

# Multimodal Homesickness Prevention in Boys Spending 2 Weeks at a Residential Summer Camp

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*Homesickness* is the distress or impairment caused by an actual or anticipated separation from home. It is characterized by preoccupying thoughts of home and attachment objects. In its severe form, homesickness is subjectively distressing and has clinically significant cognitive, emotional, and behavioral sequelae. This study provided 75 boys who ranged in age from 8 to 16 years and who were 1st-year campers at an overnight summer camp with an inexpensive, multimodal homesickness prevention package. Results suggest that combining environmental information, psychoeducation, social support, explicit coping instruction, caregiver education, practice time away from home, and surrogate caregiver training can reduce homesickness and associated behavior problems. These data support the theory that novelty reduction, attitudinal shifts, pre-separation coping enhancement, and supportive social environments diminish the negative emotional intensity of homesickness.

*Keywords:* homesickness, prevention, adjustment, separation, home

*Homesickness* is the distress or impairment caused by an actual or anticipated separation from home. It is characterized by preoccupying thoughts of home and attachment objects (Thurber, 1995). Although homesickness is an ancient phenomenon, no preventive interventions have yet been empirically tested. However, contemporary researchers have defined and measured homesickness (e.g., Archer, Ireland, Amos, Broad, & Currid, 1998; Fisher, 1989; Shin & Abell, 1999) and distinguished it from related phenomena, such as depression, separation anxiety disorder, and nostalgia (Batcho, 1995; Thurber, 1995, 1999; Verschuur, Eurelings-Bontekoe, & Spinhoven, 2001). In addition, more than 30 empirical studies have documented the risk factors for homesickness, which include little previous experience away from home, insecure attachment to caregivers, low perceived control, pre-separation negative attitudes, social disconnection, and significant cultural and environmental shifts (see Thurber & Sigman's, 1998, study for a review).

Homesickness is typically a mild, normative developmental experience, but its prevention warrants clinical research because the subjective distress and level of impairment among homesick persons can become extreme. Homesickness is an especially significant source of distress and impairment for immigrants, foreign students, foreign employees, displaced persons, and refugees

(Eurelings-Bontekoe, Brouwers, & Verschuur, 2000; Griffin-Pierce, 1997; Schreier & Abramovitch, 1996; Stroebe, van Vliet, Hewstone, & Willis, 2002; Tikoo, 1994; van Tilburg & Vingerhoets, 1997; Vernberg & Randall, 1997). Higher mobility in the world's population than ever before means that multinational companies, international aid organizations, community mental health centers, universities, boarding schools, and children's summer camps are increasingly interested in homesickness prevention and intervention.

This homesickness prevention study was designed to target some known risk factors for homesickness (see above) and to capitalize on the most frequent and effective coping mechanisms children use. The latter include the following: maintaining a positive attitude about the separation and the new environment, engaging in fun physical activities, corresponding with home, keeping time in perspective, and seeking social support (Thurber & Weisz, 1997a, 1997b). Youths at summer camp are an ideal study population because their homesickness intensity ranges from mild to severe, their stay away from home is discrete, and their contact with home is controlled (i.e., limited to letters only).

A combination of environmental information, psychoeducation, social support, explicit coping instruction, caregiver education, practice time away from home, and surrogate caregiver training was hypothesized to significantly reduce the homesickness intensity of 1st-year campers at a boys' residential summer camp. See Table 1 for a summary of these treatment elements, goals, and theoretical rationales.

## Method

### *Participants*

Participants were all boys who ranged in age from 8 to 16 years (mean age = 13.3 years,  $SD = 1.7$  years) who were enrolled at a traditional, residential, boys' summer sports camp that offered 2-week sessions. The camp was set in a 270-acre pine forest adjacent to a large lake. Three

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Table 1  
*Homesickness Prevention Program's Elements, Goals, and Theoretical Rationales*

