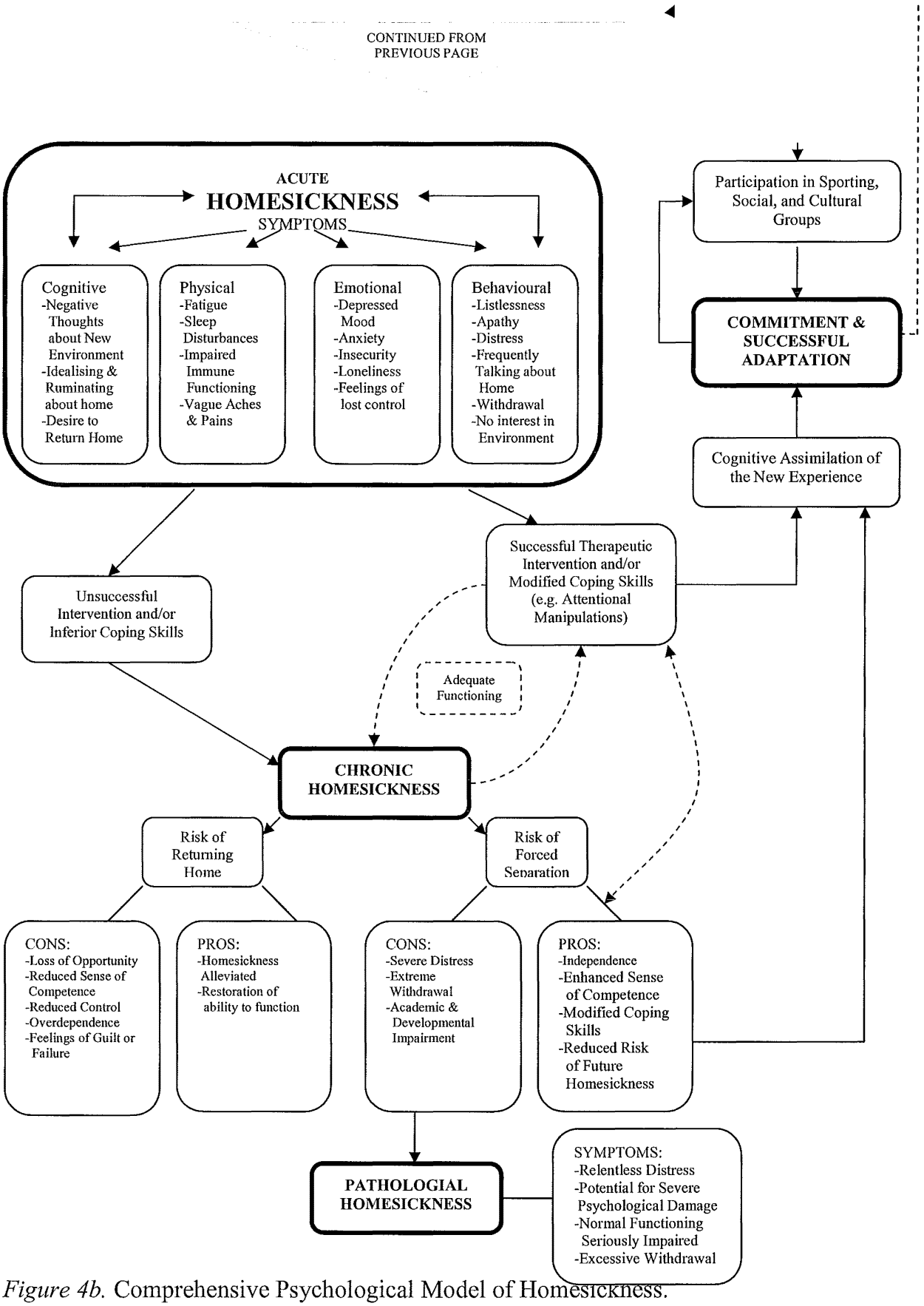

Figure 4b. Comprehensive Psychological Model of Homesickness.

The 'Comprehensive Psychological Model of Homesickness' draws from the work of leading theorists (e.g., Fisher,1989; Thurber,1999; Vingerhoets, 1997; Peacock, 1988; Van Tilburg et al.,1996; Fisher et al.,1986; Thurber, 1999; Brewin et al., 1989) and illustrates the pre-dispositional factors, etiology, and dynamic nature of homesickness. At the outset, the model acknowledges that a number of personal vulnerabilities, including attachment issues, personality features, and little prior knowledge of the new environment, may predispose an individual towards developing homesickness. Thus the model attends to the belief that individuals who are vulnerable to homesickness may differ from their non-homesick counterparts prior to leaving home.

Following relocation the new environment is recognized to provide a source of strain, there is believed to be a period of cognitive appraisal of weighing up life at home in comparison to life in the new environment. The model illustrates that when existing coping mechanisms and support are adequate, and there is a perception of low demands and high control, then it is likely that the individual will successfully cognitively assimilate the new experience, and subsequently have the resources available to participate in cultural and sporting activities. Participation in activities and groups may in turn enhance commitment and facilitate successful adjustment to the new environment. It is hypothesized that a positive cycle of enhanced commitment and continued participation may emerge.

Alternatively, when coping mechanisms and support are deficient it is proposed that the individual may perceive high demand and low control, in turn there is a possibility that psychological processes including interruption, conflict, reduced control, role change, and separation and loss, may impact on the individual in such a manner that there is a failure to cognitively assimilate the new experience. Unless coping mechanisms are modified, then 'Acute Homesickness' is projected to be inevitable.

It is hypothesized that if there is a lack of therapeutic intervention and no improvement in coping skills, then a state of 'Chronic Homesickness' may subsequently emerge. At this stage, consideration must be given to the risk of returning home in relation to the risks of forced separation. If the individual returns home, then it is expected that homesickness will be alleviated, however there may be a loss of opportunity, overdependence, and feelings of guilt or failure. On the other hand, if there is forced separation there may be severe distress, academic and developmental impairment, extreme withdrawal and there is even the potential that a state of 'Pathological Homesickness' may emerge.

In an episode of 'Pathological Homesickness' there is the potential for severe psychological damage. The emotional, cognitive, behavioral and physical reactions of homesickness would be amplified. The individual who is suffering from pathological homesickness may experience relentless distress and excessive withdrawal. Furthermore, it is reasonable to predict that an individual who has experienced 'Pathological Homesickness' in the past may become anxious and avoidant of future separations from home. Alternatively, if therapeutic interventions are offered and there is an improvement in coping skills and successful alleviation of the 'Pathological' state, then forced separation may present the opportunity for an enhanced sense of competence and independence, in addition to a reduced risk of future homesickness. There may even be cognitive assimilation of the new experience, heightened 'Commitment', and 'Successful Adaptation' to the new environment.

By including a path from 'Commitment and Successful Adaptation' back to 'Environmental Demands' the model attends to the potential for new environmental strain and the dynamic nature of the homesickness phenomenon. In relation to 'Chronic Homesickness' it is tentatively proposed that there is the possibility for a continuous mild state of homesickness in which coping skills are sufficient to ensure that adequate, but sub-optimal, day to day functioning is achieved, but there is a lack of comprehensive cognitive assimilation. Thus there is the need for a therapeutic intervention that enhances cognitive assimilation and in turn successfully ameliorates the deleterious effects of homesickness.

CHAPTER TWO: NARRATIVE THERAPY

2.1 THE EMOTIONAL NARRATIVE - AN OVERVIEW

Psychologists consider emotional expression to be essential for optimum mental and physical health; where as inhibition of emotion is believed to be psychologically and physically detrimental (Rachman, 1980; Esterling, L'Abate, Murray, & Pennebaker, 1999). Participation in psychotherapy usually involves labeling or acknowledging a problem and discussing its causes and consequences. The mere act of emotional disclosure is a powerful therapeutic agent that has been shown to reduce distress and to ameliorate physical and mental well-being (Pennebaker, 1997; Esterling et. al., 1999).

One medium of emotional expression that has recently actuated psychological interest is expressive writing. Written emotional disclosure is an approach to treatment for disorders such as depression, anxiety, and panic attacks that has increased in recent years. Emotional writing is both cost effective and mass orientated (L'Abate, 1991; L'Abate, Boyce, Fraizer, & Russ, 1992; Esterling et. al., 1999; Mumford, Schlesinger, and Glass, 1983).

The emotional narrative refers to a behavior that includes recalling a stressful event and writing about the incident, using both descriptive and emotional words (Esterling et. al., 1999). The basic premise of narrative psychology is that individuals account for critical events in their lives by putting them in a story-like format. A good story is guided by an underlying reason or goal and includes well-ordered and related events (Pennebaker and Seagal, 1999).

Mancuso and Sabrin (1998) propose that the development of a coherent emotional life is related to the individual's ability to draw causal relationships and form stories, a skill that is usually mastered in early childhood. This process enables the individual to recall events in an organized fashion whilst integrating thoughts and emotions. Once a complex event is put into story format, it is simplified. The emotional effects of an experience are considered to be more manageable when the event has structure and meaning. Structure and meaning in turn enable the individual to acquire a sense of predictability and control over their life (Pennebaker and Seagal, 1999). Whether written or spoken, it is well established (Esterling et. al., 1999; Pennebaker and Beall, 1986; Pennebaker and Seagal, 1999; Donnell and Murray, 1991) that organizing emotional personal experiences into a story is associated with many benefits.

Therapeutic emotional writing ranges from unstructured 'open-ended' writing, to 'guided' or 'focused' writing, and finally, to 'programmed' writing which is the most structured type of writing. In 'open-ended' writing the patient writes about whatever comes to mind. In 'programmed' writing, one specific clinical topic is broken down into components, and constitutes a workbook. 'Guided' or 'focused' writing falls somewhere between 'open-ended' and 'programmed' writing. The participant writes about their thoughts or feelings regarding general topics, such as incidents that have provoked anxiety (Esterling et al., 1999).

The critical element of a therapeutic story is that the participant is encouraged to explore their emotions and thoughts no matter what the content might be. Topics that have produced congruent benefits include writing about directly experienced traumas (Pennebaker and Beall, 1986), starting college (Pennebaker, Colder and Sharp, 1990), writing about the experience of being laid off from one's job (Sepra, Buhrfeind, and Pennebaker, 1994), and intriguingly, even writing about imaginary traumatic experiences (Greenberg, Wortman, and Stone, 1996). The effects of emotional writing have not been found to be related to individual differences, nor are the effects dependent on the presumed audience. The predicted benefits of the narrative are unrelated to whether the story is intended to be viewed by the therapist, the experimenter, or simply to be kept by the participant (Pennebaker, 1997; Pennebaker and Seagal, 1999).

Although written disclosure can improve mental and physical health, Pennebaker and Seagal (1999) propose that merely having a story may not be sufficient to assure good health. Pennebaker and Francis (1996) developed a computer program called the Linguistic Inquiry and Word Count (LIWC) that analyzed essays and specifically measured emotional and cognitive categories of word usage.

A subsequent study (Pennebaker, Mayne, and Francis, 1997) examined the use of negative-emotion (e.g., sad) and positive-emotion (e.g., happy) words and found that the authors of the narratives that used numerous positive emotion words experienced many health improvements. Interestingly, authors who used either very high negative-emotion words or very few negative emotion words were found to most likely experience continuing health problems. Pennebaker and Seagal (1999) suggest that individuals who used a large number of positive emotion words balanced by a moderate use of emotion words from the negative category acknowledge their problems with a general sense of optimism.

The findings of the LIWC analysis for cognitive word categories were even more intriguing. The authors who went from using few causal and insight words in the first session to using a high rate of them by the final writing session showed consistent improvements in mental and psychological health. Building a story is considered critical in reaching an understanding. Therapeutic writing facilitates the integration of thoughts and feelings, and the individual constructs a coherent recollection of the event. Once the emotional story is formed, the experience can be summarized, stored, and forgotten more easily – a sense of resolution is achieved (Pennebaker and Seagal, 1999).

2.2 THE THEREPEUTIC EFFECTS OF EMOTIONAL WRITING

Emotional writing is a powerful therapeutic technique. A substantial number of studies have demonstrated that encouraging individuals to write about the distressing experiences in their lives for as little as fifteen minutes per day for three to five consecutive days (Pennebaker, 1997) brings about a variety of positive changes across a range of domains.

The Psychological Effects

The social and cognitive benefits of constructing an emotional narrative include the ability to more quickly secure a new job - as evidenced by recently laid off senior-level engineers (Serpa, Buhrfeind, and Pennebaker, 1994), and improved grades in college (Pennebaker and Francis, 1996), and can function as a means of avoiding both stress and anxiety (Burt, 1994).

Although the positive effects of an emotional narrative are well documented, concern has been expressed that an upsurge in negative mood may follow each writing session (Murray & Segal, 1994), and this residual negative effect may potentially result in session avoidance. Interestingly, emotional state after writing is dependant on how an individual feels before the session, the better the individual feels before the session, the worse they feel afterwards and alternately, the worse an individual feels prior to writing, the better they feel afterwards.

Esterling et al. (1999) suggest that regular face-to-face patient-therapist therapy sessions be used in combination with the writing sessions, allowing interpersonal processes such as support and empathy to ameliorate the negative effect. Although confronting painful experiences may cause discontent in the short term, an overall improvement in mood and general health has been found to be a long term effect of emotional writing, even without face-to-face therapy (Donelly & Murray, 1991).

Effects on Physical Health

Confronting painful emotional experiences has been found to have a positive effect on physical health. From a reduction in doctor-visit rates (Pennebaker and Beall, 1986), to beneficial improved immune function. Immunological improvements have been found in a variety of studies including measured *t*-helper cell growth and activity (Pennebaker, Kiecolt-Glaser, and Glaser, 1988), significantly lower Epstein-Barr virus antibody titer values (i.e., better immune function) (Esterling, Antoni, Fletcher, Margulies, and Schneiderman, 1994), and improved immunological response to viral challenge (hepatitis-B vaccination) (Petrie, Booth, Pennebaker, Davison, and Thomas, 1995).

2.3 WHY APPLY NARRATIVE THERAPY TO HOMESICKNESS?

The purpose of the present research is to investigate the effects of emotional writing on levels of homesickness amongst boarding school pupils. The realization that the therapeutic emotional narrative has been shown to have a positive influence on a number of areas of both physical and mental health that are known to be detrimentally effected by the homesickness phenomenon provides the impetus for the investigation.

Pennebaker and Francis (1996) investigated cognitive, emotional, and language processes in disclosure in a group of first year college students who were randomly assigned to write about either their thoughts and feelings about coming to college or about superficial topics for three consecutive days. Although homesickness was not directly investigated, writing about college was found to reduce health center visits for illness and to improve subjects' academic performance. Both health and academic performance are recognized to be negatively correlated with homesickness (Fisher, 1989).

Depressed mood, feelings of insecurity, low self esteem, loss of control, anxiety, and absentmindedness (Van Tilberg et al., 1996; Fisher, 1989) are characteristic of the emotional and cognitive symptomatology of homesickness. Therapeutic writing has been associated with increased insight, self-reflection, optimism, sense of control and improvements in self-esteem (Esterling et al., 1999), together these changes may result in decreased depression and anxiety (Esterling et al., 1999). An association between homesickness and an increase in cognitive failures such as academic performance have also been found (Fisher, Murray & Frazer, 1985; Fisher & Hood, 1987). Research reported by Pennebaker and Francis (1996) indicated that academic performance (measured as grade point average) significantly increased for participants who undertook therapeutic emotional writing.

