

THE UNIVERSITY  
OF ADELAIDE  
AUSTRALIA

**Back home: Distress in re-entering  
cross-cultural missionary workers and the  
development of a theoretical framework for  
clinical management**

**Susan Selby**

January 2011

Discipline of General Practice  
School of Population Health and Clinical Practice  
Faculty of Health Sciences  
University of Adelaide

*Thesis submitted in fulfilment of the requirements for the  
Degree of Doctor of Philosophy*

*Roads go ever on  
Under cloud and under star,  
Yet feet that wandering have gone  
Turn at last to home afar.  
Eyes that fire and sword have seen  
And horror in the halls of stone  
Look at last on meadows green  
And trees and hills they long have known.*

*Gandalf looked at him. 'My dear Bilbo!' he said. 'Something is the matter with you! You are not the hobbit that you were.' And so they crossed the bridge and passed by the mill by the river and came right back to Bilbo's own door. 'Bless me! What's going on?' he cried.*  
(Tolkien, 1999, pp. 276-277)

**For my husband, Derrick, with my heartfelt thanks**

CONTENTS

CONTENTS..... III

LIST OF TABLES ..... XI

LIST OF FIGURES ..... XII

ABSTRACT..... XIII

MANUSCRIPTS CONTRIBUTING TO THIS THESIS..... XV

DECLARATION ..... XVI

    Copyright Holders..... XVIII

CONFERENCE PRESENTATIONS ARISING OUT OF THIS THESIS ..... XX

AWARDS ARISING OUT OF THIS THESIS ..... XXII

ACKNOWLEDGEMENTS..... XXIII

STATEMENTS OF AUTHORSHIP ..... XXVIII

    Back Home: A Qualitative Study Exploring Re-entering Cross-cultural  
    Missionary Aid Workers’ Loss and Grief. *Omega* 2009, 59, 19–38.. XXVIII

    Resilience in Re-entering Missionaries: Why do Some do Well? *Mental  
    Health, Religion and Culture* 2009, 12, 701–720..... XXXI

    Special People? An Exploratory Study into Re-entering Missionaries’ Identity  
    and Resilience. *The Journal of Religion and Health* 2010 [electronic  
    version] ..... XXXIII

    Cross-cultural Re-entry for Missionaries: A New Application for the Dual  
    Process Model. *Omega* 2010-2011, 62, 329–351..... XXXV

CHAPTER 1: BACKGROUND, RESEARCH QUESTIONS AND THESIS  
OVERVIEW ..... 1

    1.1 The Re-Entering Cross-cultural Missionary Worker and their General  
    Practitioner..... 1

    1.2 Aims, Research Questions and Approach of This Thesis..... 5

    1.3 My Role as Researcher ..... 8

    1.4 The Thesis Argument and Outline..... 10

CHAPTER 2: THE LITERATURE AND CULTURAL ADAPTATION:  
ACCULTURATION AND REACCULTURATION OR RE-ENTRY ADJUSTMENT ... 14

2.1	Introduction.....	14
2.2	Terminology of Cultural Adaptation .....	15
2.2.1	Acculturation .....	15
2.2.2	Reacculturation or re-entry adjustment.....	16
2.3	Who Re-enters?.....	17
2.4	Re-entry Adjustment Theories.....	19
2.4.1	Affective theoretical concepts .....	20
2.4.2	Behavioural theoretical concepts .....	21
2.4.3	Cognitive theoretical concepts.....	22
2.5	What does the Literature Tell Us about Psychological Distress during Re-entry?.....	24
2.5.1	What is psychological distress? .....	25
2.5.2	Psychological distress associated with migration: acculturation and re-entry adjustment .....	26
2.5.3	Loss and grief and re-entry adjustment.....	29
2.5.4	The loss and grief paradigm.....	34
2.5.5	The resilience paradigm.....	38
2.6	Psychological Care during Re-entry .....	39
2.6.1	Group care: re-entry transition programs.....	40
2.6.2	Individual care: non-clinical and clinical.....	42
2.7	What is missing?.....	48
2.8	Conclusion .....	49
CHAPTER 3: THE STUDY DESIGN .....		50
3.1	Introduction.....	50
3.2	Following the Research Questions: My Evolving Journey .....	51
3.3	Answering Question 1: Mixed Methods.....	54
3.3.1	Theoretical basis and rationale .....	55
3.3.2	The survey: the less dominant quantitative method.....	56

3.3.3	The semi-structured interview: the dominant qualitative method ...	57
3.3.4	Reliability, validity and rigour .....	60
3.4	Answering Question 2: Developing a Framework for Clinical Use .....	62
3.5	Ethical Considerations .....	62
3.5.1	Beneficence .....	63
3.5.2	Respect for persons .....	65
3.6	Overview of Study Design .....	67
3.7	Conclusion .....	69
CHAPTER 4: THE IMPLEMENTATION OF THE STUDY .....		70
4.1	Introduction .....	70
4.2	Sample .....	70
4.2.1	Rationale .....	71
4.2.2	Inclusion criteria .....	71
4.2.3	Recruitment .....	74
4.3	Answering the First Research Question: Development of Data Collection Instruments .....	76
4.3.1	The survey .....	76
4.3.2	The semi-structured interview .....	86
4.4	Answering the First Research Question: Data Collection .....	90
4.4.1	The survey .....	90
4.4.2	The semi-structured interview .....	91
4.5	Answering the First Research Question: Data Analysis .....	92
4.5.1	The survey .....	92
4.5.2	The semi-structured interview .....	95
4.6	Answering the Second Research Question .....	102
4.7	Conclusion .....	103
CHAPTER 5: BIOGRAPHIES AND THE QUANTITATIVE RESULTS SUMMARY FOR ALL PARTICIPANTS .....		104

5.1	Introduction.....	104
5.2	The Study Participants: Their Re-entry Context and Our Interaction .....	104
5.2.1	Neil.....	105
5.2.2	Jenny .....	107
5.2.4	Pam .....	108
5.2.5	Joan .....	109
5.2.6	Chas .....	111
5.2.7	Greta.....	112
5.2.8	Sam .....	113
5.2.9	Trudy.....	114
5.2.10	Felicity .....	115
5.2.11	Carrie .....	116
5.2.12	Lily.....	117
5.2.13	Grant .....	118
5.2.14	Bernie.....	119
5.2.15	Helen.....	119
5.3	Quantitative Results for All Participants from Loss Review (Section A) and Grief Measure (Section B) of RGDI .....	120
5.4	Limitations of the Quantitative Data .....	121
5.5	Conclusion .....	122
CHAPTER 6: THE QUALITATIVE RESULTS IN THREE ARTICLES .....		123
6.1	Introduction.....	123
6.2	Back Home: A Qualitative Study Exploring Re-entering Cross-cultural Missionary Aid Workers’ Loss and Grief.....	124
6.3	Resilience in Re-entering Missionaries: Why Do Some Do Well? .....	145
6.4	Special People? An Exploratory Study into Re-entering Missionaries’ Identity and Resilience.....	169
6.5	Supporting Evidence for the Qualitative Data from the Quantitative Data.....	188