Element	Goal(s)	Rationale(s)
"Sneak Preview" color orientation brochure for campers	<ol style="list-style-type: none"> <li>1. Reduce novelty by familiarizing 1st-year campers with the camp environment, daily schedule, and activities</li> <li>2. Enhance positive attitudes about the camp experience by showcasing camp activities, facilities, and social environment using colorful photographs and lively text</li> <li>3. Normalize feelings of homesickness and the seeking of social support</li> <li>4. Provide contact information (e.g., camp address, phone, and fax number)</li> </ol>	<ol style="list-style-type: none"> <li>1. The more unfamiliar the separation environment seems, the more difficult the adjustment can be</li> <li>2. Negative attitudes about the separation environment are associated with more intense feelings of homesickness</li> <li>3. Feeling abnormal and alone augments homesickness intensity and duration</li> <li>4. Opportunities to gather more information and answer lingering questions reduces anxiety</li> </ol>
"Kids Can Cope With Homesickness" booklet for families	<ol style="list-style-type: none"> <li>1. Normalize feelings of homesickness and the seeking of social support</li> <li>2. Instruct incoming 1st-year campers and their parents about the most effective coping strategies children use</li> <li>3. Educate parents about effective and destructive ways of providing support, both before and after the separation. Discourage parents from expressing ambivalence about the camping experience.</li> <li>4. Provide contact information (e.g., camp address and fax number) a second time</li> </ol>	<ol style="list-style-type: none"> <li>1. Feeling abnormal and alone augments homesickness intensity and duration</li> <li>2. Information about effective coping increases perceived control and arms 1st-year campers with ways to diminish homesickness intensity</li> <li>3. Parents will be more likely to provide effective support (e.g., letter writing); less likely to inadvertently sabotage the separation (e.g., by making a pick-up deal such as "If you feel homesick, I'll come pick you up.")</li> <li>4. Opportunities to gather more information and answer lingering questions reduces anxiety</li> </ol>
Practice time away from home	<ol style="list-style-type: none"> <li>1. Practice spending time away from home, then debrief the experience as prescribed in the "Kids Can Cope With Homesickness" booklet</li> </ol>	<ol style="list-style-type: none"> <li>1. Practice time away from home gives children an opportunity to practice effective coping, habituate to the circumstance of being without parents in a novel or non-home environment, and gain confidence about future separations</li> </ol>
Phone call from staff member	<ol style="list-style-type: none"> <li>1. Reduce novelty by familiarizing 1st-year campers and their parents with a current staff member</li> <li>2. Answer questions that children and parents have about camp</li> </ol>	<ol style="list-style-type: none"> <li>1. Knowing at least one person prior to arriving at camp for the first time enhances positive attitudes and reduces anxiety based on fear of the unknown</li> <li>2. Accurate information about the demands of the separation environment reduces anxiety</li> </ol>
Specialized staff training	<ol style="list-style-type: none"> <li>1. Educate surrogate caregivers by providing information on the pathogenesis and symptoms of homesickness</li> <li>2. Train surrogate caregivers to assess children's coping methods and coping goals</li> <li>3. Prepare surrogate caregivers to help homesick children by providing opportunities to role play counseling approaches</li> </ol>	<ol style="list-style-type: none"> <li>1. Accurate information about the risk and protective factors for homesickness dispels myths and enables camp staff to accurately assess individual cases</li> <li>2. Staff can help homesick campers stop using ineffective coping methods and begin using a customized combination of effective methods</li> <li>3. Staff can normalize homesick feelings, provide social support to homesick children, and help them regain a sense of control and efficacy in their emotion regulation</li> </ol>

*Note.* For expanded theoretical discussions about homesickness, see the following studies: Thurber and Sigman (1998), who discuss insecure attachment, novelty reduction, pre-separation expectations, and environmental attitudes; Thurber and Weisz (1997a, 1997b), who discuss theories of coping with homesickness; Fisher (1989), who discusses cognitive theories of homesickness; van Tilburg and Vingerhoets (1997), as well as Eurelings-Bontekoe et al. (2000), who discuss cultural theories of homesickness and acculturation stress. See Zwingmann (1959) for a review of historical theories of homesickness.

months prior to the start of camp, all prospective 1st-year camper families ( $n = 80$ ) received two illustrated color booklets.<sup>1</sup> The first booklet (16 pages) aimed to enhance positive attitudes and familiarize boys with the camp; the second booklet (12 pages) aimed to educate parents and children about homesickness phenomenology and provide instructions on empirically validated ways to cope with it. One month later, one of several veteran camp staff members called these families to communicate his enthusiasm about their enrollment and answer questions they had about life at camp and coping with homesickness.