A range of physical health factors (Van Tiburg et al., 1996) are adversely affected by the homesickness phenomenon, these symptoms may be reflected by multiple visits to the camp infirmary (Zimmerman & Bijur, 1995), vague physical complaints, a large number of days off school for non-traumatic illness, and an increase in visits to the doctor (Fisher, Frazer, & Murray, 1986). Esterling et al. (1999) reported that improved immune system function, fewer physical symptoms, reductions in visits to the physician and time missed from work, are changes promoted by emotional writing.

There has been a longstanding oversight of empirically investigated interventions for homesickness. There is a need for a treatment for homesickness that ameliorates psychological well-being, advances intellectual capacity and promotes physical health. It is well established (e.g., Esterling et. al., 1999; Pennebaker and Beall, 1986; Pennebaker, et al., 1990; Pennebaker and Seagal, 1999; Sepra et al., 1994) that writing about distressing personal experiences in an emotional manner has a positive influence on both physical and mental health, and academic performance. In light of the benefits of emotional disclosure, there should be a reduction in homesickness symptoms and advanced academic performance for students who participate in an emotional writing exercise.

It has been proposed that not only is it the meaning given to a move which is critical in determining an individual's adaptation (Peacock, 1987), but also that the most significant correlate of failure to adjust to a new environment is an individual's inability to cognitively assimilate the new experience (Fisher, 1989). Given that building a story is considered critical in reaching an understanding, and that therapeutic writing facilitates the integration of thoughts and feelings, then it should follow that individuals who participate in an emotional writing exercise about going to boarding school will not only enhance their understanding and cognitive assimilation of the boarding school experience, but also achieve a sense of resolution about the relocation and subsequently reveal a decreased level of homesickness.

Written emotional disclosure is an exceptionally powerful paradigm that is both cost effective and mass orientated. Translating significant psychological events into words is uniquely human, and the mere act of having an individual write down their problem may have tremendous therapeutic value in and of itself (Pennebaker, 1997). It is hoped that the present research will motivate additional investigation and theorizing, and contribute to a better understanding of both the homesickness phenomenon and the therapeutic narrative. Most importantly, it is believed that the development of strategies and interventions for homesickness will facilitate real improvements in the quality of life of those who are separated from their home environment.

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CHAPTER THREE: AN INVESTIGATION OF THE EFFECTS OF NARRATIVE THERAPY ON HOMESICKNESS

3.1 AIM OF THE INVESTIGATION

It has been recognized that there is a need for a treatment for homesickness that ameliorates psychological well-being, advances intellectual capacity and promotes physical health. In light of the benefits of written emotional disclosure, it should follow that there will be a reduction in levels of homesickness for students who participate in a narrative exercise. The aim of the present investigation is to test this hypothesis. The population will comprise of 3rd and 4th form boarding pupils from two gender specific secondary schools. Participants will be randomly assigned to two groups; the control group will write descriptively about non-emotional topics, where as pupils in the experimental group will construct an emotional narrative that contemplates their transition to boarding school. Data concerning the pupil's homesickness scores, average grade, and school attendance will be analyzed.

3.2 METHOD

Participants

Participants were year 9 and 10 pupils, ages 13 to 15 years old who were boarding at High Schools in Christchurch. One girls-only school and one boys-only school were used. The study was described as an "investigation of homesickness" and the "boarding school experience". Consent was obtained in writing prior to the start of the investigation. The pupils co-operated on a voluntary basis.

Of the 46 year 9 and 10 boarders at the boys school, 46 (100%) gave consent to participate. A total of 39 males completed the study. At the girls school, a total of 32 (91%) gave consent to participate. 25 girls were present to complete the initial questionnaires, and there was a final number of 21 girls who completed the entire study. Thus the core sample reduced to a total number of 60. More males (n = 39) than females (n = 21) completed the study. The sample was intended to represent a cross section of English-speaking, adolescent pupils who attended boarding school in Christchurch New Zealand. Demographic information provided by the pupils indicated that nearly all of the pupils were from rural areas in the South Island.

Materials

Three types of questionnaires were used in this study. An opening questionnaire that requested demographic information, hobbies and interests was the first to be completed. The second questionnaire consisted of a self reported Homesickness Scale (HS), similar to the basic binary 'Pain Scale' measure used in Western hospitals. The HS was designed to be a straight-forward self report of the individual's personal level of homesickness. It was a five point numerical rating scale semantically anchored at 1 (rarely), 3 (sometimes), and 5 (often). Although homesickness changes over time self assessed binary measures of homesickness have been found to have a high mean 1-week test-retest reliability (Thurber,1999), to have internal consistency, and to have been validated with observer reports of homesickness (Thurber, 1995).

There was also a good case for utilizing a measure for homesickness which enabled the phenomenon to be assessed on the basis of answers to specified questions. Depression inventories, for example, do not require the individual to first define 'depression' and then assess ones personal level of depression on a binary scale. Instead, a number of different questions that are assumed to be assessing depression are usually responded to. Positive endorsement of more of the symptoms reflects a greater intensity level of depression. This hierarchical model of mental disturbance where more symptoms imply more severity is implicit in most clinical questionnaires (Fisher, 1989).

The third questionnaire that was used in this study was a modified version of the Dundee Relocation Inventory (DRI) (Fisher, 1989, second version – questionnaire F). The DRI measured the intensity of the pupils homesickness based on responses made to a number of different statements. The questionnaire consisted of 24 items (the 2 dummy items used by Fisher were omitted), and utilized a three-category rating scale. The subjects were scored on zero to two on each of the questions (Never = 0, Sometimes = 1, Often = 2) the scoring was reversed for positive items. The DRI had a potential score range from 0 to 48, a greater score suggested a greater degree of homesickness. A test-retest reliability coefficient of o.59 of 54 homesick students across a two week period has been found for the DRI (Fisher, 1989). Although the coefficient is smaller than may be desirable (Burt, Strongman, and Costanzo, 1998), it remains significant statistically at least $p < 0.05$. In terms of the tests construct validity, Fisher (1989) reports that the DRI has a correlation coefficient of 0.40 (p <0.02).

Two booklets were designed to include the questionnaires. The first had a total of three pages (see Appendix 1). Page one comprised of the Demographic Questionnaire (DQ). The DQ was intended to act as a straightforward non-threatening opening to the booklet. The second page consisted of the self reported binary Homesickness Scale (HS), and the Dundee Relocation Inventory (DRI) was provided on the final page. The second booklet, designed to be used later in the study, included only the HS and the DRI.

The Basic Emotional Narrative Writing Paradigm

The standard laboratory writing technique (Pennebaker, 1997) was employed. Students were randomly assigned to one of two groups. Both groups were asked to write about assigned topics for 3 consecutive days, for 20 minutes each day. Writing was completed during 'prep' with no feedback given. Writing 'packs' were supplied to the pupils. The packs consisted of a front page instruction sheet and 1 piece of A4 size paper. 'Packs' were collected by the researcher after the 20 minute exercise. New 'packs' were used on each of the four days.

Group1: Control Group.

Participants assigned to the control condition were asked to write about non-emotional descriptive topics. On Day One the students were asked to describe the room they were sitting in, on the second day the pupils were asked to describe their school bag including its contents, and on Day Three they described their school grounds. The instruction sheet for the control group was a variation on the following:

For the next 3 days, I would like for you to partake in a descriptive writing exercise. Each day you will be assigned a topic to write about. All of your writing will be completely confidential. Don't worry about spelling, sentence structure, or grammar. The only rule is that once you begin writing please continue to do so until your time is up.

Today your exercise is to describe the room you are sitting in.

Group 2: Experimental Group.

Participants assigned to the experimental group were asked to explore their deepest thoughts and feelings about coming to boarding school. The standard instruction sheet for those assigned to the experimental group included the following:

For the next 3 days, I would like for you to write about your very deepest thoughts and feelings concerning coming to boarding school. I'd like you to really let go and explore your deepest thoughts and emotions. You might tie your topic to your relationship with others, including parents, friends or relatives; to your past, your present, or your future; or to who you have been, who you would like to be, or who you are now. You may write about the same or general issues or experiences on all days of writing or on different topics each day, as long as you write about coming to boarding school. All of your writing will be completely confidential. Don't worry about spelling, sentence structure, or grammar. The only rule is that once you begin writing please continue to do so until your time is up.

Procedure

The pupils participated in the third term for a total of five days during the after-school 'prep' period. The Year 9 and 10 girls participated in the study from their respective prep rooms; the rooms had individual seating for up to 20 girls. The Year 9 and 10 boys were seated collectively in the dining hall, there were four boys to a table and a total of 46 boys in the room. The importance of confidentiality and personal work was reiterated at each session. Day One was during the first week of term three and took approximately 15 minutes which allowed for a brief introduction and completion of the first booklet (which included the DQ, HS, and DRI). The pupils were then randomly assigned to either the experimental or the control group.

During the next week, the pupils participated in the writing exercise. The writing exercise ran for three consecutive days for 15 minutes each day. At the beginning of each of session participants were given 'writing packs' (as described above). In short, pupils assigned to the control condition were given writing packs that asked them to write about non-emotional descriptive topics; and participants in the experimental group were supplied with packs that requested the pupils explore their deepest thoughts and feelings about coming to boarding school. The 'packs' were collected in at the completion of each session.

On the final night, all of the participants in the emotional writing (experimental) group at the Girls School (N = 16) were provided with a journal and asked to continue their writing in the journal. To ensure privacy, the journal was accompanied by both an instruction sheet and a check-sheet. The check-sheet was similar to that utilized by Burt (1994). The sheet (see Appendix 2) was divided into six rows (representing weeks 1-6), and seven columns (reflecting the entry type variable). The participants were asked to place a tick into the appropriate box on the check sheet each time they made an entry into the diary. The entry type variables included:

a) a description of the days activities; *b*) thoughts, feelings or emotions related to coming to boarding school; *c*) other thoughts feelings or emotions; *d*) problems and hassles; *e*) solutions to problems and hassles; *f*)future plans; *g*) other.

It had been anticipated that the participants in the emotional writing group from the Boys School would be supplied with diaries also, however over the 3 day writing period it became evident that this may indeed be compromising the boys safety and leaving them open to bullying, for this reason the therapeutic intervention with the boys was restricted to the three day writing period.

Six weeks after the initial 3 day writing task was completed, the DRI questionnaire was re-administered to participants from both the Girls and the Boys School. At this time 'journal check sheets' were collected from the participants in the emotional writing (experimental) group at the Girls School.

Information concerning the participants Grades and Absenteeism was obtained from school reports at the end of the academic year in December. Grade 1, which was calculated from the first Semester's school reports provided a 'base-line' grade, and reflected the subjects' grade status prior to any intervention. The average grade from the three core subjects of English, Maths and Science was calculated. Grade 2 was based on the second semester report, and was utilised to detect any post intervention effect. Similarly, Absenteeism 1 reflected the total number of half days absent from school at the end of the first semester, and Absenteeism 2 indicated number of half days absent from school after the therapeutic writing intervention. In accordance with the schools wishes information concerning Physical Health was not collected.

Statistical Analysis

Basic statistical techniques were used to describe the prevalence of homesickness prior to application of a therapeutic intervention. ANOVA was employed to identify the trends related to both the group differences, and the effect of narrative therapy. The *t-test* and *Tukey HSD* for unequal *n* were utilised to determine the significant differences between group means, the tests indicated if the means were found to be different at the 0.05 level.

For the purpose of statistical analysis the homesick or not homesick classification was obtained from the collective median score of the initial DRI questionnaire (DRI 1) data.

Subject Grouping

The participants were categorised as Homesick (HS) or Not-Homesick (NHS), Male (M) or Female (F), Control (C) or Experimental (E). The groups:

- Male Control Homesick (MCHS)
- Male Control Not-Homesick (MCNHS)
- Male Experimental Homesick (MEHS)
- Male Experimental Not-Homesick (MENHS)
- Female Control Homesick (FCHS)
- Female Control Not-Homesick (FCNHS)
- Female Experimental Homesick (FEHS)
- Female Experimental Not-Homesick (FENHS)

3.3 RESULTS

The results section is structured in four parts. The first section consists of observational data and describes the prevalence of homesickness within the population prior to the application of a therapeutic intervention. The second section analyses the group differences. The third section examines the effect of narrative therapy on the homesickness phenomenon. The fourth section provides a brief analysis of data related to the diary check sheets.

Of the 46 male boarding pupils, 46 (100%) gave consent to participate. 41 boys completed the study, and two boys were ultimately eliminated from the sample because their DRI 1 questionnaires showed haphazard responding. The final number of the core sample of boys was 39. There were a total of 35 year 9 and 10 pupils boarding at the girls school, 32 (91%) gave consent to participate. 25 girls completed the initial questionnaires; however a final number of 21 girls completed the entire study. Thus there were a total of 66 participants on the first night, removing the 2 questionnaires that showed haphazard responding reduced the initial sample to 64. The data that pertains to the prevalence of homesickness (results section one) was compiled from a total of 64 subjects. However, the data from subjects who did not complete the study (n = 4) was removed from the sample for the statistical analysis of the effects of narrative therapy (results sections two, three, and four), consequently these sections are based on a total of 60 cases.

Prevalence and Intensity of Homesickness

The results indicated that 100% of the sample endorsed a nonzero rating on the DRI 1 measure of homesickness. The DRI questionnaire consisted of 24 items, and had a potential score range from 0 to 48, a greater score suggested a greater degree of homesickness. Examination of scores revealed a median of 13, an overall mean of 15.09 and a standard deviation of 8.08. The scores ranged from 4 to 36, with, an inter-quartile range of 9 to 20.5. The distribution of DRI 1 scores is displayed below in a box-and-whisker plot (see Figure 5).

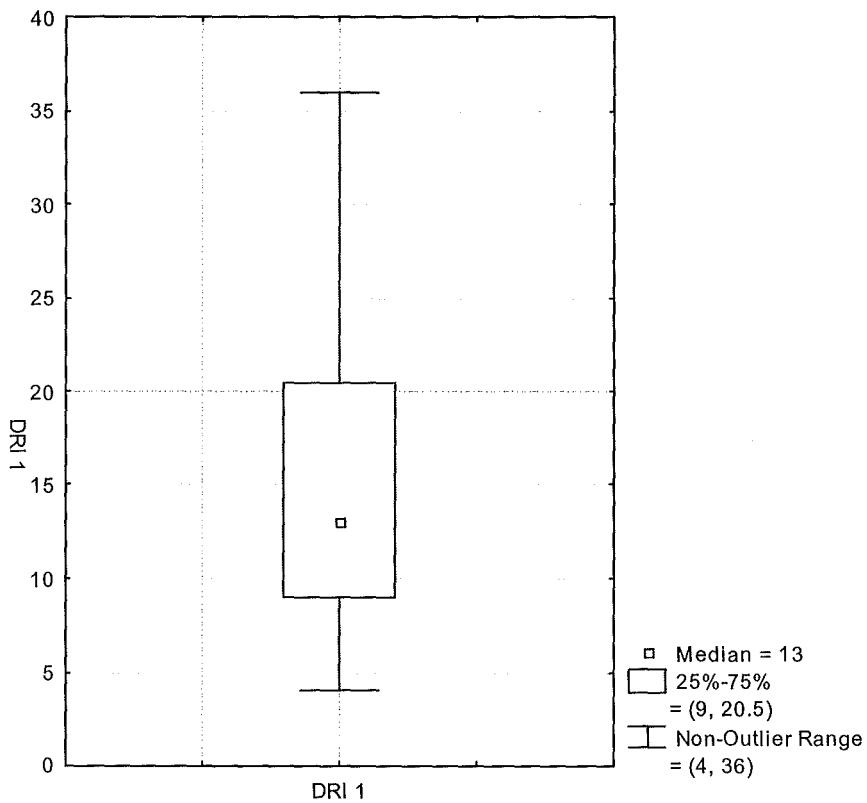

Figure 5. Box-and-whisker plot of the distribution of DRI 1 scores.