6.6	Conclusion .....	188
CHAPTER 7: THE STUDY FINDINGS: A NEW APPLICATION FOR THE DUAL PROCESS MODEL .....		
190		
7.1	Introduction.....	190
7.2	Cross-cultural Re-entry for Missionaries: A New Application for the Dual Process Model .....	190
7.3	Application of the Dual Process Model Applied to Re-entry in the Australian General Practice Setting .....	229
7.4	Conclusion .....	231
CHAPTER 8: THE JOURNEY, THE FINDINGS AND THE FUTURE.....		
233		
8.1	Introduction.....	233
8.2	The Loss and Grief Paradigm for Re-entry .....	234
8.3	The Role of Resilience in Re-entry.....	236
8.4	A New Theoretical Framework for Re-entry: The Dual Process Model Adapted for Re-entry (DPMR) .....	238
8.5	Limitations of the Study .....	239
8.6	Suggestions for Re-entrants’ Communities from the Results of this Study .....	241
8.6.1	Suggestions for the sending organisation .....	241
8.6.2	Suggestions for the faith community .....	242
8.6.3	Suggestions for family and friends .....	242
8.7	Further Research .....	243
8.8	Conclusion .....	244
GLOSSARY: DEFINITIONS USED IN THIS THESIS .....		
245		
APPENDIX 1: SEARCH STRATEGY FOR THE LITERATURE REVIEW IN CHAPTER 2 .....		
253		
APPENDIX 2: ETHICS APPROVAL FROM THE UNIVERSITY OF ADELAIDE .....		
255		
APPENDIX 3: THE PARTICIPANT INFORMATION SHEET .....		
257		
	Participant Information Sheet for The Development of a Repatriation Program to Deal with Issues of Grief and Loss in Adult Australian Cross-Cultural Workers.....	257

The University of Adelaide Human Research Ethics Committee Document for People who are Subjects in a Research Project .....	260
Contacts for Information on Project and Independent Complaints Procedure .....	260
APPENDIX 4: CONSENT FORM.....	262
Standard Consent Form for People who are Subjects in the Research Project: The Development of a Repatriation Program to Deal with Issues of Grief and Loss in Adult Australian Cross-Cultural Workers .....	262
APPENDIX 5: THE SURVEY .....	264
Appendix 5A. The Re-entry Demographics Questionnaire originally known as the <i>Demographics Questionnaire</i> .....	265
Appendix 5B. The Re-entry Grief Diagnostic Instrument also known as <i>The Loss and Grief Questionnaire for Re-entry to Australia</i> .....	270
Appendix 5C. The DASS 21 Questionnaire .....	278
APPENDIX 6: LETTER TO MISSION ADMINISTRATOR (DE-IDENTIFIED) .....	279
APPENDIX 7: EMAIL INVITATION TO BE SENT BY THE MISSIONARY ORGANISATION TO PARTICIPANTS.....	282
APPENDIX 8: INVITATION TO PARTICIPANTS IN SURVEY PACK.....	284
APPENDIX 9: RE-ENTRY DEMOGRAPHICS QUESTIONNAIRE: FIRST VERSION .....	286
APPENDIX 10: THE GRIEF DIAGNOSTIC INSTRUMENT .....	290
APPENDIX 11: PERMISSION TO USE THE GRIEF DIAGNOSTIC INSTRUMENT	299
APPENDIX 12: THE RE-ENTRY GRIEF DIAGNOSTIC INSTRUMENT: FIRST VERSION .....	300
APPENDIX 13: THE SEMI-STRUCTURED INTERVIEW SCHEDULE: FIRST DRAFT .....	307
APPENDIX 14: THE ARTICLE: SELBY, S., JONES, A., BURGESS, T., CLARK, S., MOULDING, N., & BEILBY, J. (2007). DISENFRANCHISED GRIEVERS – THE GP’S ROLE IN MANAGEMENT. <i>AUSTRALIAN FAMILY PHYSICIAN</i> , 36, 768–770.	311
APPENDIX 15: DEMOGRAPHIC RESULTS FOR PILOT AND STUDY PARTICIPANTS .....	315
APPENDIX 16: ANALYSIS, RESULTS AND DISCUSSION OF THE QUANTITATIVE DATA FOR ALL PARTICIPANTS.....	317
16.1 Introduction.....	317



16.2	Loss Assessment Results: Survey – RGDI (Section A) and Interview .....	317
16.2.1	The incidence of loss .....	318
16.2.2	Multiples of loss categories .....	318
16.2.3	Frequencies of loss categories .....	320
16.2.4	Validity .....	322
16.3	Grief Assessment Results: Survey – RGDI (Section B) and Interview.....	322
16.3.1	Grief score analysis: survey – RGDI (section B) .....	323
16.3.2	Measurement of disenfranchised grief: interview .....	326
16.4	Mental Health Indices: Survey – DASS 21 Questionnaire.....	326
16.5	Discussion.....	327
16.5.1	Loss assessment results and grief scores .....	327
16.5.2	Disenfranchised grief.....	329
16.5.3	Mental health indices .....	330
16.6	Conclusion .....	331
<b>APPENDIX 17: RESULTS OF THE QUANTITATIVE ANALYSIS FOR RESILIENT AND FRAGILE PARTICIPANTS .....</b>		<b>332</b>
17.1	Introduction.....	332
17.2	Loss Assessment Results: Survey – RGDI (Section A) and Interview .....	332
17.2.1	The incidence of loss .....	332
17.2.2	Multiples of loss categories .....	333
17.2.3	Frequencies of loss categories .....	333
17.2.4	Validity .....	333
17.3	Grief Measure Results: Survey – (Section B) RGDI and Interview.....	336
17.3.1	Survey – grief measure (section B) of RGDI: descriptive statistics; incidence of grief; reliability and validity.....	336
17.3.2	Measurement of numbers of participants with disenfranchised grief.....	337
17.4	Mental Health Indices: Survey – DASS 21 Questionnaire.....	338