As part of the in-camp registration process on opening day, all parents and campers were invited to participate in a study on boys' enjoyment of and adjustment to camp. In all, 430 of 445 families (97%) consented to participate. Seven children did not complete all the required questionnaires, resulting in a final sample of 423, of whom 75 (18%) were 1st-year camper families. The modal child's parents were technicians, semi-professionals,

or small business owners, but parents' occupational status ranged from executives and major professionals to manual and service workers to unemployed. Scholarship funding permitted admission to this camp without regard to financial means. Parents' occupational status averaged 66 ( $SD = 15$ ) on Hollingshead's (1975) scale. Of the participants, 94% were Caucasian, 4% were African American, and 2% were Asian American. The average age of the 1st-year campers was 12.1 years ( $SD = 1.6$  years). Additional demographic details on comparable samples of boys from

<sup>1</sup> These printed materials—which contain a wealth of information about the new camp environment, homesickness phenomenology, explicit coping techniques for parents and children, and instructions on maximizing the effectiveness of practice time away from home—are available from Christopher A. Thurber.

previous summers are reported in Thurber's (1995, 1999) studies and Thurber and Sigman's (1998) study.

### Materials

Four questionnaires were used to assess children's adjustment. Homesickness was measured with the Rate Your Day—Revised (RYD-R), a valid and reliable 15-item self-report measure of positive emotion, negative emotion, and homesickness. Each RYD-R item has a range from 0 (*not at all*) to 10 (*very much*). Attitudes about camp were measured with the About Me, a 22-item self-report questionnaire that includes subscales of decision control, historical homesickness intensity, and initial impressions of camp. Campers reported overall satisfaction with the camping experience using a 25-item self-report questionnaire called My Time at Camp. This instrument included both interpersonal ratings (e.g., "In general, the kids in my cabin were. . .") and environmental questions (e.g., "How did you like living in a cabin in the woods?"). In the current sample, these established measures of homesickness, emotional health, attitudes, and satisfaction had overall and subscale reliabilities ranging from  $\alpha = .74$  to  $\alpha = .82$ . (Details on scale development and psychometrics are reported in Thurber & Sigman's, 1998, study.) To measure internalizing and externalizing behaviors, cabin leaders completed the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1991) for each participant under their direct care.<sup>2</sup>

### Design and Procedure

During staff training week, all cabin leaders ( $n = 47$ ) participated in a 2-hr educational session on the phenomenology of homesickness and received detailed instructions on the best ways to support and coach homesick boys. These instructions were based on the findings reported in Thurber and Weisz's (1997a, 1997b) studies. Cabin leaders also participated in a 1-hr training on questionnaire administration and confidentiality. The staff was not privy to specific research hypotheses.

On the first evening of each participating camper's 2-week stay, cabin leaders administered the camp attitudes and expectations questionnaire (About Me) and the first homesickness index (RYD-R). Instructions were read aloud and questionnaires were completed in the privacy of each child's bunk bed. Nonparticipants received blank pieces of paper and a pencil, with which they could do whatever they wanted during questionnaire administration. In this way, nonparticipants could remain indistinguishable from participants. Cabin leaders collected completed questionnaires and sealed them in envelopes.

Participating boys completed additional RYD-Rs on Days 2, 4, 6, 9, 11, and 13 of their 14-day stay. (Despite short retest intervals, previous studies that used daily RYD-Rs revealed no measurable practice or iatrogenic effects [Thurber, 1999].) On Day 13, boys also completed the satisfaction survey, My Time at Camp, and cabin leaders completed the CBCL subscales that measured internalizing and externalizing behaviors.

