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Homesickness: a review of the literature

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

INTRODUCTION

Homesickness refers to the commonly experienced state of distress among those who have left their house and home and find themselves in a new and unfamiliar environment. It is generally represented as an intense longing for home accompanied by a depressive mood and a variety of somatic complaints. Leaving home, as in migration and residential move, is not only associated with distress, which may be labelled 'homesickness', but there is also evidence for far-reaching negative effects on health status. For example, there are data indicating that this event is associated with the onset of depression (Leff *et al.* 1970; Weissman & Paykel, 1973; Schmitz, 1992; Ekblad, 1993) deficiencies in the immune system (Schmitz, 1992), diabetes mellitus (Mooy, 1995), and leukaemia (Jacobs & Charles, 1980). Furthermore, change of residence is included in many life events inventories that are frequently used in stress research, including the Social Re-adjustment Rating Scale (Holmes & Rahe, 1967). Thus, there are strong indications that this stressor may have dramatic consequences for vulnerable individuals. Moreover, it has been suggested that, from a clinical point of view, homesickness is an especially relevant issue in refugees. It may not only interfere with integration into new societies, but it may also lead to adjustment problems, when being back in the home country, because the situation there turns out to be less ideal than it was in the imagination.

Through history, homesickness has not only been of interest to poets and writers, but also scientists have shown interest in this phenomenon although to a much lesser degree. Nevertheless, as far back as the seventeenth century, the importance of a systematic study of homesickness was recognized, particularly by Swiss investigators. For instance, Johannes Hofer concluded that homesickness was an illness of young people who were socially isolated in strange countries, whereas Scheuzer speculated that the cause of nostalgic feelings among Swiss soldiers in France was the deprivation of the refined Swiss air (see Rosen, 1975). On the other hand, Detharding (cited in Bergsma, 1963) suggested that it was the depressing Swiss air which led to feelings of homesickness among French soldiers in Switzerland. In the seventeenth and eighteenth centuries homesickness, in these days often called nostalgia, was considered to be a disease of certain ethnic groups,

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predominantly the Swiss. Since early work on homesickness was focused, in particular, on hospitalized patients suffering from other diseases, organic pathology was stressed as an important cause of homesickness. This view was not eroded until the last decades of the nineteenth century, when developments in medicine led to a better understanding of the symptoms in the homesick. Subsequently, for no apparent reason, the interest in homesickness disappeared.

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

The recent psychological literature on homesickness is rather slim and scattered. This is rather surprising, considering the commonality and intensity of the homesickness experience and the large numbers of people who nowadays (are forced to) travel because of work, study and holidays, or due to the fact that they are prosecuted in their home countries. Homesickness has been studied among conscripts (Bergsma, 1963; Dijkstra & Hendrix, 1983; Eurelings-Bontekoe *et al.* 1994), migrant populations and refugees (e.g. Larbig *et al.* 1979; Hojat & Herman, 1985; Hertz, 1988; Eisenbruch, 1990; Schmitz, 1994), non-resident students, student nurses and boarding school children (Porritt & Taylor, 1981; Miller & Harwell, 1983; Fisher *et al.* 1984, 1985, 1986; Fisher & Hood, 1987, 1988; Brewin *et al.* 1989; Fisher, 1989; Carden & Feicht, 1991) and institutionalized people (Taylor, 1986).

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

WHAT DO WE MEAN BY HOMESICKNESS?

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

Baier & Welch (1992) performed a conceptual analysis in order to distinguish homesickness from related concepts such as separation-anxiety and school phobia. On the basis of prototypical cases of homesickness the following six criteria were formulated: (*a*) homesickness happens in all age groups, under conditions of being away from home; (*b*) frequently homesickness is not acknowledged, neither are homesickness feelings processed intrapersonally; (*c*) in adults and older children homesickness is sometimes experienced with embarrassment or denial; (*d*) homesickness reflects a persuasive feeling of sadness and thoughts about the place left: (*e*) children who are homesick are generally en-

couraged to suppress their feelings; and, (*f*) somatic complaints may accompany the longing for home or family (Baier & Welch, 1992, p. 56). For clinical practice these criteria can offer some hold, but quite some questions remain. For example, one crucial question is whether distress and avoidance behaviour in unpleasant and involuntary situations (e.g. being in the army or in a hospital) should be considered as qualitatively similar to feelings of homesickness occurring during a holiday? In the latter case there is often no objective aversive situation, merely being away from home, even with the whole family, may suffice to evoke an intemperate desire to go home in some persons (Van Tilburg *et al.* 1996).