17.4.1	Descriptive statistics .....	339
17.4.2	Comparison of loss categories from RGDI (section A) and interview with grief scores from RGDI (section B) and DASS 21 scores .....	339
17.5	Discussion.....	340
17.5.1	Loss assessment results and grief scores .....	340
17.5.2	Disenfranchised grief.....	341
17.5.3	Mental health indices .....	342
17.5.4	Clinical uses of the survey .....	343
APPENDIX 18: PERMISSION FROM MISSION AGENCIES TO CONDUCT RESEARCH (DE-IDENTIFIED) .....		344
APPENDIX 19: ARTICLE: SELBY, S., JONES, A., CLARK, S., BURGESS, T., & BEILBY, J. (2005). RE-ENTRY ADJUSTMENT OF CROSS CULTURAL WORKERS – THE ROLE OF THE GP. <i>AUSTRALIAN FAMILY PHYSICIAN</i> , 34, 863–864, 878. ....		348
APPENDIX 20: LIST OF GRIEF PHENOMENA .....		352
APPENDIX 21: CONFIRMATION OF UPCOMING PRINT PUBLICATION: SELBY, S., BRAUNACK-MAYER, A., JONES, A., CLARK, S., MOULDING, N., & BEILBY, J. (2010). SPECIAL PEOPLE? AN EXPLORATORY STUDY INTO RE-ENTERING MISSIONARIES’ IDENTITY AND RESILIENCE. <i>JOURNAL OF RELIGION AND HEALTH</i> , FEBRUARY 24, DOI: 10.1007/S10943-010-9337-8 .....		354
APPENDIX 22: CONFIRMATION OF ACCEPTANCE FOR PUBLICATION: SELBY, S., CLARK, S., BRAUNACK-MAYER, A., JONES, A., MOULDING, N., & BEILBY, J. (IN PRESS, 2011). CROSS-CULTURAL RE-ENTRY FOR MISSIONARIES: A NEW APPLICATION FOR THE DUAL PROCESS MODEL. <i>OMEGA</i> , 62, 329–351. ....		356
REFERENCES .....		357

## LIST OF TABLES

Table 1. Development of the Re-entry Demographics Questionnaire.....	78
Table 2. Loss Categories for the Loss Review (Section A) of the Re-entry Grief Diagnostic Instrument .....	81
Table 3. Development of the Loss Review (Section A) of the Re-entry Grief Diagnostic Instrument .....	82
Table 4. Items from the Grief Measurement (Section B) of the Re-entry Grief Diagnostic Instrument .....	83
Table 5. Development of the Semi-structured Interview Schedule .....	88
Table 6. Questions in the Final Semi-structured Interview Schedule.....	89
Table 7. Thematic Analysis of the Semi-structured Interview .....	100
Table 8. Suggested Mapping for the Care of Psychologically Distressed Re-entrants as Part of the Quality Framework for Australian General Practice (modified from Booth et al., 2005) .....	232

LIST OF FIGURES

Figure 1. The Thesis Map .....13

Figure 2. Research Questions .....53

Figure 3. Study Design .....68

Figure 4. The Process of Participant Entry to the Study.....75

Figure 5. Framework Analysis.....101

## ABSTRACT

A high proportion of cross cultural aid workers and missionaries who may also be involved in aid work are known to suffer from significant psychological distress on re-entry. In the Australian primary health care system, Australian general practitioners are most often the first point of contact for those with psychological distress. There is, however, little acknowledgement or understanding in the medical literature of the distress of this particular group in Australian society and their management in the general practice setting. This thesis addresses these issues with an analysis of the experiences of 15 returned adult Australian missionaries.

The thesis presents an analysis of evidence and builds theory using predominantly qualitative methods. Firstly, I comprehensively explore the evidence for the nature of the distress suffered by these re-entering missionaries. Through analysis of their accounts of their day-to-day lived experience during the interactive transition of their re-entry, I demonstrate the importance of their loss and grief, particularly their disenfranchised grief, as part of their psychological distress. I describe a new type of disenfranchised grief: self-absorbed disenfranchised grief. Some missionaries appeared to have less distress than others, which has led me to categorise two groups of re-entrants, the resilient and fragile. Further exploration of these missionaries' psychological distress led me to focus on the nature of their resilience. I demonstrate the psychological, social and spiritual constructs which increase resilience in this group in the context of multiple losses and grief as well as the role of their identity disparities. I also demonstrate a link between resilience and identity disparities.

Secondly, the results of this thesis together with the existing theoretical models for loss and grief enable me to build an evidence-based theoretical framework to address psychological distress during re-entry. I show how the Dual Process Model, which addresses

loss and grief after bereavement, may be modified to address loss and grief during re-entry based on the findings of this study. Within this framework I also demonstrate the facilitators and barriers that affect the missionaries' psychological distress during re-entry. I offer this model as a framework for dealing with missionaries' psychological distress during re-entry in the clinical setting.

## MANUSCRIPTS CONTRIBUTING TO THIS THESIS

*Published*

Selby, S., Moulding, N., Clark, S., Jones, A., Braunack-Mayer, A., & Beilby, J. (2009). Back home: a qualitative study exploring re-entering cross-cultural missionary aid workers' loss and grief. *Omega*, *59*, 19–38.

Selby, S., Braunack-Mayer, A., Moulding, N., Jones, A., Clark, S., & Beilby, J. (2009). Resilience in re-entering missionaries: why do some do well? *Mental Health, Religion and Culture*, *12*, 701–720.

Selby, S., Braunack-Mayer, A., Jones, A., Clark, S., Moulding, N., & Beilby, J. (2010). Special people? An exploratory study into re-entering missionaries' identity and resilience. *Journal of Religion and Health*, February 24, doi: 10.1007/s10943-010-9337-8 [Epub ahead of print. To be published in hard copy (Appendix 21)]

*Accepted for publication*

Selby, S., Clark, S., Braunack-Mayer, A., Jones, A., Moulding, N., & Beilby, J. (in press). Cross-cultural re-entry for missionaries: A new application for the Dual Process Model. *Omega*. [Letter of acceptance received August 7, 2010 (Appendix 22)]

---

## DECLARATION

This PhD “by a combination of conventional written narrative presented as typescript and publications that have been published and/or submitted for publication” is consistent with the minimum standards set down in the Academic Program rules outlined in the Adelaide Graduate Centre’s postgraduate program rules (PhD rule 7.1-7.7 and specifications, 2010) and the Faculty of Health Sciences PhD by publication guidelines specific to the School of Population Health and Clinical Practice available at (web link accessed November 26, 2010):

<http://health.adelaide.edu.au/research/higher/code/SchoolPhDThesisbypublicationGuidelines.pdf>

Choice of journals in this portfolio of publications is justified as follows.