### Results

As in previous research, homesickness was prevalent and varied in intensity. Of the full sample, 94% ( $n = 423$ ) of the boys and 99% of the 1st-year boys (75 of 423) reported some homesickness on at least 1 day of their stay. Mean homesickness intensity was calculated by averaging the sum, across all seven RYD-R administrations, of the three items that indexed homesickness. Mean intensity for the entire sample was 6.3 ( $SD = 5.7$ ) and spanned the scale's range of 0–30. About 9% of the sample averaged 15 or greater on this 31-point scale, on which higher scores represented more intense homesickness. Chronological age was negatively correlated with mean homesickness intensity ( $r = -.20$ ,  $p < .0001$ ), which was moderately correlated with the CBCL *T* scores

for broadband internalizing ( $r = .18$ ,  $p < .0001$ ) and externalizing behavior problems ( $r = .17$ ,  $p < .001$ ). Compared with a nearly identical sample of boys who attended the same camp the previous summer, these results suggested a decrease in homesickness intensity, weaker associations with age and internalizing behavior problems, and an unexpectedly stronger association with externalizing behavior problems (see Table 2).

To test the hypothesis that the multimodal treatment provided to 1st-year campers would reduce their homesickness intensity, I used SPSS to compare the 1st-year campers (75 of 423) from this study (Summer 2) with the 91 1st-year campers (91 of 453) who attended camp the previous summer (Summer 1; Thurber, 1999). This comparison group had participated in research on the pathogenesis of homesickness and completed the identical questionnaires but received none of the prevention package detailed in Table 1. There were no statistically significant differences between these two samples in distance from home, socioeconomic scale, previous experiences at other camps, or previous time spent away from home. However, mean age of the boys from Summer 1 was slightly older (12.1 years vs. 11.1 years),  $t(164) = 3.6$ ,  $p < .0001$ , and the boys from Summer 1 reported more intense homesickness during previous separations (12.3 vs. 8.4) on a scale from 0–30,  $t(164) = 3.1$ ,  $p < .005$ . Therefore, analysis of covariance was used in each comparison below to control for the effects of age and previous homesickness intensity. In sum, the two groups differed in only two known predictors of homesickness; both predictors were controlled for in comparative analyses.

First-year campers from Summer 2, who received a multimodal preventative treatment package, reported less intense homesickness than those from Summer 1. Mean homesickness in Summer 1 was 12.2 ( $SD = 8.3$ ) and in Summer 2 was 7.2 ( $SD = 6.0$ ),  $F(2, 163) = 42.5$ ,  $p < .0001$ ,  $\eta^2 = .44$ . Figure 1 illustrates the longitudinal course of homesickness intensity for both groups.

First-year campers who received the treatment package also began camp with more positive attitudes than the comparison group, scoring 98.5 versus 84.9 of a possible 120 on the About Me subscale that measured positive attitudes about camp. For the comparison,  $F(3, 161) = 33.7$ ,  $p < .0001$ ,  $\eta^2 = .39$ . These campers also felt more decision control than did the comparison group, scoring 40.8 versus 37.7 of a possible 60 on the About Me control subscale. For the comparison,  $F(3, 161) = 4.4$ ,  $p < .01$ ,  $\eta^2 = .08$ . Campers in the treatment group also reported greater overall satisfaction with the camp experience at the end of their stay, scoring 142 versus 129 of a possible 180 on the My Time at Camp questionnaire,  $F(3, 161) = 11.6$ ,  $p < .0001$ ,  $\eta^2 = .18$ . In addition, campers in the treatment group also felt greater perceived control over homesickness, scoring 8.3 versus 6.4 on the My Time at Camp subscale, on which 10 was the maximum,  $F(3, 161) = 8.6$ ,  $p < .0001$ ,  $\eta^2 = .14$ .

Cabin leaders reported fewer internalizing behavior problems among the boys in the treatment group, but no differences in

<sup>2</sup> The Other Problems scale on the CBCL, which contains items that do not load on any of the eight major clinical subscales, was not completed. Administration of the Other Problems scale would have required asking cabin leaders questions such as whether their campers smeared feces or masturbated excessively. Such questions were not deemed relevant to this study and might have offended some parents.