Homesickness can be conceived of as being related to adjustment disorder. According to the DSM-IV (AMA, 1994) criteria, adjustment disorder is a maladaptive response to an identifiable psychosocial stressor occurring within 3 months and remitting within 6 months of the termination of the stressor. The reaction must be in excess of a normal and expectable reaction to the stressor(s) and/or it has to impair school or work performances and hinder social activities or interpersonal relationships. Six subtypes have been distinguished which characterize the predominant symptoms. Severe homesickness may be seen as a particular form of two of these subtypes, namely adjustment disorder with depressed mood or adjustment disorder with physical complaints, when two other conditions are fulfilled, namely being away from home (the stressor) and thinking a lot about home. But, if homesickness is not severe enough to hamper daily activities, like work and social activities, then, according to DSM-IV criteria, homesickness has to be viewed as a normal reaction to being away from home. Homesickness can both be labelled as an acute adjustment disorder (remittance of symptoms within 6 months), in the case of persons whose homesickness feelings disappear or persons who return within 6 months, and as chronic adjustment disorder (persistence of symptoms for 6 months or longer) in cases of severe homesickness.

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

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

Most authors consider homesickness as a singular syndrome (e.g. Brewin *et al.* 1989; Fisher, 1989; Lu, 1990; Baier & Welch, 1992; Eurelings-Bontekoe *et al.* 1994; Burt, 1993). In contrast, the Dutch psychiatrist Rümke (1940, cited in Bergsma, 1963) distinguished several kinds of homesickness, namely homesickness for the familiar environment or area, homesickness for persons in the familiar environment, pseudo-homesickness (which is a pattern of homesickness-like reactions resulting from personality disorders) and a fourth form in which unbearableness of the new situation is the predominant aspect.

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

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

Preliminary data of our own research group strongly suggest the existence of at least four independent types of homesickness (Vingerhoets *et al.* 1995), namely homesick for persons, homesick for the environment, difficulties with adapting to the new environment and difficulties with new routines. These types considerably overlap with Rümke's (1940, cited in Bergsma, 1963) classification. Seen from a more practical and clinical perspective such a differentiation is of the utmost importance, assuming that each type may have a different aetiology and demands a specific therapeutic approach. Therefore, adequate assessment procedures and research concerning the validity of these subtypes are badly needed.

SYMPTOMATOLOGY OF HOMESICKNESS

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

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

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

Emotional manifestations of homesickness are mainly characterized by depressive mood. Moreover, feelings of insecurity, loss of control, nervousness and loneliness are frequently reported. Therefore, homesickness is often considered to be a reactive depression, comparable with depression following grief (Hamdi, 1974; Porritt & Taylor, 1981; Dijkstra & Hendrix, 1983; Taylor, 1986; Fisher, 1989; Eurelings-Bontekoe *et al.* 1994). Fried (1963; cited in Porritt & Taylor, 1981) spoke of it as 'grieving for a lost home', although he recognized that the grieving can also be directed at lost relationships. Hamdi (1974) hypothesized a two-stage process of adaptation to a new living environment: 'The process of giving up the previous way of life is marked by anger, depression, acknowledgement of loss and mourning. Resignation, detachment, adaptation, and hope indicate that the individual is prepared to accept and make the best of the new life situation' (p. 16). Thus, not only the confrontation with the new and unfamiliar environment, but also the loss of the home environment and important relationships can be crucial factors in homesickness.

PREVALENCE OF HOMESICKNESS

Homesickness is experienced by people of all cultures and all ages. Nevertheless, to provide estimations of the prevalence of homesickness is rather problematical. Apart from the above mentioned definition problems, there are good reasons to assume that the homesickness experience is, at least partially, situation specific. Prevalence rates are, therefore, always limited to specific contexts like holidays, hospitals, universities, school camps, or the army. Moreover, homesick feelings are generally not experienced continuously. Furthermore, there is evidence that only intense homesickness experiences are reported spontaneously. In a study among boarding school pupils the spontaneously reported incidence of homesickness was 18%. But when the question was probed, 60–70% reported that they had suffered from homesickness to

some degree (Fisher *et al.* 1984). This may be due to the fact that, while homesickness experiences generally are episodic, in severe cases these feelings are continuous. In the episodic homesick, periods of homesickness are predominantly reported at the beginning and the end of the day. Moreover, they occur more frequently during mental (rather than physical) and passive (rather than active) tasks. However, as homesickness is linked to depression, it could also be that this passivity is a consequence of the homesickness experience rather than a cause (Fisher, 1989).