International peer reviewed journals were chosen as this topic, whilst important in the Australian context, addresses issues which are relevant to the global community.

*Omega – Journal of Death and Dying* is the most advanced and internationally recognised journal on the subject of death and dying and is one of the journals which also address non-death loss and grief, one of the central themes of this thesis and the topic of the first article. It has also devoted an issue (Volume 61, Issue 4, 2010) to the Dual Process Model and appeared to be the most appropriate journal for the fourth article which described another use and adaptation for the Dual Process Model related to re-entry. It is an official ADEC (Association for Death Education Counseling) Affiliated Journal (2009 ISI Impact Factor: 0.554). *Mental Health, Religion and Culture* is a journal which provides an authoritative forum and a single point of reference for the growing number of professionals and academics working in the expanding field of mental health and religion (2009 ISI Impact Factor: unavailable)



which is closely related to the topic of this thesis. *The Journal of Religion and Health* (2009 ISI Impact Factor: 0.358) is a journal which explores the most contemporary modes of religious and spiritual thought with particular emphasis on their relevance to current medical and psychological research. This journal was particularly appropriate for the third article about the relationship between identity disparities and resilience in re-entering missionaries which had not been previously described.

Signed:

Dated:

14/1/11

Susan Selby  
(Candidate)

24.01.2011

Prof Annette Braunack-Mayer  
(Principal Supervisor)

14/1/11

Adjunct Assoc Prof Alison Jones  
(Co-Supervisor)

22/1/11

Dr Sheila Clark  
(Co-Supervisor)

20/1/11

Dr Nicole Moulding  
(External Supervisor)

17/1/11

Prof Justin Beilby  
(Co-Supervisor)

This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution to Susan Selby and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis when deposited in the University Library, being made available for loan and photocopying, subject to the provisions of the Copyright Act 1968.

The author acknowledges that copyright of published works contained within this thesis (as listed below) resides with the copyright holder(s) of those works.

I also give permission for the digital version of my thesis to be made available on the web, via the University's digital research repository, the Library catalogue, the Australasian Digital Theses Program (ADTP) and also through web search engines, unless permission has been granted by the University to restrict access for a period of time.

Signed:

Dated:

..

..14/1/11

Susan Selby (Candidate)

#### Copyright Holders

Baywood Publishing Co., Inc. ("Baywood Publishing") is the Copyright Holder for the articles:

Selby, S., Moulding, N., Clark, S., Jones, A., Braunack-Mayer, A., & Beilby, J. (2009). Back home: a qualitative study exploring re-entering cross-cultural missionary aid workers' loss and grief. *Omega*, 59, 19–38.

Selby, S., Clark, S., Braunack-Mayer, A., Jones, A., Moulding, N., & Beilby, J. (in press, 2011). Cross-cultural re-entry for missionaries: A new application for the Dual Process Model. *Omega*, 62, 329–351.

Taylor & Francis is the Copyright Holder for the article:

Selby, S., Braunack-Mayer, A., Moulding, N., Jones, A., Clark, S., & Beilby, J. (2009). Resilience in re-entering missionaries: why do some do well? *Mental Health, Religion and Culture*, 12, 701–720.

“Springer Science+Business media, LLC” is the copyright holder for the article which will be published in hard copy in 2011/12:

Selby, S., Braunack-Mayer, A., Jones, A., Clark, S., Moulding, N., & Beilby, J. (2010). Special people? An exploratory study into re-entering missionaries’ identity and resilience. *Journal of Religion and Health*, February 24, doi: 10.1007/s10943-010-9337-8 [Epub ahead of print.]

## CONFERENCE PRESENTATIONS ARISING OUT OF THIS THESIS

- Selby, S. (2010, November 18–21). *Jesus wept: translating research into practice for re-entry loss and grief*. Presented at the Missions and Mental Health Conference, Angola, Indiana, USA.
- Selby, S. (2010, October 1). *Jesus wept: translating research into practice for re-entry loss and grief*. Presented at the School of Population Health and Clinical Practice 2010 Higher Degree Research Symposium, The University of Adelaide, Adelaide, Australia.
- Selby, S., Moulding, N., Braunack-Mayer, A., Jones, A., Clark, S., & Beilby, J. (2008, October 2–5). *Loss and grief in Australian missionaries on re-entry: how can the GP help?* Presented at the Christian Mission in the Public Square Conference, Australian Centre for Christianity and Culture, Charles Sturt University, Canberra, Australia.
- Selby, S., Clark, S., Moulding, N., Jones, A., Braunack-Mayer, A., & Beilby, J. (2008, July 15–18). *Loss and grief in Australian cross-cultural missionary aid workers on re-entry: a mixed method study*. Presented at the 8<sup>th</sup> International Conference on Grief and Bereavement, Melbourne, Australia.
- Selby, S., Moulding, N., Braunack-Mayer, A., Jones, A., Clark, S., & Beilby, J. (2008, April 8–12). *Loss and grief in Australian missionaries on re-entry: how can the GP help?* Presented at the 5th International Lausanne Conference, Geelong, Australia.

Selby, S., Moulding, N., Clark, S., Jones, A., Burgess, T., & Beilby, J. (2007, July 24–27). *Loss and grief in cross-cultural workers on re-entry: how can we help?*

Presented at the 18<sup>th</sup> WONCA (World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians) World Conference, Singapore.

Selby, S., Moulding, N., Clark, S., Jones, A., Burgess, T., & Beilby, J. (2006, September 21). *A rudderless ship: the development of a program in general*

*practice to manage loss and grief in cross-cultural workers re-entering Australia.* Presented at the Primary Health Care Research Evaluation & Development (PHCRED) Tri-Statewide Collaboration Event, Adelaide, Australia.

Selby, S., Moulding, N., Clark, S., Jones, A., & Beilby, J. (2006, July 7–16). *A fish out*

*of water: the development of a program in general practice to manage loss and grief as missionaries re-enter.* Presented at the International Christian Medical and Dental Fellowship Conference, Sydney, Australia.

Selby, S., Moulding, N., Jones, A., Clark, S., Burgess, T., & Beilby, J. (2005, October 28). *A fish out of water: the development of a re-entry program to deal with*

*issues of loss and grief in adult Australian cross-cultural workers.* Presented at the Primary Health Care Research Evaluation and Development South Australian Showcase Day, Port Lincoln, Australia.

## AWARDS ARISING OUT OF THIS THESIS

Faculty of Health Sciences Travelling Fellowship Award, The University of Adelaide,  
Adelaide, Australia, 2010 [competitive].

The University of Adelaide Completion Scholarship, The University of Adelaide,  
Adelaide, Australia, 2010 [competitive].