Comparison of male (n = 39) and female (n = 25) mean DRI 1 scores showed that the females (DRI 1 x = 17.72) scored more highly than the males (DRI 1 x = 13.41) for average levels of homesickness. The distribution of female and male scores is illustrated below (see Figure 6). The range of scores was similar for both sexes, the females scores ranged from 5 to 36, and the males from 4 to 32.

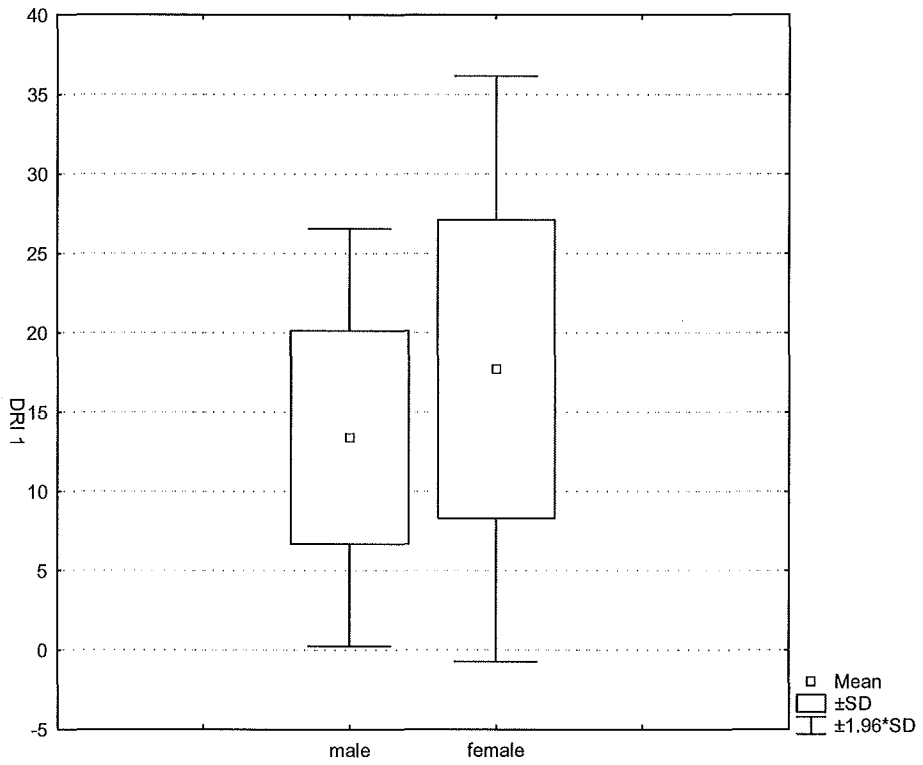

Figure 6. Box-and-whisker plot of the distribution of DRI 1 scores for males and females.

The HSS 1 data set offered the possibility for describing self assessed levels of homesickness prior to the therapeutic intervention. The HSS scale provided a binary measure of homesickness and had a potential range of 1 (rarely homesick) to 5 (often homesick). Table 1 reveals a range of scores between 1 and 5 for both males and females, and a slightly higher mean score of 2.92 for females than males ($x = 2.31$).

Table 1. Descriptive Statistics of levels of self assessed homesickness as reported on the HSS questionnaire.

	Descriptive Statistics (Spreadsheet HS2 grouped)					
HSS 1	Valid N	Mean	Median	Minimum	Maximum	Std.Dev.
Total	64	2.546875	2.000000	1.000000	5.000000	1.006797
Male	39	2.307692	2.000000	1.000000	5.000000	0.863099
Female	25	2.920000	3.000000	1.000000	5.000000	1.115049

An investigation of the relationship between the subject's scores on DRI 1 and scores on the HSS 1 revealed a strong positive correlation of 0.74, $p = 0.00$ (see Figure 7).

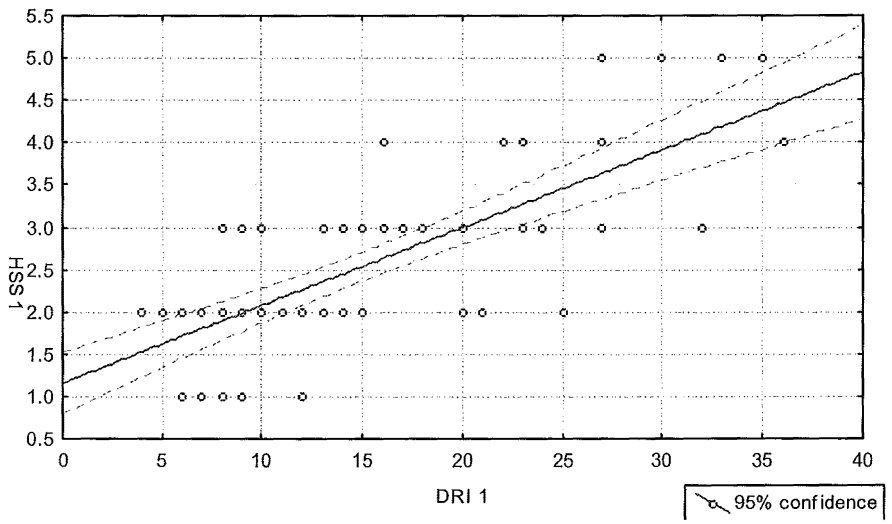

Figure 7. Scatter-plot with regression-line of the distribution of DRI 1versus HSS 1 scores.

In order to investigate the relationship between level of homesickness, academic grade, and ½ days absent from school a correlational analysis was performed. Inspection of the correlation matrix indicated that grade negatively correlates to both DRI 1 scores (r = -0.56, p = 0.00) (see Figure 8) and HSS 1 scores (r = -0.39, p = 0.002). However there appeared to be no significant relationship between absenteeism and DRI 1 (r = 0.16, p = 0.199) and HSS 1 (r = 0.16, p = 0.217) scores.

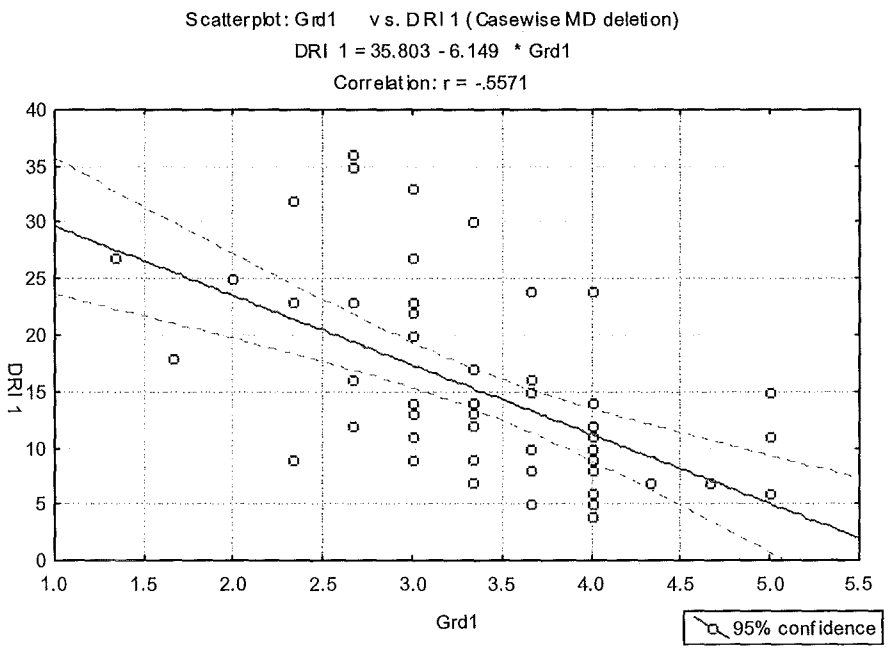

Figure 8. Scatter-plot with regression line of the distribution of DRI 1 scores versus Grade.

Group Differences

Due to the need for deeper statistical analysis, it was essential to divide the sample into groups. The initial division related to whether the subject was Homesick (H) or Not-Homesick (NH). The designation was based on the data obtained from the DRI 1. Given that the median DRI 1 score for the total sample was 13, it was decided that for the purpose of this investigation participants who scored equal to or higher than thirteen would be classified as H, and those who scored below 13 would be considered NHS. Comparison of the HS (n = 34) and NHS (n = 26) groups revealed mean DRI 1 scores (20.29) and (8.19), respectively.

Because the participants were based at two different (gender based) schools it was decided that statistical analysis should include gender. Basic analysis showed that 57.14% (n = 12) of the females were classified as homesick, as were a similar percentage of males, 56.41% (n = 22). However, further analysis revealed that on average the HS females (x = 25.17) had considerably higher DRI scores than the HS males (x = 17.64). Yet the NHS females (n = 9, x = 8.67) had only slightly higher mean DRI scores than the NHS males (n = 17, x =7.94). Table 2 provides a summary of the descriptive statistics, where as Figure 9 presents a visual illustration of gender related differences of DRI 1 mean scores between the groups.

Table 2. Descriptive statistics of DRI 1 scores for the Male and Female Homesick and Not-Homesick groups

Group	Descriptive Statistics				
	Valid N	Mean	Minimum	Maximum	Std.Dev.
MHS	22	17.64	12	32	5.89
MNHS	17	7.94	4	11	2.3
FHS	12	25.17	15	36	7.22
FNHS	9	8.67	5	12	2.24

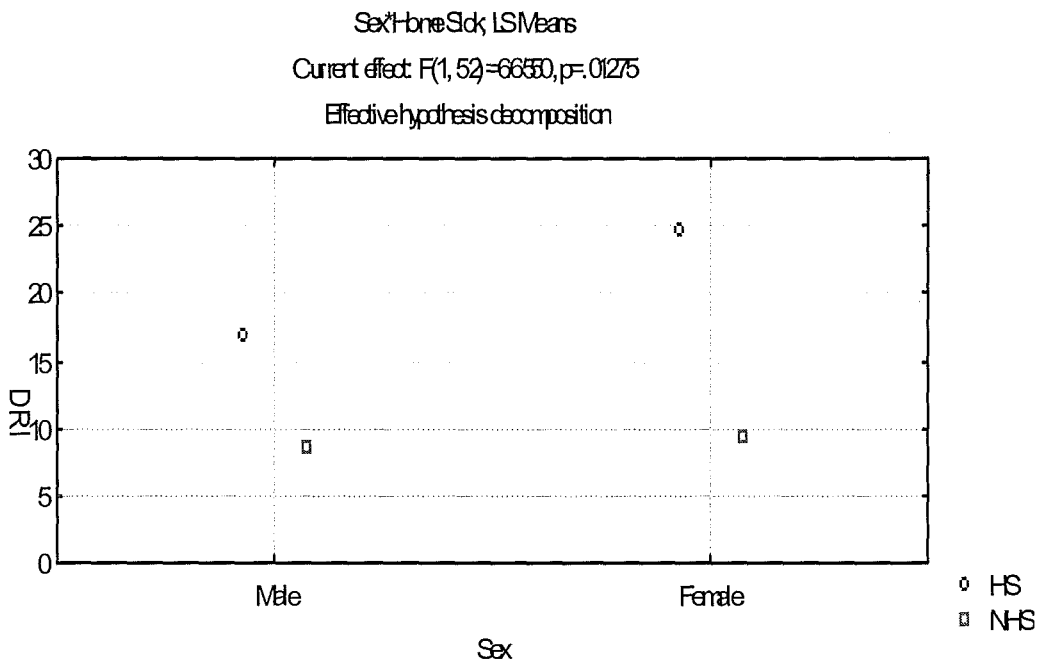

Figure 9. Graphical representation of the mean DRI 1 scores for the Male and Female Homesick and Not-Homesick groups.

The final categorisation of the sample was based on the participant's random assignment to either the Control (C) or Experimental (E) conditions. Figure 10 provides a visual illustration of the distribution of DRI 1 scores for the 8 groups. As expected, the mean DRI 1 scores were higher for the HS than the NHS subjects. The scores for the 4 NHS groups appeared to be distributed over a similar range and there was little gender related difference between the NHS groups. Consistent with earlier findings that showed females had higher levels of homesickness overall, the HS females mean DRI 1 scores were found to be higher than the HS males, this trend was apparent for both the Experimental and Control HS groups.

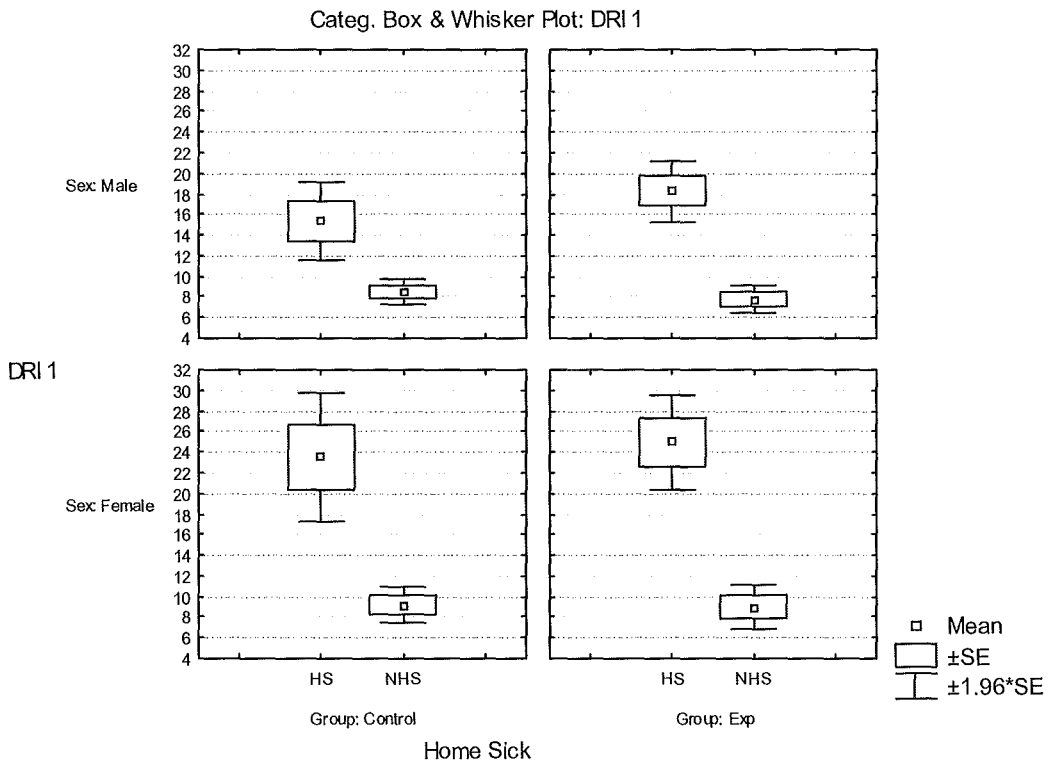

Figure 10. Graphical representation of the distribution of DRI 1 scores for the 8 groups.

Table 3 presents a summary of the mean baseline DRI 1 scores for the 8 groups. The base line scores reflect the degree of homesickness (as indicated by DRI 1 mean scores) that was present within the group before the therapeutic intervention was applied. Out of all of the groups the FEHS had the highest baseline levels of homesickness (x = 25.50), and the MENHS had the lowest (x = 7.77).

Table 3. Descriptive Statistics for the Groups Baseline Levels of Homesickness as reflected by DRI 1 mean scores.