Fisher (1989) concludes that 50–75% of the general population have had at least one homesickness experience, whereas serious forms are estimated to occur in 10 to 15% of these cases. In a recent Dutch study (Thijs, 1992) even higher prevalence rates were found: only 7·3% of a sample of 206 adults reported that they had never experienced any homesickness. However, it should be noticed that in this study other states like, for instance, nostalgia were included in the homesickness category probably resulting in an over-estimation. Although no pertinent data are available, results so far strongly suggest that homesickness is a commonly experienced psychological state following leaving the home environment.

MODELS OF HOMESICKNESS

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

Loss

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

The importance of attachment in the development of homesickness is stressed by several authors (e.g. Hamdi, 1974; Porritt & Taylor, 1981; Brewin *et al.* 1989) and it is often mentioned as a cause of psychological and physical problems of immigrants (e.g. Proshansky *et al.* 1983; Hojat & Herman, 1985; Aroian, 1990; Juthani, 1992). Unfortunately, until now this model has not been tested empirically. Aroian (1990) has observed that loss and disruption was a predominant theme in interviews with 25 Polish migrants in the US. For instance, one of Aroian's subjects described the feeling as: 'You have to divorce yourself from the past' (Aroian, 1990, p. 7). Brewin *et al.* (1989) found a relationship between self-reported dependency and homesickness, in a study among first-year psychology students. They concluded that anxious attachment and dependency on others is a risk factor for developing homesickness, because individuals with these characteristics tend to react intensely to all anticipated separations. Furthermore, many studies have shown a link between anxious attachment and/or dependency, on the one hand, and adult psychopathology, especially depression and agoraphobia, two syndromes associated with homesickness, on the other hand (e.g. Gittelman & Klein, 1985; Pettem *et al.* 1993; West *et al.* 1993; Carnelley *et al.* 1994).

Interruption of life style

The interruption and discontinuity model is the second theoretical framework. This model features the view that interruption or discontinuity of life styles and routines may lead to feelings of anxiety, distress, and fear (Mandler, 1990). These negative emotions can be labelled as homesickness, when being away from home. Old routines, habits, and behavioural plans become ineffective in the new situation; so, one cannot

fall back on them. The person is unable to cope with the situation, because old plans still dominate the present behaviour, which is inappropriate in the new environment. Some support for this view is found in the literature on acculturation, where adjustment problems due to lack of knowledge of how to behave, and disruption of careers and educations are recurring themes (e.g. Westermeyer *et al.* 1983; Grove & Torbiörn, 1985; Aroian, 1990; Juthani, 1992).

Reduced control

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

Fisher (1989) has reported some support for this hypothesis in a study among first-year university students. It was found that homesick students differed from the non-homesick in terms of both perceived demands of university life and lower control over these threats and requirements. Burt (1993) also has concluded, on the basis of results from a study among first-year students, that homesickness is a reaction to a lack of control over the environment. Because of the retrospective design of these studies, it can also be hypothesized that homesickness causes lack of control over the environment instead of the other way round. However, this is not very likely, because Lu (1990) found in Chinese students that perceived high social demands, within the first 2 weeks after arrival in the UK, were a significant predictor for homesickness after 2 months.

Role change and self-consciousness

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

Conflict

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

Conclusion

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

RECENT RESEARCH

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

Personal factors

It is generally believed that homesickness is more common among children than adults, and sometimes it has even been suggested that adults are not susceptible to it at all (Baier & Welch, 1992). Unfortunately, no data are available concerning the difference of prevalence between

children and adults. Thijs (1992) found a considerable occurrence of youth histories, when adults were asked about their homesickness experiences. However, this outcome may actually be an over-estimation, because adults, compared with children, generally have greater freedom to avoid situations that are associated with negative mood, including homesickness. Moreover, children may feel very distressed when they are separated from their attachment figures, most often their parents. As a consequence, children are often considered to be homesick, while they are actually experiencing separation anxiety.

Whether there are any sex differences in the experience of homesickness is still unclear. Conflicting results have been reported up to now. Fisher (1989), for instance, did not find sex differences in populations of school children, university students, and student nurses. Brewin *et al.* (1989) also reported that homesickness was equally prevalent among male and female students, although they also emphasized sex differences in coping with homesickness. Women were more likely than men to discuss their feelings with others, to look for cheerful company, and to try to find out if others feel the same. Gruijters (1992), on the other hand, found that women were more susceptible to homesickness than men. It remains to be established, however, to what degree such discrepancies are due to differences in sampling or measurement methodology. For example, women generally have higher scores on symptom checklists (e.g. Verbrugge, 1985; Gijsbers-van Wijk & Van Vliet, 1989). Whether or not gender differences are found, may therefore depend on the operationalization of homesickness, in particular on how many items refer to symptoms.