The Peoples Award for the Most Popular Presentation, School of Population Health  
and Clinical Practice 2010 Higher Degree Research Symposium, The  
University of Adelaide, Adelaide, Australia, 2010.

*Primary Health Care Research, Evaluation and Development (PHCRED)* Research  
Development Program (RDP) Fellow, Adelaide, Australia, 2006 [competitive].

Faculty of Health Sciences Award for Part-time Research Students, The University of  
Adelaide, Adelaide, Australia, 2004 [competitive].

## ACKNOWLEDGEMENTS

*Through wisdom is a house built; and by understanding it is established; and by knowledge shall every room be filled with precious and pleasant riches.*

*Proverbs 24:3*

There have been very many people who have been part of this journey as I re-entered University and learnt again. I wish to acknowledge them below and to those whom I do not specifically mention, my sincere thanks for also being part of the re-entry.

### *The participants*

Thank you for sharing your precious journeys with me and for enabling others to benefit from your participation. Special thanks to Belinda.

### *The sending agencies*

Thank you for your co-operation, time and support in the recruitment of participants.

### *Funding assistance*

Thank you to the Faculty of Health Sciences, The University of Adelaide for supporting this research with a part-time research student's award (2004) and a Travelling Fellowship Award (2010). Thank you to the PHCRED program for their support of my RDP fellowship (2006). Thank you to the Discipline of General Practice, The School of Population Health and Clinical Practice for the award of a completion scholarship (2010).

*Administrative, technical and editing assistance*

My sincere thanks to the following people for their excellent professional help.

Maria McGivern and Bill Winser edited this thesis, according to ASEP Standards: *Language and Illustrations* and *Completeness and Consistency*.

Sue Farrant and Wendy Trimper for their invaluable assistance with transcription.

Sabine Schreiber for her guidance through the Ethics application and her encouragement and support.

Michel Draper for his expert help, patient assistance and encouragement with library matters and Endnote.

Dr Gillian Laven and Lucy Zuzolo for their help with Endnote and encouragement and support.

Dr Anne Wilson for her help with understanding NVivo2 and her encouragement and support.

Dr Nancy Briggs and Michelle Lorimer, statisticians, provided statistical advice and conducted the analysis of the descriptive statistics.

Isabel Mason, Meg Mignone, Gerry Hupfeld and Nicky Bennett who provided administrative support and technical assistance.

Peter Beilby, Paul Williams and Paul Carter for their computing assistance.

*Special people*

Thank you to Joan Lester whose original research sent me down a path towards the questions and the answers. She constantly encouraged me by email from the USA.

Joan and her husband, Lee, were gracious hosts when my husband and I visited them in 2009.



Thank you to Teresa Burgess for valuable guidance and encouragement particularly in the early days and for your continuing care over breakfast as the project has unfolded. Thank you for your confidence that I was able to write an article and for your collaboration in my first efforts.

*My supervisors*

Few people are privileged to have five supervisors who have continuously encouraged, guided and supported me over a period of 7 years. I wish to thank them in the order in which they joined the project.

Dr Sheila Clark – Thank you for having a vision for this journey when it was only vague questions in the recesses of my mind. Thank you also for your amazing expertise in the field of loss and grief which has been an inspiration. Thank you for all the reviving coffees, cakes and tissues when things were difficult.

Professor Justin Beilby – Thank you for believing that I would be able to do this, even when I was very unsure. Thank you for your clarity of thought which always helped me avoid the dead ends. Thank you for continuing to be involved despite your heavy workload.

Dr Alison Jones – Thank you for your personal commitment to my journey through this research, your constant encouragement and expert guidance. You enabled me to widen my vision and gave me the tools to recognise the important parts. Thank you for your humour and for those wonderful early morning discussions at Cibos.

Dr Nicole Moulding – Thank you for giving me another view from the social sciences which greatly enriched the project. Thank you for your attention to detail and for your enthusiasm about the project and its findings. Thank you for your care and support as I battled with the data.

Professor Annette Braunack-Mayer – Thank you for joining this project when it was at a cross road and guiding me down the road less travelled to precious places. Thank you for your pearls of expertise and wisdom which have enabled me to harvest knowledge and understanding. Thank you for continuing to be part of the project as your workload increased and for your personal concern and encouragement.

*My colleagues and friends*

Thank you to my special friends Sally Noble, Ann Grant, Peter and Lucy Carberry whose support has enabled the completion of this task.

Thank you to my fellow students who made the journey so rich, amusing and put it in perspective, especially Jo Dollard, Heather Tan, Antonina Mikocka-Walus, Rosie King, Marijeta Kurtin, and Karina Bria. Thank you, Jo, for always being available to answer questions and for teaching me about the “killer instinct” to enable completion. I am grateful to Caroline Laurence for her constant encouragement, wise advice and for checking the final draft of an article. I would also like to thank Karin Ried and Chris Holton for their encouragement and for providing research discussion opportunities and my colleagues in the Discipline of General Practice for their support. Thank you to Judy, Louise, Rosemary, Wendy, Sharyn, and all my friends who are still friends despite my increasingly hermit-like existence over the past 7 years.

*Prayer supporters*

Thank you to my prayer partner of 25 years, Judy Black. She has been a constant source of loving support and encouragement. The difference her prayers have made to this journey will only be discovered in the future. Thank you to my prayer email

group, especially, Sherri Greef, Val Trim, Jo Chalmers, Rick and Viv Cambrell, Leigh and Kerryn Cameron and my daughter, Katie. Your sacrificial prayers have been the oil in the engine at every stage. Thank you to Anne, my spiritual director, for showing me what brings life. Thank you to my church, Knightsbridge Baptist, and the prayer group led by Catherine Carr. Thank you to the home groups I have been part of over these years who have prayerfully supported the work. Thank you to those whom I have not named but who have been interceding faithfully.

### *Family*

Thank you to my family for having a part-time wife and mother over these past seven years. Thank you to my children and their partners, Michael and Yen-Lee, Matt, Katie and Kinanga, Phil and Lisa, for your shining examples of perseverance in your studies and your love and care. Thank you to my grandson, James, for keeping me laughing. Thank you to my parents, Roland and Pattie Chambers who valued learning from the beginning. Thank you to my grandparents, Dorothy Harrison, George and Winifred Chambers, who enabled me to have this opportunity by experiencing the distress of crossing cultures.

I thank my darling husband Derrick for his complete support, love and patience as he has been attacked by untidy linen presses, dealt with my computing woes, proof read articles and had his relaxation times interrupted by just another urgent article I had to find. This is your thesis and words cannot express how thankful I am for your generosity in enabling me to complete this work.