Sex	Group	Home Sick	DRI 1 Means	DRI 1 N	DRI 1 Std.Dev.
Male	Control	HS	15.40000	5	4.335897
Male	Control	NHS	8.50000	4	1.290994
Male	Exp	HS	18.29412	17	6.222587
Male	Exp	NHS	7.76923	13	2.554533
Female	Control	HS	24.50000	4	7.852813
Female	Control	NHS	8.25000	4	2.061553
Female	Exp	HS	25.50000	8	7.425824
Female	Exp	NHS	9.00000	5	2.549510

The Effect of Narrative Therapy on Homesickness

Comparison of the control and experimental groups mean DRI scores from Time 1 to Time 2 revealed that there was no statistically significant change in levels of homesickness. However, despite the absence of statistically significant change, trends indicated that narrative therapy may have had a beneficial effect F(1, 52)=3.4006, p=.07087 on levels of homesickness.

Figure 11 illustrates that the mean DRI scores for the Experimental group decreased over time (x = 15.37 and 14.63, respectively for Time 1 and Time 2, *Tukey HSD* = 0.73, not significant), where as mean DRI scores for the Control group actually increased over time (x = 14.24 and 15.94, respectively for Time 1 and Time 2, *Tukey HSD* = 0.45, not significant.).

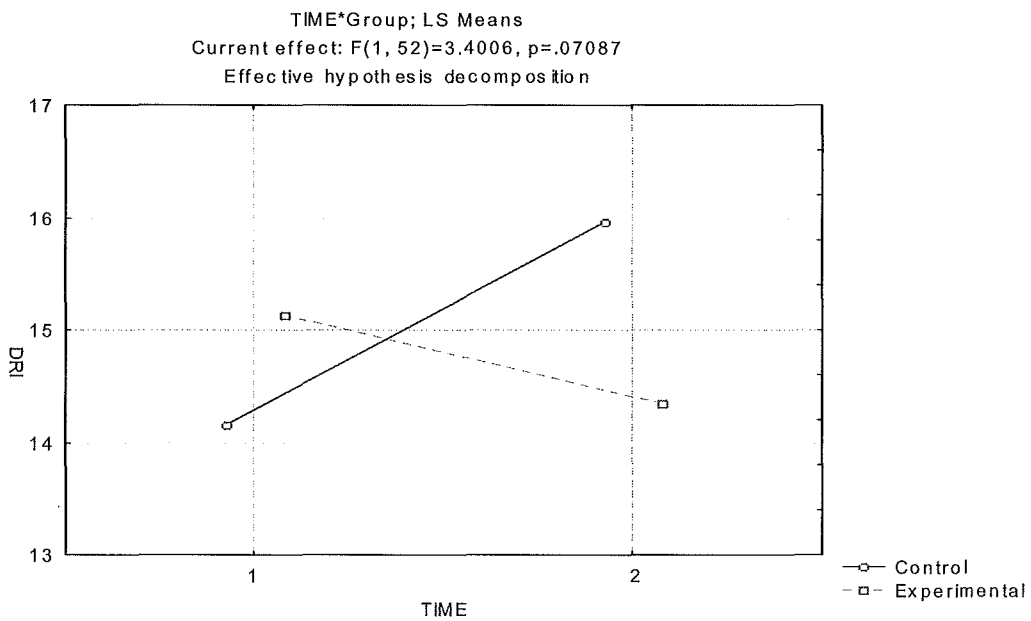

Figure 11. The Effect of Narrative Therapy on levels of Homesickness as reflected by DRI scores.

Further analysis revealed an unexpected finding for the Experimental groups. That is, when levels of homesickness were controlled for, it emerged that although the average level of homesickness decreased from Time 1 to Time 2 for the Experimental Homesick group (x = 20.60 and 18.72, *Tukey HSD* = 0.50, not significant), it actually increased for the Experimental Not-Homesick group (x = 8.11 and 8.94, *Tukey HSD* = 0.99, not significant) (see Figure 12). Interestingly, where the Experimental groups' level of homesickness decreased over time, the Control groups levels of homesickness actually appeared to increase over time for both the HS and NHS participants (see Figure 12 also).

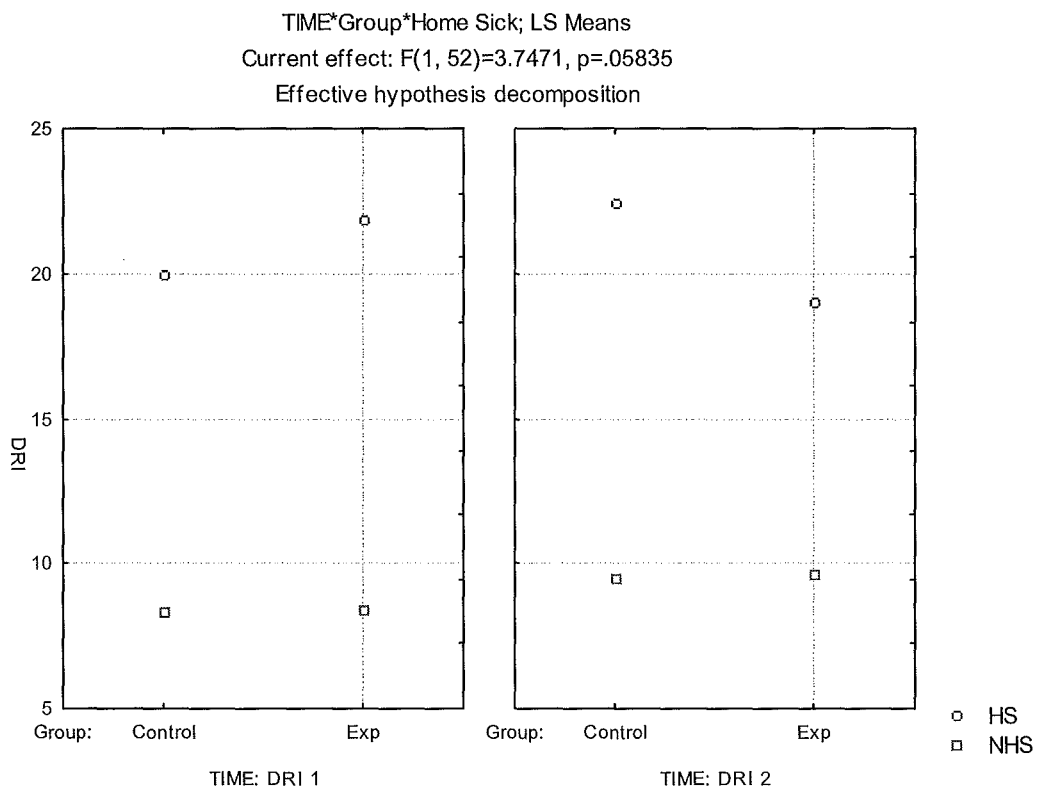

Figure 12. The Effect of Narrative Therapy on levels of Homesickness as reflected by mean DRI scores.

When gender was included, it became evident that the strongest effect occurred for female subjects (see Figure 13). The mean DRI score for the FEHS subjects dropped considerably from Time 1 (x = 25.50) to Time 2 (x = 20.00) (*Tukey HSD* = 0.11, not significant) where as the FCHS mean score actually increased over time (x = 24.50 and 29.25, respectively for Time 1 and Time 2) (*Tukey HSD* = 0.81, not significant). Closer inspection of Figure 9 revealed that the FENHS subjects mean DRI appeared to increase over time (x = 9.00 and 11.20, respectively for Time 1 and Time 2) (*Tukey HSD* = 0.99, not significant).

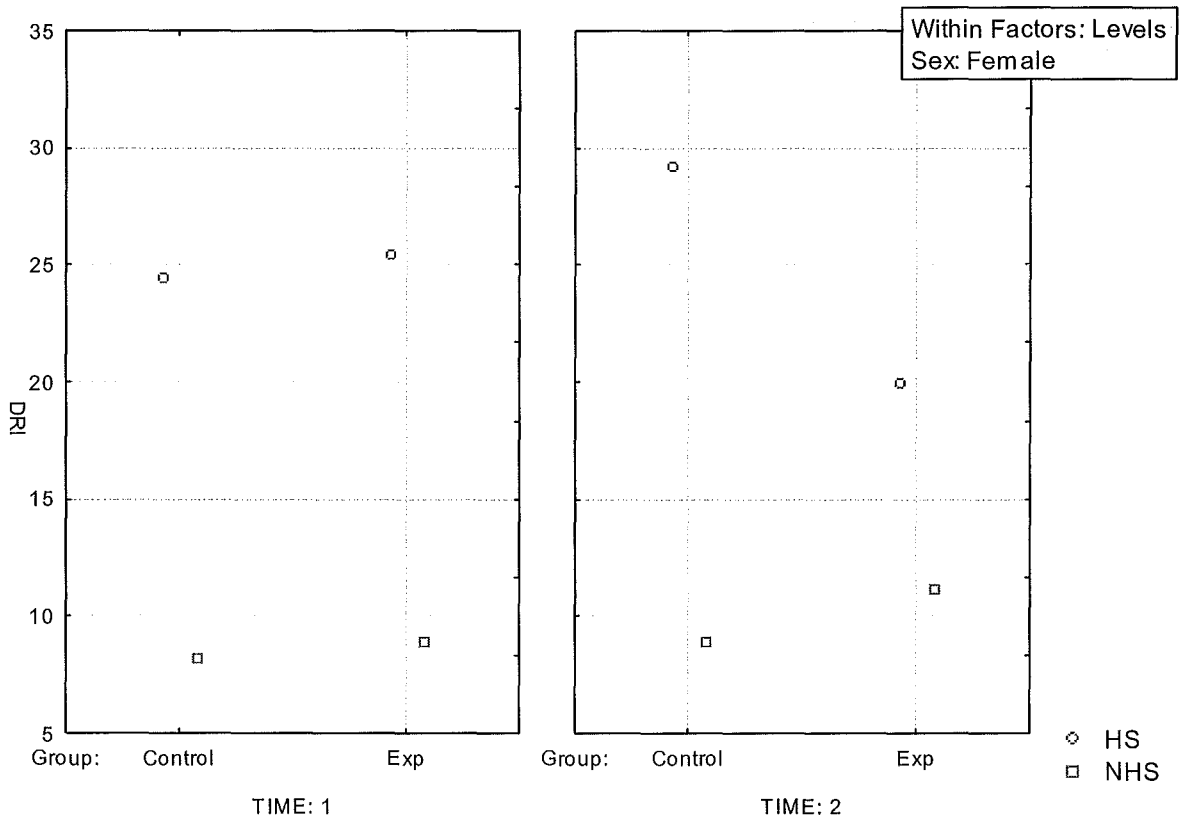

Figure 13. The Effect of Narrative Therapy on mean DRI scores for the four Groups of Female Participants.

For the male participants, narrative therapy appeared to have only a very minor effect that was not statistically significant (see Figure 14). Nonetheless, the changes in mean DRI scores for the four male groups reflected similar trends to those that were found for the female groups. That is, the mean DRI score for the MEHS subjects dropped from Time 1 (x = 18.29) to Time 2 (x = 18.11) (*Tukey HSD* = 1.00, not significant) where as the MCHS mean DRI score increased over time (x = 15.40 and 15.60, respectively for Time 1 and Time 2) (*Tukey HSD* = 1.00, not significant). Like the FENHS subjects, the MENHS mean DRI actually increased over time (x = 7.76 and 8.07, respectively for Time 1 and Time 2) (*Tukey HSD* = 1.00, not significant).

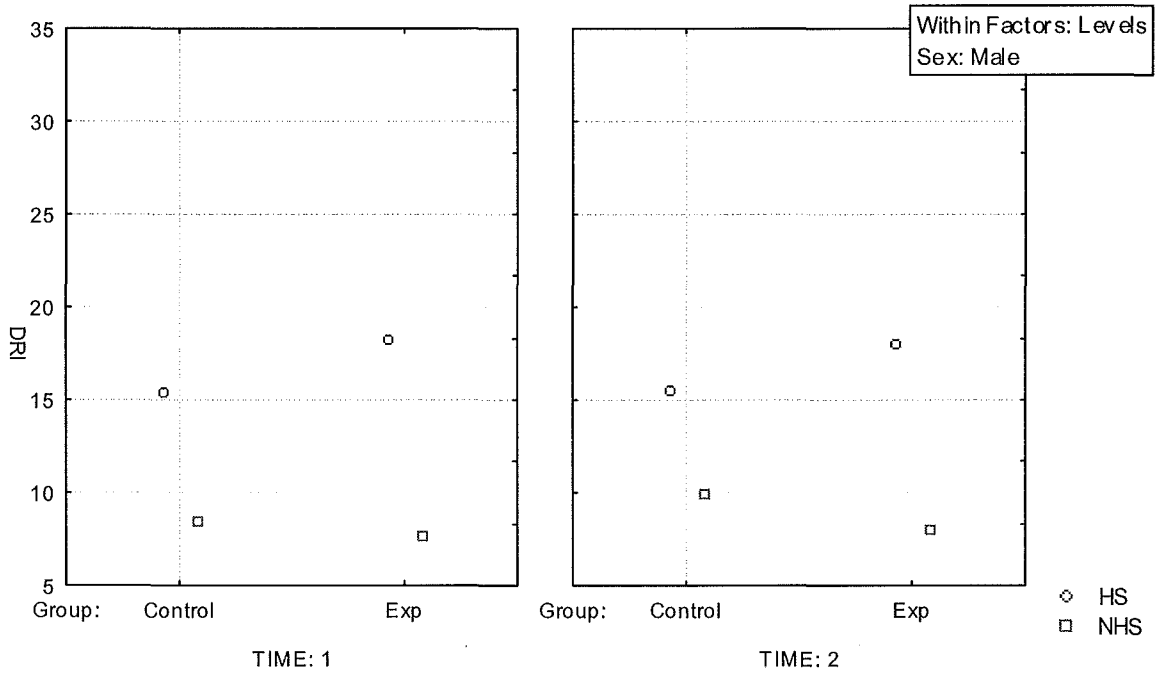

Figure 14. The Effect of Narrative Therapy on mean DRI scores for the four Groups of Male Participants.

Analysis of the HSS scores revealed trends that for the for the most part, were analogous to trends that were found for the DRI scores (see Figure 15). It is interesting to note, however, that where the FENHS mean DRI increased over time, the FENHS mean HSS actually remained the same from Time 1(x = 2.20) to Time 2.