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

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

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

In a recent longitudinal study, it was shown that 'dependency on others' is another predictor of homesickness (Brewin *et al.* 1989). This finding supports the linkage of homesickness to separation anxiety. Dependency on family and parents was also found to be a characteristic

feature of homesick students compared with non-homesick students (Carden & Feicht, 1991).

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

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

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

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

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

Situational factors

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

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

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

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

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

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

FISHER'S MULTI-CAUSAL MODEL OF HOMESICKNESS

On the basis of the above it can be concluded that little is known about the exact relation of specific personal and situational factors to homesickness. In addition to the wide variety in definitions, the relevant literature is rather fragmented, and virtually no replication studies have been done. Furthermore, there is no trace of an integration of the findings into a comprehensive, all embracing theoretical model. Fisher (1989) was the first to attempt to summarize a number of the following key findings into a multi-causal model. According to this model, homesickness is a complex syndrome associated with distress, psychoneurotic symptoms, absent-mindedness, intrusive home-related thoughts, dissatisfaction with the new situation, high demands of and low control over

the new situation, low decisional control over the move, and depressive feelings before the move. It occurs in 50–70% of most populations and is independent of age and sex. Only in severely homesick individuals the homesickness experience is continuous; otherwise it occurs in episodes, mostly in the morning and the night and during passive and mental tasks.

These observations led to the formulation of a descriptive, composite model of homesickness. In this model a two-part challenge is reflected: (*a*) the separation from the familiar environment; and (*b*) the entrance into the new setting. Separation from home can be accompanied by perceived loss, interruptions of plans, and withdrawal which leads to psychological disruption and compulsive ruminative thoughts about home. At the same time the confrontation with the new environment can give rise either to strain and dissatisfaction or to commitment. These strains and dissatisfactions may lead to compulsive ruminations about home, whereas commitment to the new environment ensures that the person is challenged by it and looks out for more information and new experiences. Commitment can block the psychological disruption due to leaving home. Information from the new environment competes for attentional resources with ruminations about home. Thus, if the degree of commitment is high, information concerning the new environment competes successfully with homesick thoughts, resulting in successful adjustment and adequate adaptation to the new situation. In contrast, those who are unable to become committed to a satisfactorily degree, are more likely to become homesick.

So, both separation from the old home environment and the experience of the new environment are regarded as important factors in the development of homesickness. What is lacking in the model, however, are factors that determine the intensity of the feelings associated with both the new and the old environment. In addition, neither the specific elements of the old environment that cause the distress (e.g. persons or the physical environment), nor the personal characteristics of homesick-prone persons are addressed.

METHODOLOGICAL ISSUES

Assessing the presence and intensity of homesickness objectively is problematical. The major problems concern criterion validity, because there are no clinical criteria for diagnosing homesickness. Furthermore, interpretation of test–retest reliability coefficients is not easy. The homesickness phenomenon is not likely to be stable, gradual adaptation to the new environment decreases the intensity of the homesickness; sometimes to such a degree that it ceases to exist. Stressors, on the other hand, may reactivate or intensify these feelings. Thus, low test–retest reliability coefficients can be due to low reliability of the test or to recovery of homesickness.

Despite of these methodological difficulties, three homesickness questionnaires have been developed which seem to have satisfactory reliability and validity. The Dundee Relocation Inventory (DRI; Fisher, 1989) measures homesickness following the transition from home into residence at school or university. It consists of 24 items referring to cognitions and feelings concerned with missing home, and two dummy questions. The test–retest reliability of the DRI was 0·59 across 2 weeks and 0·21 across 6 months in homesick university students, whereas these values for the non-homesick were 0·71 and 0·81, respectively. Data from a study among boarding school children provided support for the content validity of this instrument, but obviously more data are needed. A major drawback of the DRI is that it is specifically developed to measure homesickness in students and school children. Therefore, in its present form it cannot be applied in other contexts like moves, migrations, hospital admittances and holidays.

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

available concerning the reliability of the instrument. However, until now it is the only instrument that is able to distinguish the homesick from the non-homesick in a broad variety of situations.

The third instrument is a 29-item questionnaire to measure the vulnerability to develop homesickness (Eurelings-Bontekoe *et al.* 1995). Five subscales are defined: Extraversion, Dominance, Rigidity, Earlier Homesickness Experiences and Assertiveness. The internal consistency of these scales range from 0·62 to 0·86. Homesick conscripts, classified on the basis of clinical judgements, differed significantly from conscripts suffering from other psychopathology and healthy controls on all the five scales. In addition, applying discriminant analysis, 74% of the homesick could be classified correctly when compared with the psychopathology group and 83% when compared with healthy controls.