**Table 2**  
*Comparison of Full Samples and 1st-Year Campers From Summer 1 (No Treatment) and Summer 2 (Treatment) on Key Indices, Indicators, and Correlates of Homesickness (HS)*

Measure	Summer 1					Summer 2				
	%	<i>M</i>	<i>SD</i>	<i>r</i>	<i>p</i>	%	<i>M</i>	<i>SD</i>	<i>r</i>	<i>p</i>
<b>Full sample<sup>a</sup></b>										
HS prevalence (RYD-R)	94					94				
Mean HS intensity $\geq$ 15/30	17					9				
Mean HS intensity		7.6	8.2				6.3	5.7		
HS intensity and age				-.36	<.0001				-.20	<.0001
HS and internalizing problems (CBCL <i>T</i> score)				.35	<.0001				.18	<.0001
HS and externalizing problems (CBCL <i>T</i> score)				.02	=.68				.17	<.001
<b>1st-year campers only<sup>b</sup></b>										
HS prevalence (RYD-R)	99					99				
Mean HS intensity $\geq$ 15/30	33					11				
Mean HS intensity		12.2	8.3				7.2	6.0		
HS intensity and age				-.15	.16				-.17	.15
HS and internalizing problems (CBCL <i>T</i> score)				.42	<.0001				.31	<.01
HS and externalizing problems (CBCL <i>T</i> score)				.03	.77				.18	.12

*Note.* HS intensity, as measured by the Rate Your Day—Revised (RYD-R), varied along a 31-point scale ranging from 0 (*no homesick feelings at all*) to 30 (*extreme homesickness*). CBCL = Child Behavior Checklist.

<sup>a</sup> *n* = 316 for Summer 1 and *n* = 423 for Summer 2. <sup>b</sup> *n* = 75 for Summer 1 and *n* = 91 for Summer 2.

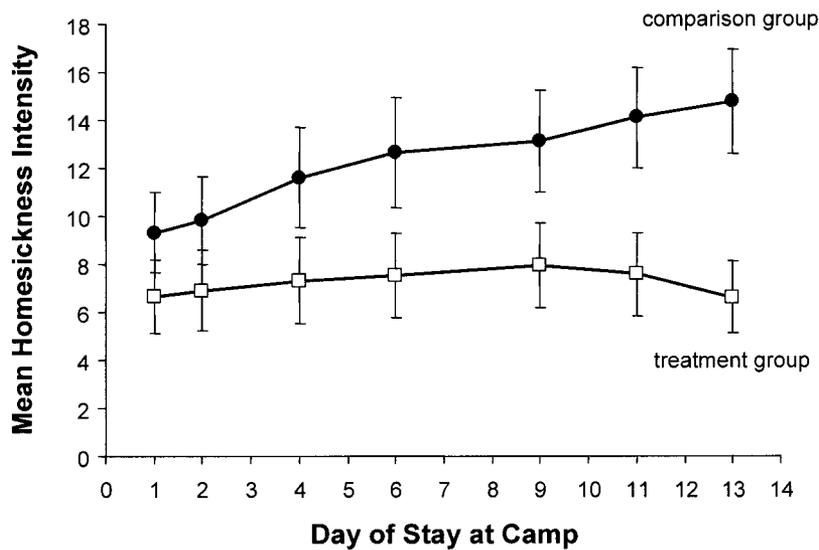
externalizing behavior problems, relative to the comparison group. CBCL broadband internalizing *T* scores for the boys in Summer 1 averaged 45; those in Summer 2 averaged 42,  $F(3, 161) = 4.0, p < .01, \eta^2 = .07$ . CBCL internalizing behaviors also correlated more strongly with RYD-R homesickness in Summer 1 ( $r = .42, p < .001$ ) than in Summer 2 ( $r = .31, p < .01$ ; see Table 2).

**Discussion**

This study provides evidence that a combination of novelty reduction, psychoeducation, social support, coping instruction, caregiver education, practice time away from home, and surrogate caregiver training can markedly reduce homesickness intensity in

boys who are spending 2 weeks in a new place without their parents. Results showed that 1st-year campers who received this multimodal preventive intervention arrived at camp with more positive attitudes and expectations; felt less homesick and more in control during their stay; evidenced fewer internalizing behavior problems; and enjoyed camp’s social, physical, and environmental aspects more than a comparison group of 1st-year campers.