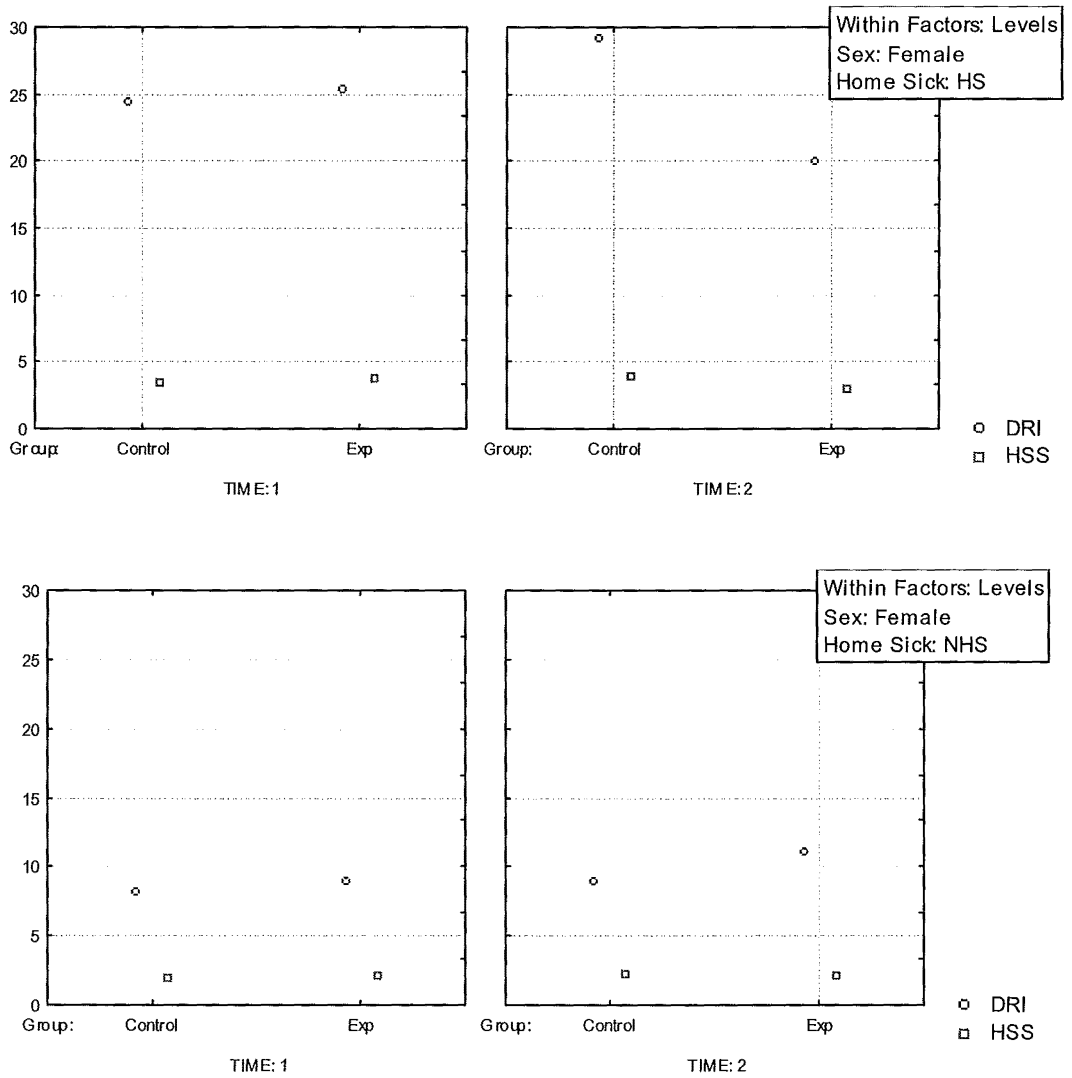

Figure 15. The Effect of Narrative Therapy on mean DRI and HSS scores for the Homesick (top panel) and Not Homesick (bottom panel) Groups of Female Participants.

For the male participants (see Figure 16), there were similar trends related to changes in DRI and HSS mean scores from time one to time two.

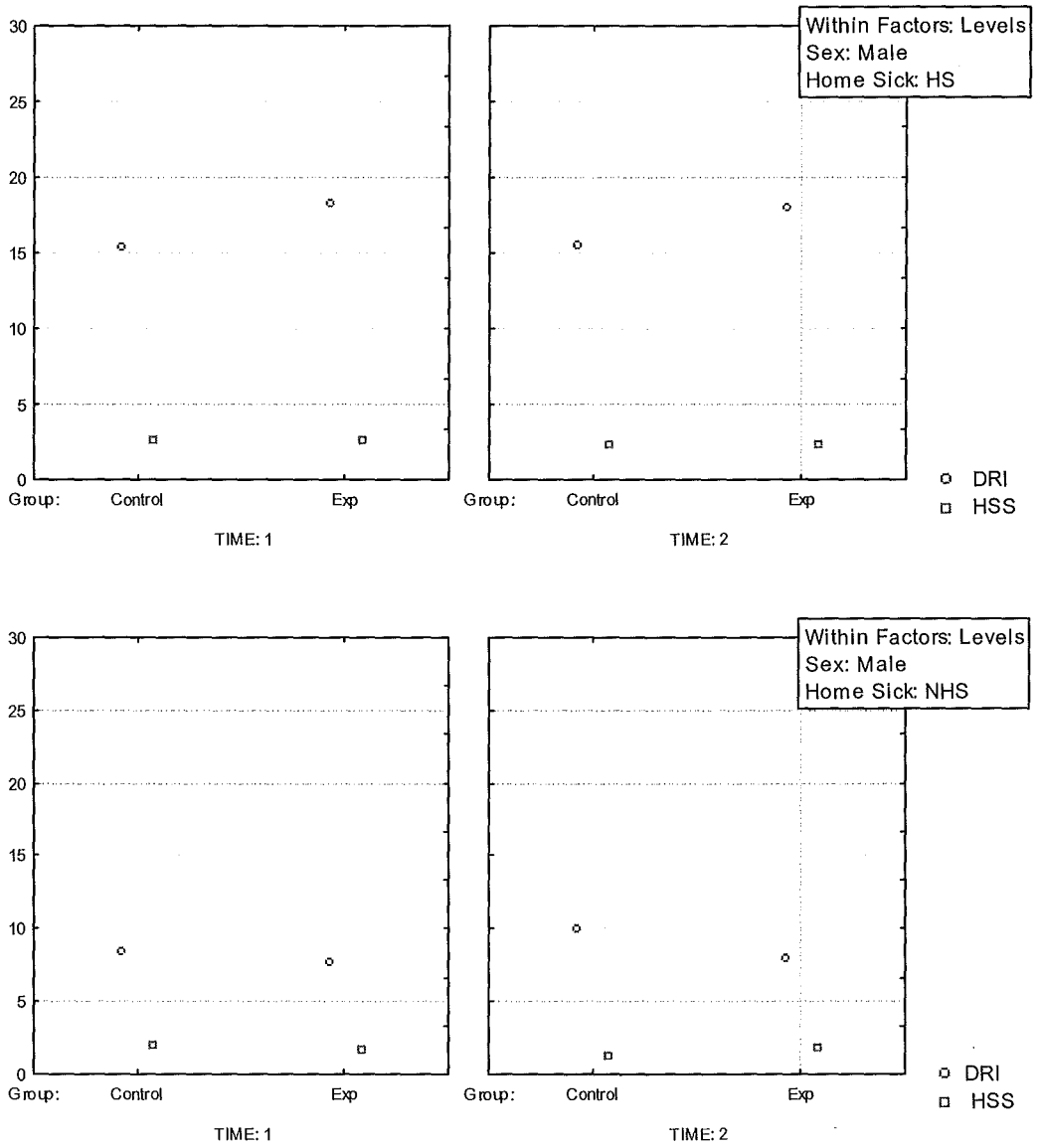

Figure 16. The Effect of Narrative Therapy on mean DRI and HSS scores for the Homesick (top panel) and Not Homesick Groups (bottom panel) of Male Participants.

Changes in the participant's average grade were also investigated. Figure 17 illustrates that there was a statistically insignificant increase in average grade over time for participants in both the Control and Experimental conditions. Encouragingly, there was slightly greater increase in grade for participants experiencing the Experimental (x = 3.34 and 3.59, respectively for Time 1 and Time 2, *Tukey HSD* = 0.31, not significant), rather than the Control (x = 3.43 and 3.51, respectively for Time 1 and Time 2, *Tukey HSD* = 0.58, not significant.) conditions, the interaction was not significant at F (1, 56) = 0.05, p = 0.83.

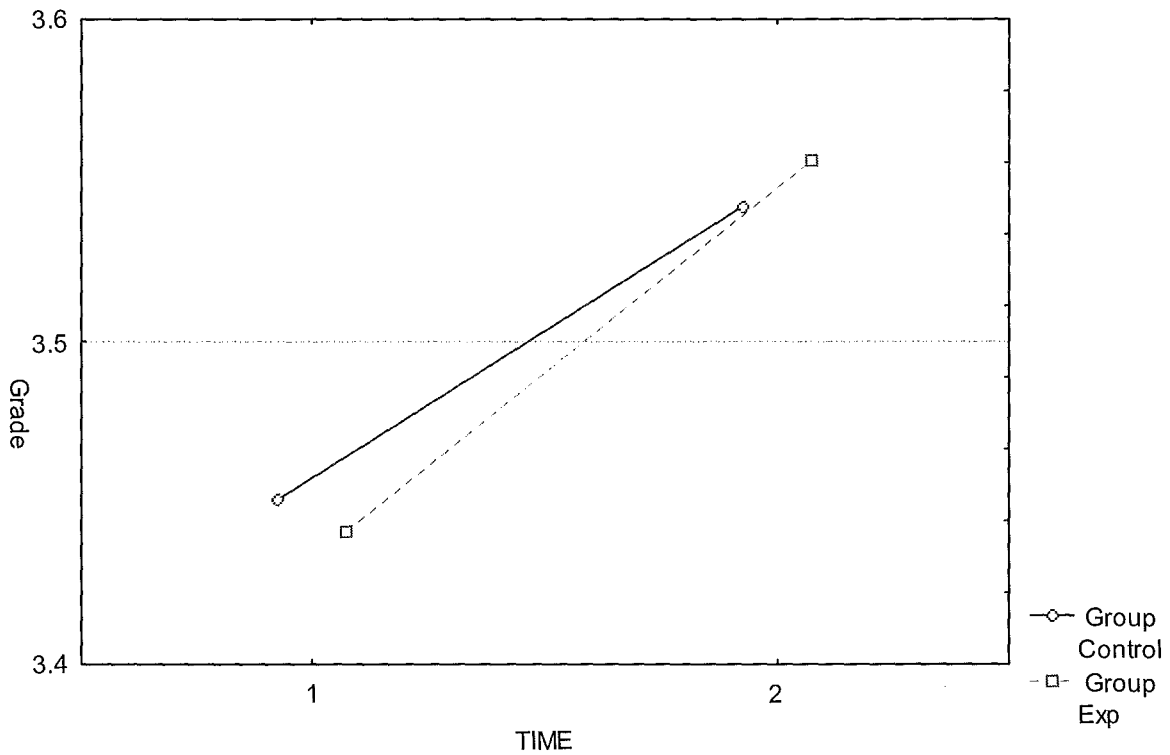

Figure 17. Average Grade at Time 1 and Time 2 for participants experiencing the Control versus the Experimental Conditions

When levels of homesickness were controlled for, an interesting finding emerged (see Figure 18). That is, the Experimental Homesick groups (x = 2.97 and 3.12, respectively for Time 1 and Time 2, *Tukey HSD* = 0.33, not significant), appeared to have experienced a greater increase in grade than the Experimental Not-Homesick (x = 3.85 and 3.89, respectively for Time 1 and Time 2, *Tukey HSD* = 1.00, not significant) group. Furthermore, the average grade of the Control Homesick group remained unchanged (x = 3.20) from Time 1 to Time 2. Although not statistically significant, F (1, 56) = 1.81, p= 0.18, general trends pointed toward a greater improvement in grade for those in the Experimental rather than Control groups.

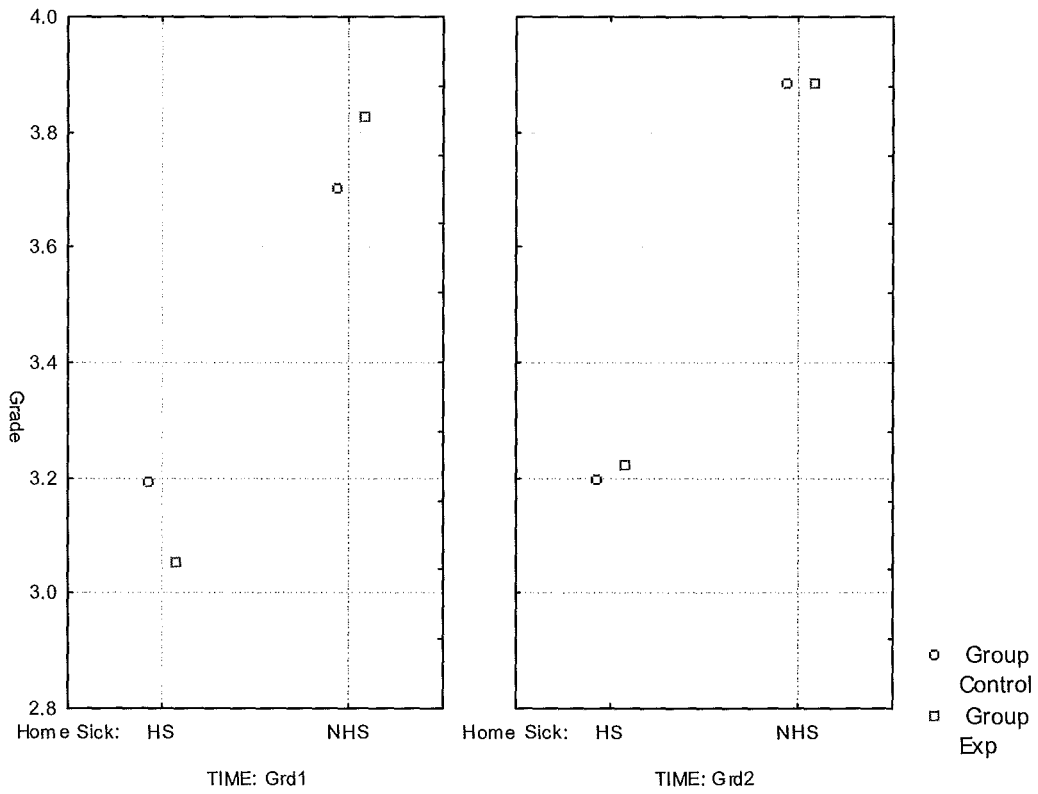

Figure 18. Average Grade at Time 1 and Time 2 for Homesick and Not-Homesick groups within either the Control or Experimental Conditions

When gender was also included, it emerged that the greatest increase in average grade appeared to have occurred for the FEHS group Homesick (x = 3.33 and 3.55, respectively for Time 1 and Time 2, *Tukey HSD* = 0.71, not significant) (see Figure 19, Panel 1). Furthermore, it appeared that the only group that had experienced a decrease in average grade was the MENHS Homesick (x = 3.92 and 3.84, respectively for Time 1 and Time 2, *Tukey HSD* = 0.99, not significant) (see Figure 19, Panel 2).

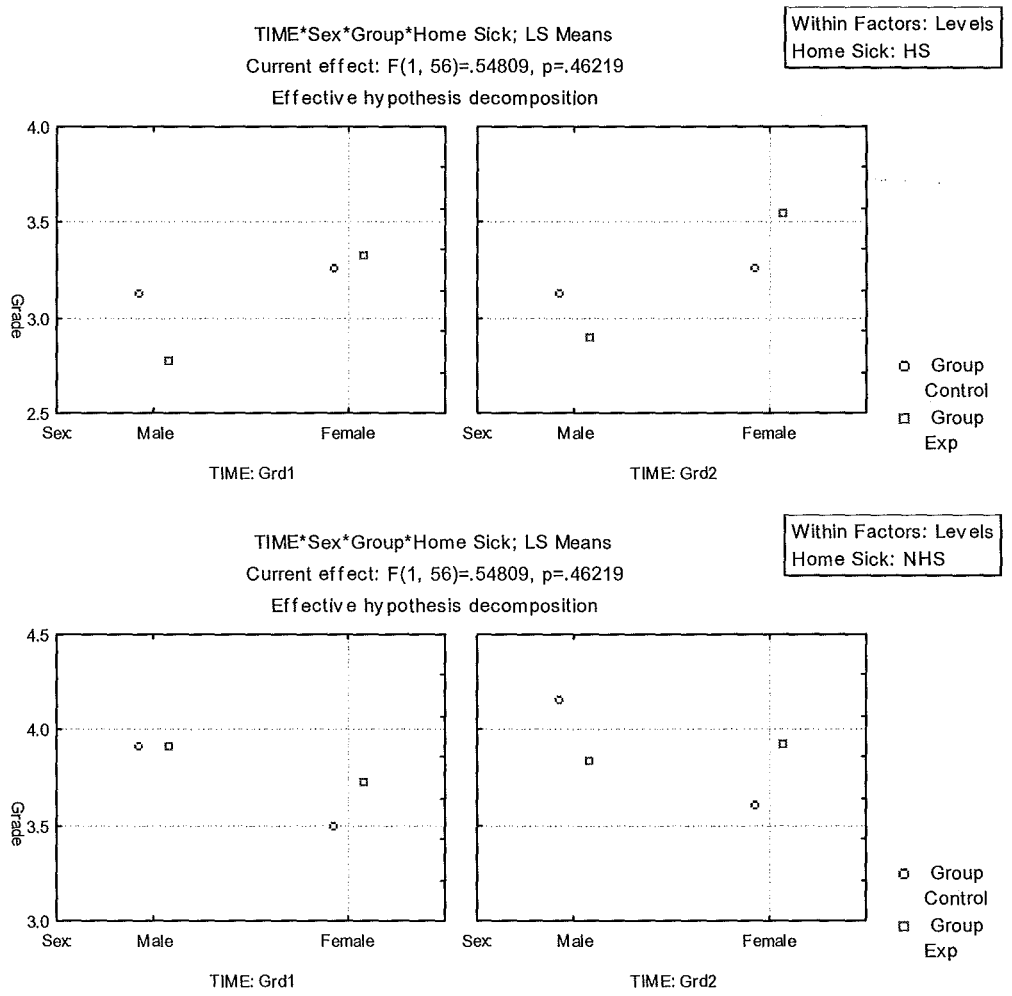

Figure 19. Average Grade at Time 1 and Time 2 for Homesick groups (top panel) and Not-Homesick groups (bottom panel).