Finally, I thank and praise my Lord and Saviour, Jesus, for giving me the privilege of completing this project to the glory of His name. Of course, He will always have the final word on re-entry.

STATEMENTS OF AUTHORSHIP

Back Home: A Qualitative Study Exploring Re-entering Cross-cultural Missionary  
Aid Workers' Loss and Grief.  
*Omega* 2009, 59, 19–38.

*Susan Selby, The University of Adelaide (Candidate)*

Conceived and conceptualised manuscript orientation and structure, developed study design, carried out literature review, undertook familiarisation of data, identification of thematic framework and predetermined concepts as major themes, coded the data, compared data and undertook concept mapping, wrote the manuscript and acted as the corresponding author. I certify that the statement of contribution is accurate.

Signed ..... Date ..19/1/11.

*Nicole Moulding, The University of South Australia*

My contribution to this paper involved: Contribution to data interpretation and manuscript evaluation. I certify that the statement of contribution is accurate and permission is given for Susan Selby to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed . ..... Date ..20/1/11.

*Sheila Clark, The University of Adelaide*

My contribution to this paper involved: Supervised development of the work, helped in data interpretation and manuscript evaluation. I certify that the statement of contribution is accurate and permission is given for Susan Selby to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed ..... Date *22/1/11*

*Alison Jones, Royal Australasian College of Physicians*

My contribution to this paper involved: Supervised development of the work and manuscript evaluation. I certify that the statement of contribution is accurate and permission is given for Susan Selby to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed ..... Date *14/1/11*

*Annette Braunack-Mayer, The University of Adelaide*

My contribution to this paper involved assistance with development of the work and manuscript evaluation. I certify that the statement of contribution is accurate and permission is given for Susan Selby to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed .. Date *24.01.2011*

*Justin Beilby, The University of Adelaide*

My contribution to this paper involved assistance with development of the work and manuscript evaluation. I certify that the statement of contribution is accurate and permission is given for Susan Selby to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed .....

.....Date .....

17/1/11

Resilience in Re-entering Missionaries: Why do Some do Well?

*Mental Health, Religion and Culture* 2009, 12, 701–720.

*Susan Selby, The University of Adelaide (Candidate)*

Conceived and conceptualised manuscript orientation and structure, developed study design, carried out the literature review, analysed the data by the three methods described, wrote the manuscript and acted as the corresponding author. I certify that the statement of contribution is accurate.

Signed ..... Date 14/1/11

*Annette Braunack-Mayer, The University of Adelaide*

My contribution to this paper involved: Contribution to data interpretation and manuscript evaluation. I certify that the statement of contribution is accurate and permission is given for Susan Selby to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed . Date 24.01.2011

*Nicole Moulding, The University of South Australia*

My contribution to this paper involved: Contribution to data interpretation and manuscript evaluation. I certify that the statement of contribution is accurate and permission is given for Susan Selby to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed ... Date 20/1/11

*Alison Jones, Royal Australasian College of Physicians*

My contribution to this paper involved: Contribution to data interpretation and manuscript evaluation. I certify that the statement of contribution is accurate and permission is given for Susan Selby to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed ... .....Date ... 14/1/11 ..

*Sheila Clark, The University of Adelaide*

My contribution to this paper involved: Supervised development of the work, helped in data interpretation and manuscript evaluation. I certify that the statement of contribution is accurate and permission is given for Susan Selby to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed .....Date ... 22/1/11 ..

*Justin Beilby, The University of Adelaide*

My contribution to this paper involved assistance with development of the work and manuscript evaluation. I certify that the statement of contribution is accurate and permission is given for Susan Selby to include this paper in this thesis for examination towards the Doctor of Philosophy. ^

Signed .....Date ... 17/1/11 ..



Special People? An Exploratory Study into Re-entering Missionaries' Identity and Resilience.

*The Journal of Religion and Health* 2010 [electronic version]

*Susan Selby, The University of Adelaide (Candidate)*

Conceived and conceptualised manuscript orientation and structure, developed study design, carried out the literature review, analysed the data, wrote the manuscript and acted as the corresponding author. I certify that the statement of contribution is accurate.

Signed .....

.....Date 14/1/11

*Annette Braunack-Mayer, The University of Adelaide*

My contribution to this paper involved: Contribution to data interpretation and manuscript evaluation. I certify that the statement of contribution is accurate and permission is given for Susan Selby to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed .

.....Date 24.01.2011

*Alison Jones, Royal Australasian College of Physicians*

My contribution to this paper involved: Contribution to data interpretation and manuscript evaluation. I certify that the statement of contribution is accurate and permission is given for Susan Selby to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed .....

.....Date 19/1/11

*Sheila Clark, The University of Adelaide*

My contribution to this paper involved: Supervised development of the work, helped in data interpretation and manuscript evaluation. I certify that the statement of contribution is accurate and permission is given for Susan Selby to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed ..... Date ..2.2.11..

*Nicole Moulding, The University of South Australia*

My contribution to this paper involved: Contribution to data interpretation and manuscript evaluation. I certify that the statement of contribution is accurate and permission is given for Susan Selby to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed ..... Date 20/1/11

*Justin Beilby, The University of Adelaide*

My contribution to this paper involved assistance with development of the work and manuscript evaluation. I certify that the statement of contribution is accurate and permission is given for Susan Selby to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed ..... Date 17/1/11

Cross-cultural Re-entry for Missionaries: A New Application for the Dual Process Model.

*Omega* 2010-2011, 62, 329–351.

*Susan Selby, The University of Adelaide (Candidate)*

Conceived and conceptualised manuscript orientation and structure, carried out the literature review, modified the Dual Process Model, applied the study results to the Dual Process Model, wrote the manuscript and acted as the corresponding author. I certify that the statement of contribution is accurate.

Signed ..... Date ..14.1.11..