To conclude, further research should deal more adequately with assessment issues and the definition of homesickness. Especially in children the danger exists that one actually focuses more on separation anxiety than on homesickness. But, also in adults adverse aspects of the new situation may activate the attachment system resulting in an intense desire to go home, but without the ruminative thoughts and obsession with home, which are characteristic of the homesick.

INTERVENTIONS

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

Fisher (1989) has proposed a stress-management therapy for the homesick, directed at the expression of feelings and the formation of commitment to the new environment. Expression of feelings through writing has been proven to be beneficial for college freshman (Pennebaker *et al.* 1990). Hamdi (1974) and Taylor (1986) also have suggested that expression of feelings can be helpful to the homesick. Furthermore, reassurance, sensitivity to the problems of the homesick, ego enhancement, and contact with family members (either by telephone or visits), have been proposed to help the homesick child. Chartoff (1975) has reported some success with Rational Emotive Therapy (Ellis, 1957; Ellis & Grieger, 1986) in reducing homesickness in youngsters. More effective, however, were telephone calls, that is, allowing youngsters to speak for 5 min to their parents. In Chartoff's study, parents were instructed to express understanding, but to deny permission to come home. Porritt & Taylor (1981) have suggested that exploration of other problems and support in resolving them might reduce the need to cling to old attachments, and demonstrated that behavioural techniques, e.g. thought stopping and time-outs for worry can give some relief. Furthermore, they suggested that the use of fantasized conversation with support figures. Finally, Dijkstra & Hendrix (1983) have distinguished three goals for intervention in homesick conscripts: (*a*) to alter the situation (e.g. by sending them home); (*b*) to enhance the adjustment abilities of the conscripts (e.g. by training assertive behaviour); and (*c*) to dispel the homesickness through psychotherapy. Unfortunately, it is not made clear by these authors what this therapy exactly implies.

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

1 Homesickness occurs frequently among both children and adults. It is often perceived as socially undesirable, which frequently leads to feelings of shame and withdrawal. Therefore, it is important to create more acceptance of these particular feelings. Then, homesick people will no longer be reluctant to express their feelings, which leads to more social support. In addition, homesick individuals are no longer urged to 'hide' themselves, which obviously interferes with explorations of the new environment.

2 It is important to create involvement and a certain degree of commitment with the new environment. Exploration has to be stimulated and the individual has to be intrigued by appealing aspects of the new behavioural context.

3 Active and physical activities, like sports, games, museum visits, etc., take one's mind off

things. In contrast, passive and mental activities (e.g. reading) cannot compete very well with the feelings of homesickness.

4 For critical moments, e.g. unavoidable passive situations such as eating and going to sleep, it is important that both potential sufferers and accompanying persons anticipate these situations and are aware of these 'high risk' moments.

5 Homesick individuals have a high need for social support, however, they often lack the appropriate skills to acquire it. Learning new social skills and training in assertive behaviour is therefore of the utmost importance.

6 It is important to scrutinize the cause of the homesickness experiences, because different causes may require different interventions. For example, if the adversity of the new environment is the major cause of homesickness, then skills to cope more adequately with the new environment and direct manipulations of problematical situations should be the core of the intervention programme. If, however, missing the old environment, or significant persons, is the major cause, then, other approaches will be more appropriate.

CONCLUSION

In spite of the confusing literature and the lack of a clear definition, there is a strong agreement that homesickness is a psychological state that is primarily centred on a preoccupation with the home environment. This state is accompanied by specific physical, cognitive, emotional, and behavioural reactions. Until now, psychologists have not paid much attention to homesickness. It turns out that there are firm associations with personal characteristics like rigidity, neuroticism, and lack of self-confidence. Furthermore, homesick persons seem to have a strong need for social support, but they lack social skills to acquire it. The latter finding offers a lead for possible psychological interventions.

Distance from home proved to be of less importance than length of the stay and the presence of acquaintances or familiar persons. In addition, freedom of choice over the move reduces the likelihood of becoming homesick. These findings suggest that the occurrence of homesickness feelings in situations like a hospital admittance, cannot be precluded. Serious forms of homesickness may hamper recovery (Baier & Welch, 1992) and an intervention or even replacement into the home situation might be necessary.

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

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

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

and more insight can be obtained into this highly intriguing, but regrettably neglected phenomenon.

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