An unexpected result surfaced in relation to Absenteeism. That is, the mean number of half days absent increased more dramatically for the Experimental (x = 5.93 and 9.21, respectively for Time 1 and Time 2, *Tukey HSD* = <0.01) than the Control (x = 8.45 and 10.05, respectively for Time 1 and Time 2, *Tukey HSD* = 0.85, not significant) groups (see Figure 20).

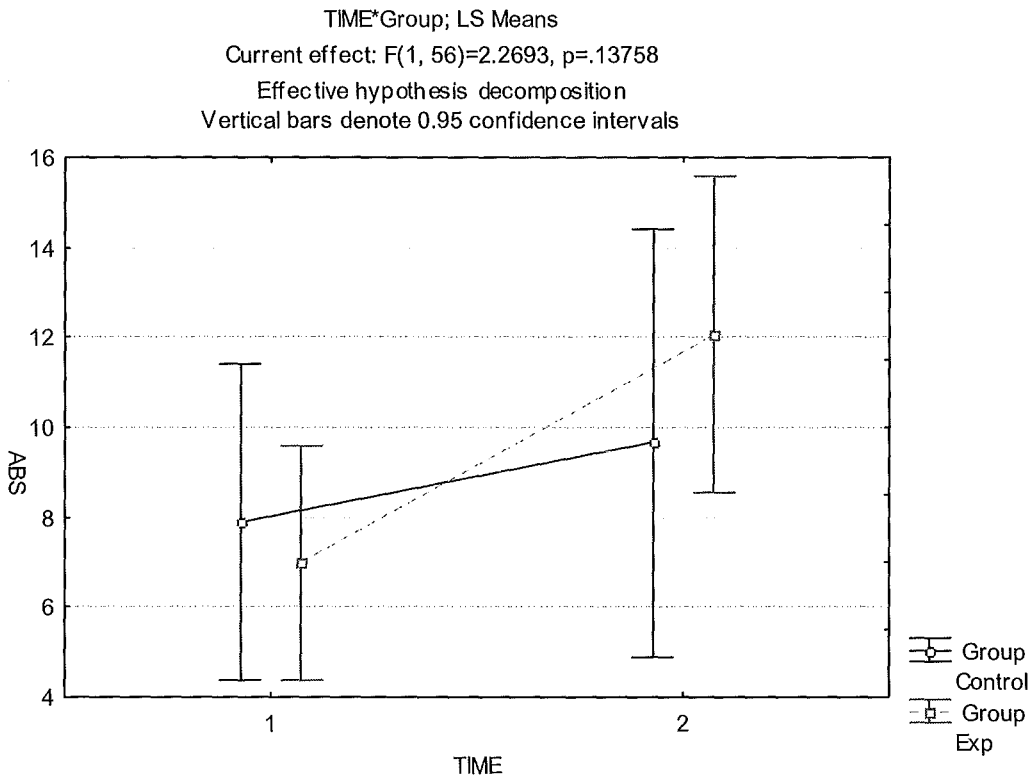

Figure 20. ½ Days Absent at Time 1 and Time 2 for the Control and Experimental Groups.

Further analysis revealed that it was the Female Experimental group who experienced the greatest increase in absenteeism (x = 11.00 and 18.00, respectively for Time 1 and Time 2, *Tukey HSD* = 0.11, not significant) (see Figure 21).

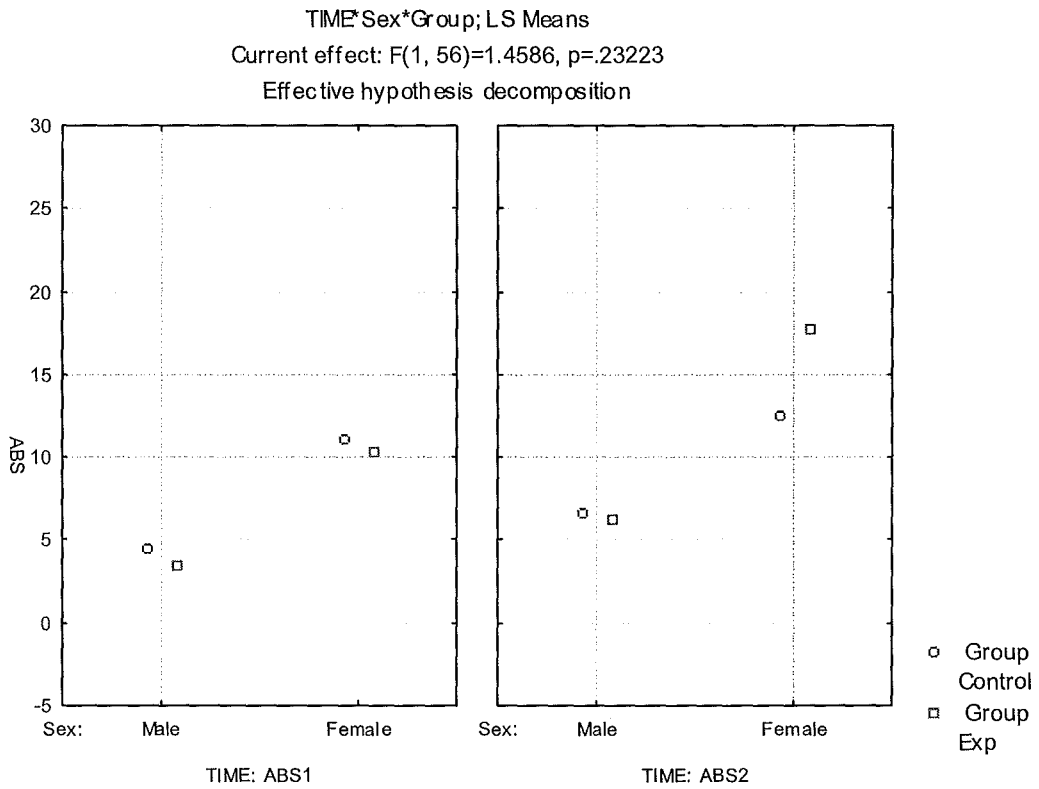

Figure 21. ½ Days Absent over Time for Male and Female participants in the Control Experimental Groups.

When levels of homesickness were included in the analysis for the Female participants in the Experimental condition, it appeared that absenteeism increased slightly more for the not-homesick (x = 8.60 and 16.80, respectively for Time 1 and Time 2, *Tukey HSD* = 0.52, not significant) than homesick (x = 12.33 and 18.67, respectively for Time 1 and Time 2, *Tukey HSD* = 0.95, not significant) participants (see Figure 22).

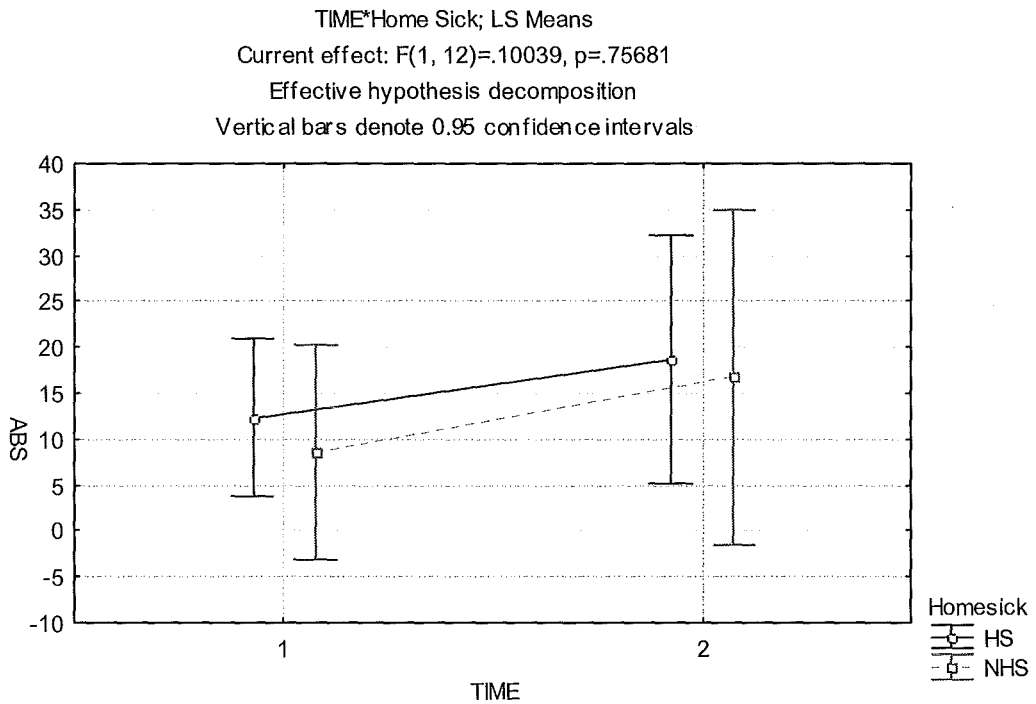

Figure 22. ½ Days Absent over Time for Homesick and Not-homesick participants in the Female Experimental Group.

Diary Completion and Trends

Of the 14 female participants in the Experimental condition who were given diaries, 6 (42%) returned the diary check sheets. The incidence of reported problems averages out to about five or six per person during the six week period. As shown by table 4, the most common entry categories were 'thoughts about things other than boarding school life' (x = 11.84), 'thoughts about boarding school' (x = 9.33), and 'problems and hassels' (x = 9.33). Interestingly, the highest median score was gained for the 'thoughts about boarding school' category.

Table 4. Descriptive Statistics for Frequency of Problems that were Recorded on the Diary Check Sheets.

	Descriptive Statistics				
Variable	Mean	Median	Minimum	Maximum	Std.Dev.
Thgts BS	9.3333	9.0000	1.0000	18.0000	7.84007
Thgts Oth	11.8333	7.5000	0.0000	36.0000	13.48209
Describ	7.8333	6.5000	1.0000	17.0000	5.60060
Probs	9.3333	8.5000	0.0000	21.0000	8.45380
Solut	4.3333	3.5000	0.0000	11.0000	4.50185
Futu	6.5000	2.0000	0.0000	17.0000	8.19146
Oth	8.0000	5.0000	0.0000	26.0000	9.20869

There was a decrease in mean DRI scores both for those who did, and those who did not return their diary check sheets, however the decrease in scores was not statistically significant (see Figure 23). Interestingly, there was a more substantial drop in mean DRI scores for those who did return the diary check-sheets (x = 20.63 and 17.38, respectively for Time 1 and Time 2) than for those who did not return the check sheet (x = 16.80 and 15.40, respectively for Time 1 and Time 2). Of note, the participants who returned the check-sheets had a higher mean DRI at time one than those who did not return the check-sheet.

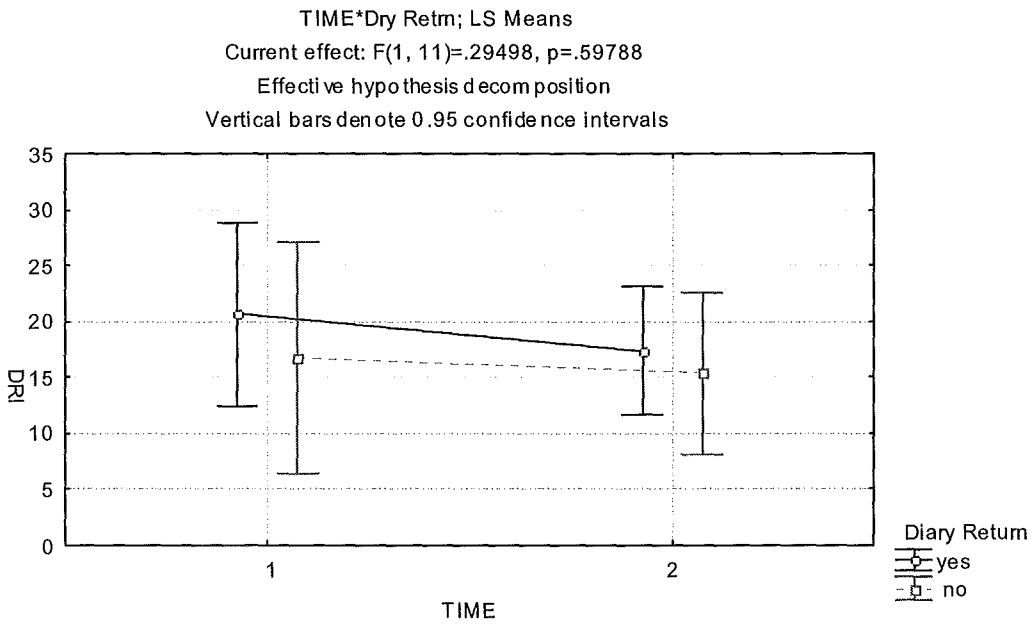

Figure 23. Mean DRI scores at Time 1 and Time 2 for Female Participants in the Experimental Group who Did and Did Not Return the Diary Check-Sheet.

Due to the small sample size and low levels of return very little could be concluded from these results, and further statistical analysis may have of provided misleading information.

3.4 DISCUSSION AND LIMITATIONS

The discussion section is structured in three parts. The first section will review the findings of the data related to prevalence and intensity that was observed within the population prior to the application of a therapeutic intervention. The second section will examine the effect of narrative therapy on the homesickness phenomenon. Finally, the limitations of the present study will be discussed in the third section.

Prevalence and Intensity of Homesickness

In exploring the phenomenology of homesickness the present study found that homesickness was prevalent and varied in intensity. The results indicated that 100% of the sample endorsed a nonzero rating on the DRI 1 measure of homesickness; however such measurement of absolute prevalence grossly overestimates true homesickness. Nevertheless, it could be suggested that all of the subjects that were sampled had exhibited some degree of homesickness. Examination of scores revealed a median of 13, an overall mean of 15.09 and a standard deviation of 8.08. The scores ranged from 4 to 36, with, an inter-quartile range of 9 to 20.5. The obtained DRI 1 mean is close to the 17.5 mean that was obtained by Fisher (1989) whilst using the DRI measure in an investigation of first year university students.

Comparison of male and female mean DRI 1 scores showed that the females (DRI 1 x = 17.72) scored more highly than the males (DRI 1 x = 13.41) for average levels of homesickness. The finding that the females had slightly higher levels of homesickness than males differed from earlier research, Fisher (1989), for example, found few clear direct sex differences in relation to developing homesickness.