*Sheila Clark, The University of Adelaide*

My contribution to this paper involved: helped in data interpretation and manuscript evaluation. I certify that the statement of contribution is accurate and permission is given for Susan Selby to include this paper in this thesis for examination towards the Doctor of Philosophy

Signed ..... Date ...22.1.11

*Annette Braunack-Mayer, The University of Adelaide*

My contribution to this paper involved manuscript evaluation. I certify that the statement of contribution is accurate and permission is given for Susan Selby to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed . ..... Date 24.01.2011

*Alison Jones, The University of Adelaide*

My contribution to this paper involved manuscript evaluation. I certify that the statement of contribution is accurate and permission is given for Susan Selby to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed ..... Date 14/11/11

*Nicole Moulding, The University of South Australia*

My contribution to this paper involved manuscript evaluation. I certify that the statement of contribution is accurate and permission is given for Susan Selby to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed ..... Date 20/1/11

*Justin Beilby, The University of Adelaide*

My contribution to this paper involved assistance with development of the work and manuscript evaluation. I certify that the statement of contribution is accurate and permission is given for Susan Selby to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed ..... Date 17/1/11

## CHAPTER 1: BACKGROUND, RESEARCH QUESTIONS AND THESIS OVERVIEW

### 1.1 The Re-Entering Cross-cultural Missionary Worker and their General Practitioner

*We had planned to return from [host country] in time to see our eldest into high school so our departure was planned ... I went from being someone to being nothing, which was sort of what happened when I went to [host country] six years ago. I went from being somebody in my church and somebody at my workplace to being nobody of any account, not even being able to communicate with people, so now I had the same thing coming back into my home country. All of the networks that I had before had disappeared, friends had moved on, there wasn't work to come back to; I had no more reputation with anyone. ... I ended up being just a name and a number in a file basically and that's it. So the job applications that I sent out just went nowhere and somebody else would get the job. Yeah, it was quite a difficult situation. ... I knew from re-entry books and pamphlets that I had read that I was going to face it but it still didn't stop it being difficult to face. It's kind of like being on the deck of a ship in a storm. If you don't even know what to call what's going on it's extremely frightening, but even when you know that that thing over there is a wave and that thing over there is wind-driven rain, and that thing over there is lightening – you've got names to label things and categorise it*

*in your mind but reality is you're still stuck on this heaving deck in a storm being lashed by the rain and occasionally illuminated by flashes of lightening. And it's still a difficult thing to experience even though you've got a way of describing what you're going through ... then for the doctor to say: "Phil<sup>a</sup>, you are a nice guy. It's just that you're really messed up, and I really think you ought to consider going on medication to get you out of this particular hole." And I described it to my doctor a bit like this: I felt as though I was inside an aviary, inside the cage and that there were birds swooping and flying around in the cage and each one was a feeling, usually a negative feeling, and every so often the bird would just come down and swoop over me and as it swooped over me I would feel that feeling with some intensity, and then it would fly away and the feeling would go with it and I just felt you know as if I was just out of control of the emotion that I was feeling. I was just at the mercy of these birds that would swoop upon me whenever they felt like it. It wasn't a very pleasant experience ... I find myself sort of having gone from an environment where people were happy to see me, wanted to see me, always had something for me to do, to come back here and to find that nobody wants me ...having gone from being significant to insignificant, known to unknown, from being purposeful to purposeless ... it's like being in a yacht pushed before the wind with your keel down and you're ploughing along and all of a sudden someone comes along and pulls the rudder off and all of a sudden the boat's just spinning around, at a loss to know what to do.*

---

<sup>a</sup> Pseudonym

This is Phil's description of his experience eight months after re-entering Australia permanently following six years working for a mission organisation in Asia.

The cross-cultural missionary worker who is returning to Australia after living and working in another culture is not the only person who is at a loss to know what to do on their re-entry to their homeland when they experience the distress of re-entry adjustment. In the Australian Primary Health Care system, Australian general practitioners (GPs) are most often the first point of contact for different groups with psychological distress (Henderson, Andrews, & Hall, 2000; Stain, Kisely, Miller, Tait, & Bostwick, 2003). There is, however, little acknowledgement in the medical literature of the distress of this particular group in Australian society and their management in the general practice setting. This is despite over 40% of such workers having some degree of psychological distress on re-entry (Lovell, 1997) and the extensive literature concerning re-entry adjustment in various groups of sojourners (Austin, 1986; Doyle, M. E. & Peterson, 2005; Lovell, 1997; Onwumechili, Nwosu, Jackson II, & James-Hughes, 2003; Sussman, N. M., 2001; Szkudlarek, 2009). Over the past 15 years, as I have cared for missionaries in a general practice setting on their re-entry, I have felt that I lacked a useful framework for their care. Phil identifies his distress during his re-entry, but we need to understand the comprehensive nature of this distress and identify a suitable theoretical framework to inform an appropriate management plan in the general practice setting. This thesis is my response to this dilemma.

With increasing global awareness, over 200 Australian (Australian Council for International Development, 2007), American (Duke University Libraries, 2008), and British (Bond, 2008) Non-Government Organisations currently send aid workers

overseas with at least 100,000 posts on offer at any given time (Higney & Calvi-Pariseti, 2004). Missionaries may also be involved in aid work. There are over 200,000 missionaries worldwide (Johnstone, Mandryk, & Johnstone, 2006) with approximately 4,000 of these leaving Australia to work in other cultures for missionary organisations (Johnstone et al., 2006). These cross-cultural workers leave their Australian culture, journey to a new host culture where they may be a part of another sub-culture, and then return to their Australian culture again, sometimes repeatedly (Adler, N. J., 1981; Onwumehili et al., 2003). During the time they have been away, their own culture has again changed, transforming it into another culture they need to negotiate (Storti, 2001). On their re-entry to Australia these workers experience psychological distress called re-entry adjustment or reverse culture shock (Austin, 1986) which may be more severe than the culture shock they experienced on first entering another culture (Black, Gregersen, & Mendenhall, 1992; Jordan, 1992) and they are likely to seek assistance from their GP (Henderson et al., 2000; Stain et al., 2003).

Macdonald (2004) has defined Primary Health Care (PHC) as “a system of medical care and promotion of health focused on the health needs of a given community, a whole care system, dealing with the immediate presenting problem, but seeking to contribute to strategies to prevent the problem more „upstream“ ” p. 286. He noted that Australia has largely followed this model in contrast to Britain and Europe. Nevertheless, the care of the special subpopulation of missionaries and aid workers has been largely neglected in PHC in Australia compared with the UK (Dogstar, 2008; Peppiatt & Byass, 1991). The Royal Australian College of General Practitioners recommends a way forward:



“Awareness of the needs of special subpopulations may be important for planning interventions in General Practice for reducing health inequalities.”

(Furler, Naccarella, James, MacDonald, & Hill, 2005, p. 30)

Addressing the psychological distress and the needs of re-entering adult Australian missionaries involves detailed exploration of the sources of their distress. In addition, adequate management and prevention of re-entering workers’ psychological distress may prevent complications with their associated morbidities (Sobie, 1986) such as depression and anxiety (Lovell, 1997; Sussman, N. M., 2001).