The effectiveness of an intervention often rests on how well it extinguishes the target problem’s etiology. For homesickness, this etiology can be idiosyncratic. For some children, homesickness is caused by anxious attachment or concern about harm befalling their caregivers. This form of homesickness is similar to separation



*Figure 1.* Mean self-reported homesickness intensity as a function of time. I bars indicate 95% confidence intervals.

anxiety but with obvious temporal dissimilarities. For other children, homesickness is caused by the anxiety of a radically new social and physical landscape. For many, homesickness is a developmentally normative phenomenon exacerbated by negative expectations, immature coping skills, fears of abnormality, and lack of social support. As research on children's coping with homesickness has shown, the most effective coping is a mix of primary control (changing things that can be changed) and secondary control (adjusting to things that cannot be changed; Thurber & Weisz, 1997b). Effective coping is also layered, combining multiple strategies. The current prevention package was not customized for individual children but included as many potentially helpful, empirically rational elements as was practical. Certainly, one goal for future studies is to examine, alone and in various combinations, the elements summarized in Table 1. Such research would elucidate what works best for different children, whether the same things work for girls as for boys, what does and does not work in different contexts, and what is most helpful to children of different ethnicities.

Limitations of this study include a single-gender, mostly Caucasian, mostly middle-class sample and the simultaneous application of treatment components. Previous research on childhood homesickness has found no gender differences in the experience of homesickness (Thurber, Sigman, Weisz, & Schmidt, 1999) and only one small difference in coping style (Thurber & Weisz, 1997a). Nevertheless, future studies can address these limitations by applying single aspects of the treatment package or by sampling different populations, such as young refugees, boarding school students, and adult business people. Generalizing this study's results to girls, children of other ethnicities, and instances of homesickness in other contexts—such as immigration or foster care placement—should be done cautiously. It is also possible that the positive attitudes, increased control, decreased homesickness, and increased enjoyment reported by the boys in Summer 2 reflect some cohort effect, not a treatment effect. Factors rejecting this explanation include nearly identical demographic characteristics between the two samples; nearly identical weather, camp staff, and activity offerings from Summer 1 to Summer 2; and historical stability in homesickness intensity at this camp, prior to this study being done.

One strength of this prevention package was its low cost and portability. The price of the printed materials, phone calls, and staff training was less than \$10 per child, and the package could be used—with minor modifications—at any camp, boarding school, or company. Anecdotal evidence from personal interviews suggested that in addition to reducing homesickness intensity, the camp's directors received fewer phone calls from nervous parents and fewer camp activities were derailed by cabin leaders counseling severely homesick campers.

Although intense homesickness among 1st-year campers decreased from 33% to 11%, the absolute prevalence of homesickness in the entire sample (94%) did not decrease from Summer 1 to Summer 2. This suggests that homesickness is indeed normal and perhaps the goal should never be to eliminate it altogether. Almost everyone misses something about home when he or she is away. Thus, although a prevention package can reduce the incidence of moderate-to-severe homesickness, some feelings of homesickness are normal and may be adaptive by prompting the development of nascent coping skills. In so doing, an experience

with homesickness, when anticipated and properly supported, may inoculate a child against future episodes of severe homesickness. Therein lies the answer to the following question: Who cares about a few kids who get homesick at summer camp? This research not only advances contemporary theories of the pathogenesis of homesickness but it also explains an efficient and effective way to bolster emotion regulation and coping skills at an early age. Perhaps the adjustment to college, business travel, or geographical moves is also eased by such experiences.

Previous research proposed a homesick disposition theory (Thurber & Sigman, 1998) that explained how children's negative attitudes, low perceived control, and dearth of previous separation experiences predisposed them to the kind of severe homesickness associated with clinically significant symptoms of anxiety and depression. The current study shows one way to instill positive attitudes, increase feelings of control, and provide children with a growth experience that has lifelong implications for positive adjustment to separation and novelty.

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