There are several potential explanations that may go some way towards accounting for the gender differences that were found in the present study. The most visible of which is that the participants were based at gender specific schools, thus they experienced distinctly different environmental demands and supports. The different environments may have directly affected the level of homesickness that was experienced, or possibly the level of homesickness that was reported.

Interestingly, the Education Review Office (ERO) had completed supplementary reviews of the schools just prior to the investigation taking place. The focuses of the reviews were distinctly different for the two schools. The males' school was "*invited to consider its priorities*" (http://www.ero.govt.nz/publish/reppub.ns4/Schools) for review, and the hostel was incorporated into the general review of the school, where as for the females school, the terms of reference for the review was to "*investigate the quality of the...Hostel*" (http://www.ero.govt.nz/publish/reppub.ns4/Schools) in particular.

It would be remiss not to attend to anecdotal reports of feelings of discontent and pessimism that emerged at the female's school and appeared to contrast to a type of partisanship that was perceptible at the male's school. Feelings of dissatisfaction with relationships with the boarding hostel staff and environment that were expressed included a lack of trust and support, inconsistent and unfair discipline, cold draughty prep rooms, and limited access to computers and the Internet. Interestingly, ERO identified many of these facets under the 'Areas for Improvement' portion of the report:

> ...The physical spaces and resources for study do not adequately support students in their learning. The Year 9 and 10 students study in a separate area that has inadequate heating and no resources to support or encourage their learning... There is a small collection of reference material in the Year 9 common room but this is outdated...There is limited access to computers and the Internet. There is one computer per twenty students and no formal procedure for making bookings...There are inadequate systems for identifying and dealing with physical hazards...There is no documented record of safety checks...inadequate procedures for monitoring the time that medicines are administered...Staffing levels are insufficient to ensure the safety and wellbeing of boarders...Students are still not confident about their relationships with all boarding house staff.

individual's predisposition towards developing homesickness. On the other hand, if the pupil's home-life provided a secure consistent environment with freedom and personal space, then hostel life may seem comparatively unpredictable and restrictive. It is also likely that personality traits, in combination with individual expectations and pre-relocation knowledge about the new environment may have contributed to the intensity of any homesickness that was experienced.

The 'Comprehensive Psychological Model' recognizes the influence of environmental demands and hypothesizes that if coping skills are deficient then a state of homesickness may emerge. It is proposed that if there is no improvement in coping skills then the homesickness may become 'Pathological'. Given that the present investigation was undertaken in the second semester then it is plausible to propose that any pupils who were experiencing 'Pathological Homesickness' may have already returned home. Furthermore, it may be that some pupils who remained at boarding school may have been experiencing a state of 'Chronic Homesickness'. It is proposed that chronic homesickness is a continuous mild state in which coping skills are sufficient to ensure that adequate, but sub-optimal, day to day functioning is achieved. For the homesick female pupils in particular, it may be that the environmental demands were such that coping skills although sufficient, were not able to be improved as much as necessary to allow the pupil to achieve cognitive assimilation, commitment and successful adaptation to the new environment.

Generally students are not willing to confide in staff members. Staff do not consistently respect the confidentiality of their discussions with students...Some staff do not recognize students' health issues nor do they take their symptoms seriously... The current approach to discipline does not encourage girls to take responsibility for their own behavior. It is negative, inconsistent and based on punishment... Currently counselling and advocacy are not available to boarders out of school hours. ...There are concerns from a range of sources about the way that information is dealt with and confidentiality maintained. There is no specific support system for international students at the hostel... (http://www.ero.govt.nz/publish/reppub.ns4/Schools).

In contrast, the ERO report of the males' school only identified two key areas within the hotel that needed improvement:

Hostel manager guidelines. The principal has not clearly documented his expectations of the hostel manager so that current good practice is more likely to be sustained as personnel change.... Consideration should be given by the hostel manager to establishing a more formal staff appraisal system. Giving staff feedback on what they do well and identifying areas for improvement would help to maintain consistently high levels of staff performance (http://www.ero.govt.nz/publish/reppub.ns4/Schools).

When the gender differences that were found by the present study are considered within the context of the ERO reports and then applied to theoretical formats such as Fisher and Hood's (1987) 'Job Strain' model and Fisher's (1989) 'Composite Model of Homesickness', a probable explanation emerges. Given that numerous factors ranging from basic safety and heating to provision for a safe emotional environment were found to be deficient in the female's hostel but not the males hostel, then it would be reasonable to suppose that levels of perceived strain and demand were higher for the female participants than the male. Furthermore, there may have been a greater disparity between what was desired and what was obtained for the females than males.

Fisher's (1989) 'Composite Model of Homesickness' suggests that the male's hostel environment may have moderated any homesickness created by loss, separation, interruption, reduced control, or role change. On the other hand, there is the possibility that the deficiencies in the females hostel environment actually contributed to the development of homesickness, especially if the hostel was not compatible with the individual's expectations.

It would be negligent not to attend to the reality that not all of the female subjects were found to be homesick, and that although the males were less homesick than the females in general, a number of males were found to have high levels of homesickness. Thus although the models (Fisher and Hood, 1987; Fisher, 1989) are useful in that they attend to the influence of the new environment, if the new environment was the sole mediator in the development of homesickness then one might expect the levels of homesickness to be constant within the specific environmental sample. Consequently, the 'Comprehensive Psychological Model' of homesickness may provide a useful framework from which to theorize about the differences in levels of homesickness that were found in the present study.

The 'Comprehensive Psychological Model' attends to the pre-dispositional factors, etiology, and dynamic nature of the homesickness phenomenon. At the outset, the model acknowledges that a number of personal vulnerabilities, including attachment issues, personality features, and little prior knowledge of the new environment, may predispose an individual towards developing homesickness. Thus the model adheres to the principle that individuals who are vulnerable to homesickness may differ from their non-homesick counterparts prior to leaving home. For example, elements of the pupils home environment may influence their perception of the hostel environment, an unstable or even abusive home-life, for instance, may result in the hostel being perceived of as safe stable environment that may be preferable to home. Alternatively, an unstable home-life coupled with insecure attachments to key figures may actually intensify the

Of the many different interpretations for the gender differences that were found in the present study, gender role socialization may be of some relevance. Given that gender specific socialization has been implicated in the higher incidence of mental health problems such as depression among women (Kaplan, 1986; Kaplan et al., 1983), then it is reasonable to speculate that the differences in gender socialization that are present in Western society may have contributed to the finding that females experienced a greater intensity of homesickness than males. Research by Brewin et al. (1989) may offer some support for the proposal that gender role socialisation may impact upon homesickness. Brewin et al. (1989) reported that although homesickness is equally probable in men and women, gender influenced the subject's reactions to homesickness. Females were found to be more likely to discuss homesickness than males, and it may follow that females are also more open to reporting it.

Arndt (1986) believes that not only are males socialized to deny the existence of negative emotional feelings but some are brought up so instrumentally that they are actually unable to recognize their negative emotions. Consequently it would follow that the male boarding pupils may not have been equipped to identify and recognize their negative emotions. However using the DRI, a scale that assessed homesickness on the basis of answers to specified questions, should have gone some way to overcoming this problem. It is more probable that some of the males may have actually denied the existence of homesickness. In addition there may have been a reporting bias

secondary to a perceived social desirability, (homesickness is thought by many to be a weakness) (Fisher, 1989), and it may follow that it was perceived of as less socially acceptable for males to admit to homesickness than females.

An investigation of the relationship between the subject's scores on DRI 1 and scores on the HSS 1 revealed a strong positive correlation of 0.74. This is noteworthy because the relationship between *self assessed* binary measures of homesickness and *validated homesickness* scales have not yet been directly investigated. The strong positive correlation for the relationship between the DRI 1 and the HSS 1 is however, consistent with studies that have found self assessed homesickness levels to have been validated with *observer reports* of homesickness (Thurber, 1995).

In order to investigate the relationship between level of homesickness, academic grade, and ½ days absent from school a correlational analysis was performed. The correlation matrix revealed that grade negatively correlates to both DRI 1 scores (r = -0.56) and HSS 1 scores (r = -0.39). The finding that the intensity of homesickness was negatively correlated with academic performance is consistent with earlier research that suggests that homesickness may exercise a negative influence on academic performance, at least over the short term. An association between homesickness reporting and an increase in cognitive failures, handing work in late and decrements in work quality have been found (Fisher, Murray & Frazer, 1985; Fisher & Hood, 1987).

It is possible that the academic difficulties may be secondary to other symptoms that are associated with homesickness such as obsessional thoughts about home, absentmindedness, sleep difficulties, apathy, and physical complaints. Earlier research (Fisher et al, 1985) reported significant positive correlations between the frequency measure of homesickness (that is, how frequently homesickness episodes are experienced) and the degree to which academic work was affected ($r = 0.46$), the degree to which there was a lack of concentration ($r = 0.47$) and work handed in late ($r = 0.42$).

Theoretical models proposed by Fisher (1989) offer several potential explanations for the effect of homesickness on academic performance. Consistent with the 'competing demands model' (Fisher, 1989) it is possible that the degree to which the pupil had committed to hostel life determined how much attentional resource was available for academic work as opposed to being consumed by thoughts about home. It is also possible, as proposed by the 'demand strength model' (Fisher, 1989) that the intensity of homesickness that was experienced influenced attentional ability, that is, the more homesick the pupil, the more attentional resources were captivated by 'home' related thoughts and desires. The models were not directly investigated in the present study; however it is prudent to mention that support (Burt, 1993) has been found for both model's, the evidence for the former model, that commitment enhances academic functioning, was stronger than the support for the later.

The 'Comprehensive Psychological Model' of homesickness may be a framework that is also of some use for speculating about the negative correlational relationship between grade and level of homesickness. The rationale underlying the state of 'Chronic Homesickness' may be of particular relevance. The 'Comprehensive Psychological Model' proposes that chronic homesickness is continuous mild state of homesickness in which coping skills are sufficient to ensure that adequate, but sub-optimal, day to day functioning is achieved. Thus it would follow that pupils who were in a chronic state of homesickness may have lower grades than their not-homesick counterparts, but not necessarily failing grades. That is, those who are experiencing chronic homesickness may produce school work that is passable, but below their academic potential. Furthermore, the model proposes that individuals who are in a chronic state of homesickness have not comprehensively cognitively assimilated the relocation experience, and thus have not to achieve complete commitment to the new environment. Interestingly, Burt's (1993) research that found that commitment enhances academic functioning, thus there is some support for the proposal that those who are experiencing chronic homesickness and have not committed to the new environment may be more susceptible to academic decrement.

Although earlier research (Fisher et al, 1985) indicated that poor attendance at lectures was more likely to be greater in university students who were homesick, the present study found no significant relationship between absenteeism and DRI 1 ($r = 0.16$) and HSS 1 ($r = 0.16$) scores. It is probable that the present finding differed from Fisher et al's (1985) due to differences in the populations. While it was compulsory for 3rd and 4th form participants of the present study to attend classes, it is not usually obligatory for university students to attend lectures.

The Effect of Narrative Therapy on Homesickness

The study found some support for the therapeutic effects of narrative therapy on levels of homesickness. When examined collectively, comparison of the Control and Experimental groups mean DRI scores from Time 1 to Time 2 showed a small reduction in levels of homesickness for the Experimental group, where as the level of homesickness for the Control group actually increased over time.

Further analysis revealed an unexpected finding for the Experimental groups. That is, when levels of homesickness were controlled for, it emerged that although the average level of homesickness decreased for the Experimental Homesick group it actually increased for the Experimental Not-Homesick group. Thus a number of the participants that received narrative therapy essentially worsened over treatment. This was an interesting finding, of which there are several potential explanations.

Fisher's (1989) attentional resource model proposes that the demands or threats of a new environment are differentially resisted by internal resources, and that the new environment provides information which competes for resources with homesick ruminations. It is possible that those boarding pupils who were not homesick were committed to the hostel environment and that the environment moderated the homesick experience for them because it provided competing sources of information that attenuated homesick ruminations, furthermore, it may be that the not-homesick participants had actively decided not to think about home. It has been established (Fisher, 1987; Fisher and Hood, 1987; Thurber, 1997) that internal and 'self focused' thoughts may be attenuated by external sources of information that dominate attentional resources. It is possible to speculate that narrative therapy may have 'flicked the balance' of attentional resources for those participants who were not homesick. It may be that narrative therapy actually promoted undue deliberation of the hostel environment and boarding experience thus essentially stimulating the ruminative activity that is associated with homesickness.

It is not unusual for 'efficacy of treatment' studies to occasionally find results that suggest that the treatment of interest may be problematic for some subjects. Investigations related to posttraumatic stress disorder (PTSD), for example, have found that exposure therapy (which typically includes imaginal exposure (IE) to memories of the trauma) has been associated with symptom exacerbation and high drop out rates (Pitman, Altman, Greenwald, Longpre, Macklin, Poire, Steketee, 1991; Tarrier, Pilgrim, Sommerfield, Faragher, Reynolds, Graham, Barrowclough, 1999). At a very basic level narrative therapy and IE could be compared as both are confronting deeply personal issues and both are emotionally powerful. Furthermore, Esterling et al. (1999) propose that written disclosure is merely another form of exposure to traumatic stimuli, in which the participant is re-exposed time and again to the same traumatic stimuli, permitting the development of greater insight and control. Tarrier et al. (1999) believe that IE treatment for PTSD that focused specifically on the meaning and the consequences of the trauma may well be effective, where as discussion of thoughts and emotional reactions resulting from the trauma could result in therapy avoidance amongst other problems. It is conceivable that a similar mechanism may have influenced the effect of the narrative writing exercise in the present study. The Experimental groups were instructed to "*...write about your very deepest thoughts and feelings concerning coming to boarding school...*", it may be that any negative effect from the underlying mechanism was particularly potent for those who had low levels of homesickness at the outset.

It is feasible to propose that the increased level of homesickness that was observed in the ENHS group was attributable to an upsurge in negative mood that occurred after the writing sessions. Interestingly, it has been identified that emotional state after writing is dependant on how an individual feels before the session, the better the individual feels before the session, the worse they feel afterwards and alternately, the worse an individual feels prior to writing, the better they feel afterwards (Murray & Segal, 1994). This finding may go someway towards explaining the mechanism underlying the problematic results that were found for the ENHS participants in the present study.

Critics may argue that it is difficult to determine whether the rate of symptom exacerbation among the ENHS participants was any different from what would have been observed in the absence of treatment or with different treatments. For that reason it essential that the reader's attention be directed to the findings of the Control group. The mean level of homesickness for the Control Not-Homesick (CNHS) group was undeniably observed to also increase over time, however not to the extent that ENHS mean level of homesickness increased. Thus it would be sound to propose that at least some increase in the level of homesickness that was found for the ENHS group may have been attributable to the passage of time. Homesickness is a dynamic phenomenon nonetheless, and it is well established that experiences are episodic (Fisher, 1989; Van Tilburg, et al., 1996).

When gender was included as a variable in the statistical analysis of the effect of narrative therapy on homesickness it became evident that the strongest effects, both negative and positive, occurred for the female subjects. Nevertheless the changes in mean levels of homesickness for the male groups reflected similar trends to those that were found for the female groups; however the effect of narrative therapy appeared to have been only very minor for the males. There are a number of possible explanations for finding that the strongest effects occurred for the female subjects.

It is noteworthy that to date no consistent personality or individual difference measures have been found to distinguish who does and does not benefit from emotional writing. The most frequently examined variables that have *not* been found to relate to outcomes include gender, age, anxiety, negative affectivity, and inhibition or constraint (Pennebaker, 1997; Pennebaker & Seagal, 1999). Thus it is feasible to speculate that the gender related differences that were found in the present study may have been complicated by additional factors. As previously discussed, the most obvious of which is that because the participants were based at gender specific schools they experienced distinctly different environmental demands and supports. The different environments may have directly affected not only the level of homesickness that was experienced, but also their engagement and connection with the narrative exercises.

There were two major defects of the present study that resulted in procedural differences between the two schools. Firstly, an ideal environment would include participants seated in completely private individual cubicles. Due to the nature of the present study providing participants with individual cubicles was not a feasible option, thus it was decided to seat the participants individually at small study tables in their 'prep rooms'. This method was followed at the females school with encouraging observations, the participants were quiet, and appeared to be engaged with the writing task. However there was a less desirable circumstance at the males school. At the schools request the male participants were seated four to a table in the dining hall (the tables usually seat six). There appeared to be a disregard for the regular requests to undertake personal work and not to converse with others at the table. Some of the male participants were observed to be having conversations with each other and even sharing their work. Thus the male participants appeared to have a very low level of engagement with the task compared to the females. The low level of engagement that was observed among the male participants may very well have affected the lower level of the effect that narrative therapy had for the male participants as compared to the female.

The second main defect was that at the schools recommendation, the male experimental participants were not given diaries; unfortunately this experimental flaw resulted in the female and male experimental groups being exposed to somewhat different narrative interventions. It may be that the more pronounced effects that were observed for the female participants were related to their continuation of the writing exercise. In light of the low number of participants, the divergent environmental circumstances between the hostels, and differences in level of task engagement between the males and females, it would not be appropriate to draw conclusions about the effect of either narrative therapy or the diary task on the collective sample.

Nonetheless, it is worth mentioning that within the female group, levels of homesickness for those who returned the diary check sheet were noted to have reduced more significantly that for those who did not. However it is important to note that those who did not return the diary check-sheet were found to have lower levels of homesickness to start with. Even so, it would seem reasonable to tentatively suggest that for those with higher initial levels of homesickness, continuation of emotional writing through a diary or journal may enhance the beneficial effects that narrative therapy exerts on homesickness. As proposed by 'The Comprehensive Psychological Model' it may be that narrative therapy provided a therapeutic intervention that facilitated cognitive assimilation of the boarding experience, which was consequently followed by heightened commitment, enhanced adjustment, and reduced levels of homesickness.

Murray and Segal (1994) found that emotional state after writing is dependant on how an individual feels before the session. In line with Murray and Seagal's (1994) findings one may speculate that individuals who perceive higher levels of stress, dissatisfaction, and homesickness not only tend to feel better after participating in a narrative exercise, but are also more inclined to engage and stay with the task, thus gaining more benefits from the therapeutic intervention than those who are less homesick at the outset.

An alternative explanation for the more prominent effect of narrative therapy for the females as opposed to the males is that the (anecdotally) higher levels of dissatisfaction in the females hostel as compared to the males not only contributed towards the onset and increase of homesickness amongst the females, but also made the effects of narrative therapy more prominent for the females than males. It is possible that the females may have had higher levels of hostility and resentment towards boarding school (secondary to greater environmental stressors) than the males, and it is worth noting that individuals with high levels of hostility have been found to benefit more from emotional writing than those low in hostility (Christensen, Edwards Wiebe, Benotsch, McKelvey, Andrews, and Lubaroff, 1996).

When examining the gender related differences that were found in the present study it is also important to consider a number of underlying gender specific mechanisms (i.e. beyond the circumstantial or environmental distinctions). Of particular relevance is the relationship between coping style and gender. Researchers (e.g. Thurber and Weisz, 1997; Frydenberg and Lewis, 1993) have identified that where girls, on the one hand, tend to turn towards social support and wishful thinking when attempting to cope with homesickness; boys on the other hand, are more likely to engage in a physical activity in an attempt to forget about being homesick. It may be that for homesick males, it is more effective (or simply more appealing) to engage in secondary coping such as participating in distracting physical activity rather than translating their feelings and experiences into words. Although germane, this hypothesis is inconsistent with research (Pennebaker, 1997; Pennebaker & Seagal, 1999) that has found that no consistent individual differences (including gender) have distinguished who does and who does not benefit from emotional writing. Nonetheless, it would be prudent for helping professionals who are treating homesick individuals to attend to the reports that males and females engage in different kinds of coping. In addition to using a cognitive assimilation based approach to treating males with homesickness, it may be useful to concurrently encourage them to participate in physical activity in order for them to firstly engage, and then capitalize on coping skills.

Analysis of the HSS scores over time revealed trends that for the most part, were analogous to trends that were found for the DRI scores. This suggests that the changes in measured levels of homesickness were consistent with changes in self rated perceived levels of homesickness. Changes in the participant's average grade were also investigated. There was a minor increase in average grade over time for participants in both the control and experimental conditions. This indicates that at least some of the increase in grade for those in the experimental groups could be attributable to the passage of time. However, the finding that there was slightly greater increase in grade for participants experiencing the experimental, rather than the control condition was promising. This is consistent with research that has reported that writing about emotional issues related to relocating to college has been found to positively influence grade (Pennebaker & Beall, 1986; Pennebaker, Colder, & Sharp, 1990).

When levels of homesickness were included in the statistical analysis of grade related data, it emerged that the Experimental Homesick groups appeared to have experienced a greater increase in grade than the Experimental Not-Homesick group. When gender was also included, it transpired that the greatest increase in average grade appeared to have occurred for the FEHS group, this trend was consistent with the study's earlier findings related to changes in levels of homesickness. The improvement in grade, particularly for those who are homesick, was very encouraging. As previously discussed, problems with concentration and academic difficulties in homesick students are well documented (Fisher and Hood, 1987; Fisher, Murray, & Frazer, 1985). The results of the present study suggest that narrative therapy may provide a useful intervention which goes some way towards ameliorating the deleterious effect that homesickness exerts on academic performance.

An unexpected result surfaced in relation to Absenteeism. That is, the mean number of half days absent increased more dramatically for the Experimental than the Control groups. Further analysis revealed that it was the FENHS group who experienced the greatest increase in absenteeism. It is difficult to provide an explanation for this finding. It may be, that for the FENHS group the increase in absenteeism corresponded with the increase in mean levels of homesickness. However increased absenteeism was also observed for the FEHS, and levels of homesickness were found to *decrease* for this group. It is possible that a concealed factor, such as physical illness, was related to the FEHS groups increase in absenteeism. Physical ill-health was not controlled for in the present study, and it would be judicious for future studies to include this variable.

Of the 14 female participants in the Experimental condition who were given diaries, 42% returned the diary check sheets. Problems with low return levels in diary studies on homesickness have been identified by earlier researchers. Fisher and Hood (1987), for example, reported return rates of as low as 20%. The low return rate in the present study poses a problem because the initial group sizes were so small (e.g. FEHS (n = 8), FENS (n = 5). The low return level from such a small initial sample both limits the power of the analysis, and increases the likelihood of misleading results. Thus although interesting and possibly of some pre-emptive value for future research it would not be appropriate to make generalizations or draw conclusions from the diary related data.

Limitations of the Present Study

Limitations of the study concern several areas, some of which, such as procedural differences between the two schools have already been discussed. Beyond the previously mentioned procedural limitations, the most notable defect of the present study was that the group sizes were small. Due to the need for deeper statistical analysis, it was essential to divide the sample into groups. Although there was an initial total of 66 participants, only 60 participants completed the study. When level of homesickness, gender and condition were controlled for, there were a total of eight groups. A defect of the present study was that there were low numbers of participants per group, particularly for the females, for example, for both FCHS and FCNHS (n = 4), for FEHS (n = 8), and for FENS (n = 5). There was a potential sample of 35 year 9 and 10 pupils boarding at the girls school, 32 (91%) gave consent to participate, 25 girls completed the initial questionnaires; however a final number of only 21 girls completed the entire study. It is probable that the low completion rates were affected by the time of day that the study took place. Some of the participants had evening commitments including hockey practice, music lessons, and swimming that took precedence over completing the requirements of the present study. As previously mentioned, it is well established (e.g., Weiten, 1992) that small sample sizes limit the power of the analysis, and the likelihood of misleading results is much greater in a small sample. Furthermore, the characteristics of the sample (year 9 and 10 boarding pupils from two Christchurch Secondary Schools) limit generalization.

There were a number of additional constraints that emerged in relation to the present study. Firstly, in clinical practice, most assessment of incidence of psychological states involves classification of recalled symptoms leading to a 'diagnosis' by a psychologist. However, in the present investigation the pupils were aware that the research was 'An Investigation of Homesickness', and when prompted by a term or label individuals may be more likely to use the term homesickness to describe their experience. When the label 'homesickness' is present for endorsement it may indeed act as a catalyst for the grouping of feelings of distress. The labeling problem is a difficulty faced by all questionnaires which are dependant on self report (Fisher, 1989).

The labeling problem was identified as being particularly relevant to homesickness research by Fisher, Frazer, & Murray (1984). Fisher et al. (1984) found that when 'homesickness' was not alluded to, the incidence of homesickness in boarding school pupils only 18%. However, when the label was made available for endorsement the incidence of homesickness was significantly higher 60-70%. In light of the fact that the present study was referred to as 'An Investigation of Homesickness', it would be reasonable to consider that the present study may have been affected by the labeling problem. Because the label 'homesickness' was present for endorsement, the statistics related to incidence may have become inflated.

However, the willingness to endorse a given term depends on other situational factors as well, and as previously mentioned, homesickness reporting is also affected by the problem of social desirability. When questionnaires require the pupil to disclose their name the tendency to report homesickness is lower (Fisher, 1989). This confound may have influenced the prevalence related findings of the present study as participants were requested to divulge their name. Future research could employ a number identification system in an effort to avoid this problem. Evidence (Fisher, 1989) suggests that homesickness is socially sanctioned and the sufferer may feel 'feeble' or 'wimpish' when reporting it. The problem of social desirability is particularly pertinent to data relating to the male participants. Even though the importance of confidentiality and personal work was emphasized during each session, circumstantial factors may have affected some pupil's willingness to confess to homesickness.

Circumstantial factors may have affected more than just incidence reporting. As previously discussed, the male participants were seated four to a table in the dining hall and there appeared to be a disregard for the regular requests to undertake personal work and not to converse with others at the table. In sum, the male participants appeared to have a very low level of engagement with the task compared to the females. It is proposed that this was the most influential variable in diminishing the effect of narrative therapy for the males as compared to the females. Future studies should ensure that adequate provisions are made to provide private individual work-spaces for all participants.

It had been anticipated that the writing exercise would run for 4 consecutive days for 20 minutes each day. However, at the Hostel Managers request this time period was reduced to three consecutive days for 15 minutes each day. Earlier research (Pennebaker, 1997) reported that as little as 15mins a day of emotional writing had been observed to exert a positive effect on psychological and physical health. However it may be that a duration of 5 days or longer is needed for narrative therapy to exert a more pronounced beneficial effect on levels of homesickness.

An unforeseen confound for the male participants was that a regularly used disciplinary measure in the hostel was "a-15-minute", which was a 15 minute time-out type detention enforceable by both staff and prefects. It is possible that on some level, the males associated the 15 minute narrative writing task with a "15-minute" detention. Thus the 15 minute writing task may have been coupled with negative connotations that in turn affected the male's willingness to fully participate in and engage with the task.

3.5 CONCLUSION AND FUTURE DIRECTIONS

Homesickness was found to be a relatively common phenomenon of which females reported slightly higher levels than males. In terms of the measurement of levels of homesickness, the self assessed binary measure of homesickness was recognized to have been consistent with the validated homesickness scale, the DRI. Some support was found for the theory that homesickness may exercise a negative influence on academic performance, at least over the short term, however no relationship was found between absenteeism and levels of homesickness.

It was hypothesized that for students who participated in an emotional writing exercise there would be a reduction in homesickness symptoms, and advanced academic performance. Despite the absence of statistically significant change, the results offered some support for the beneficial effects of narrative therapy, particularly for homesick females. The finding that narrative therapy achieved little effect for males should not stand as a definitive conclusion due to the limitations of the study. Nonetheless, the data may be useful in directing the focus of imminent research. There is a need to extend the narrative intervention to relevant populations to gain an understanding of how robust any effects may be.

The present study offers some insight for prospective research. It is clear that future studies that use narrative therapy as an intervention for homesickness should ensure that adequate provisions are made to provide private individual work-spaces for all participants. Furthermore, in light of the finding that the not-homesick participants who were exposed to narrative therapy essentially worsened over treatment, it may be judicious for future research of this kind to encourage only those who are homesick to take part in the narrative exercise.

It emerged that there is a need for examination of cultural differences in the prevalence and experience of homesickness. Particularly relevant to New Zealand are both the homesickness experience of Maori people, and occurrences of homesickness in the immigrant population. It may also be worthwhile to investigate the potential "inoculation" versus "debilitation" effect of childhood homesickness. Anecdotal evidence suggests that experiencing mild homesickness as a child may go some way towards preventing homesickness as an adult, where as severe childhood homesickness may have far reaching negative effects such as reluctance to relocate or even take trips as an adult. Homesickness is a conceptually distinct manifestation of distress with an identifiable cause and considerable consequences, and needs to be acknowledged as such. The cost to individuals alone validates the need for theoretical exploration, empirical investigation, and comprehensive recognition of the homesickness phenomenon.

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APPENDIX 1

DEMOGRAPHIC QUESTIONNAIRE

Name:

Age:

Home Town:

Hobbies and Interests:

Year 9 or 10:

Years at Boarding School:

HOMESICKNESS SCALE

I feel homesick:

1	2	3	4	5
rarely		sometimes		often

THE DUNDEE RELOCATION INVENTORY

(SECOND VERSION – QUESTIONNAIRE F) (FISHER, 1989)

I feel able to cope here	Never	Sometimes	Often
I miss home	Never	Sometimes	Often
I feel optimistic about life here	Never	Sometimes	Often
I miss having someone close to talk to	Never	Sometimes	Often
I feel happy here	Never	Sometimes	Often
I miss my family	Never	Sometimes	Often
I feel fulfilled here	Never	Sometimes	Often
I feel unloved here	Never	Sometimes	Often
I feel unsettled here	Never	Sometimes	Often
When I have problems I contact my family	Never	Sometimes	Often
I feel excited about work here	Never	Sometimes	Often
I feel needed here	Never	Sometimes	Often
I feel uneasy here	Never	Sometimes	Often
I would like to go home more often than I do	Never	Sometimes	Often
I regret having moved here	Never	Sometimes	Often
There are people here in whom I can confide	Never	Sometimes	Often
I feel secure here	Never	Sometimes	Often
I cannot stop thinking of home	Never	Sometimes	Often
I feel very satisfied here	Never	Sometimes	Often
I have many friends here	Never	Sometimes	Often
I feel threatened here	Never	Sometimes	Often
I wake up wishing that I were home	Never	Sometimes	Often
I made a mistake moving here	Never	Sometimes	Often
I feel lonely here	Never	Sometimes	Often

APPENDIX 2

DIARY CHECK SHEET

THE INFORMATION PROVIDED ON THIS SHEET IS CONFIDENTIAL

Please indicate on the check sheet by ticking the relevant box as to what area your diary entry was about.

	THOUGHTS & FEELINGS ABOUT BOARDING SCHOOL	ANY OTHER THOUGHTS FEELINGS & EMOTIONS	DESCRIPTION OF THE DAYS ACTIVITIES	PROBLEMS & HASSLES	SOLUTIONS TO PROBLEMS & HASSLES	FUTURE PLANS	OTHER
WEEK 1							
WEEK 2							
WEEK 3							
WEEK 4							
WEEK 5							
WEEK 6							
WEEK 7							

NAME _____