Currently, there is no suitable theoretical framework for Australian GPs to manage these issues. More recent patient-centered general practice models (Booth, Portelli, & Snowdon, 2005; Sturmberg & Martin, 2006) provide an opportunity to explore and apply a theoretical framework so that distressed re-entrants can receive adequate care. Furthermore, the development of such a framework can both assist re-entering missionaries who may also have a role as aid workers (Higney et al., 2004) and facilitate the general practice management of other diverse re-entering groups such as corporate employees, spouses, students, peace corps volunteers, diplomats, third culture kids (TCKs), returning migrants, military personnel and multiple re-entrants (Doyle, M. E. & Peterson, 2005; Faizullaev, 2006; Lovell, 1997; Onwumechili et al., 2003; Pollock & Van Reken, 2001; Szkudlarek, 2009).

## 1.2 Aims, Research Questions and Approach of This Thesis

The aims of this thesis are:

- to determine the detailed nature of the psychological distress of adult Australian cross-cultural missionary workers who are re-entering Australia; and
- to develop a theoretical framework to facilitate their management in the general practice setting.

The first major research question resulting from these aims is:

1. *What is the nature of the psychological distress of adult Australian cross-cultural missionary workers who are re-entering Australia?*

I address this question both in general terms and, more specifically, through the use of two paradigms: a loss and grief paradigm and a resilience paradigm. Thus, the main subsidiary research questions that I explore in this thesis are:

- What issues of loss and grief for adult Australian cross-cultural missionary workers can be identified as they experience re-entry adjustment?
- What responses and characteristics of these workers are relevant for their re-entry adjustment?

Having addressed these questions, my second major research question is:

2. *What evidence-based theoretical framework will facilitate management of cross-cultural workers' psychological distress in the general practice setting?*

I address these aims and research questions by means of a multidisciplinary literature review and the collection of both qualitative (semi-structured interviews) and quantitative (survey/interview) data from 20 adult Australian cross-cultural missionary workers, five of whom were involved in the pilot studies. The primary methods of analysis for the qualitative data are Framework Analysis (Ritchie & Spencer, 1993), Typology Analysis (Lofland, Snow, Anderson, & Lofland, 2006) and

modified Consensual Qualitative Research (CQR) methods (Hill, C. B., Knox, Thompson, Williams, Hess, & Ladany, 2005); and the quantitative data were analysed by descriptive statistical methods (Trochim, 2006). This is the first time both Framework Analysis and modified CQR have been used in a qualitative study of re-entering missionaries.

The answers to these research questions in this thesis are provided in three ways. Firstly, the complexity of loss and grief phenomena for re-entering adult Australian missionaries is demonstrated in detail. Secondly, the constructs for the less psychologically distressed (the resilient) and the more psychologically distressed (the fragile) are described during their re-entry. Thirdly, an evidence-based framework to facilitate management of re-entering missionaries' psychological distress in the general practice setting is proposed.

As grief affects the six personal domains (Corr, 1999) which include the physical, emotional, cognitive, social, behavioural and spiritual, I shall draw on the concepts and frameworks in a number of disciplines such as medicine, psychology, sociology and theology. I have made particular use of theory and frameworks in the re-entry, loss and grief, resilience and general practice literature. I have particularly explored the loss and grief paradigm (Clark, 2003; Parkes, 1988), disenfranchised grief (Doka, 2002), resilience (Bonanno, 2004), the Dual Process Model (Stroebe, M. & Schut, 1999) and the quality framework for Australian general practice (Booth et al., 2005).

Drawing on the analogy of a satellite which monitors day to day weather conditions and longer term climate change over the entire globe, the theoretical basis of this thesis can be explained in two parts. Firstly, the day to day lived experience of re-entering participants as a personally transforming journey links with much of the

re-entry literature which describes the affective, behavioural and cognitive aspects of re-entry. Secondly, the wider view of re-entry, as an interactive transition for the missionary re-entrants with change affecting their relationships with their multiple communities and their God, is informed by the loss and grief literature, including reference to the resilience literature, the identity literature and the literature discussing spirituality. Using this literature enlarges the theoretical basis of the thesis and ultimately enables the design of a proposed evidence-based theoretical framework to address the psychological distress of re-entry in the general practice setting. The literature about paradigms for general practice emphasising a holistic approach to address all personal domains is also explored to set the proposed framework within a suitable general practice context.

### 1.3 My Role as Researcher

This part of the chapter will give a comprehensive description of my role as researcher. I show how my day to day lived experience, especially as a clinician interacted, with the broader picture of missionary re-entry to produce this thesis.

My role in this study has been one which I initially thought correlated with the “starting where you are” concept suggested by Lofland, Snow, Anderson and Lofland (2006, p. 9). My personal experience as a medical registrar for one of the largest Australian mission organisations ensured that I was challenged to care for a number of Australian missionaries as they re-entered after their experiences on the mission field. As I tried to practise along the lines of the bio-psychosocial medical model (Borrell-Carrio, Suchman, & Epstein, 2004), I realised that although many of my patients were psychologically distressed and I could give them the appropriate

Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000) diagnosis, there was something else going on which as a doctor I had not been trained to deal with. Finally, after attending a seminar on loss and grief, I realised that these issues were intricately connected with the distress my patients were experiencing. I suspect, however, my original fascination with re-entry had more to do with the childhood experience of seeing my elderly grandparents returning from the mission field nearly fifty years ago and dealing with their own re-entry adjustment by transforming our family home into a small part of colonial Africa complete with servants (my mother and father) and African memorabilia.

I became very curious about the nature of my patients' psychological distress and particularly the role of loss and grief. Although my personal experiences formed a basis for the research, as Lofland, Snow, Anderson and Lofland (2006, p. 9) noted, the impetus for the research was stimulated by my intellectual questions and my desire to make a difference to these patients' management in the general practice setting. The literature also revealed that although there was a significant body of literature discussing re-entry, there had been no systematic exploration of loss and grief issues for adult missionaries re-entering.

This research is not an exclusively inductive study as, after my initial consideration of re-entry distress, I came to the study from a loss and grief paradigm. Consequently, although the investigation commenced in this paradigm, I moved back to the broader concept of psychological distress in re-entrants as I explored the participants' stories. In line with the qualitative research process, I have been shaped by the process and there has been an inter-play between my own thoughts, feelings, and experiences and those of the participants as I collected and analysed the data. This enabled the participants and me to co-create the semi-structured interview outside the

stream of everyday life as suggested by Crabtree and Miller (1992) and to draw on my own experiences, as a short term missionary to Nepal, as Strauss and Corbin (1998) suggested, when analysing data. This also gave the participants permission to respond and they shared their stories in rich detail. I made some surprising discoveries as the study developed into a more inductive study. As I analysed the data using different methods and explored further literature, I was led away from the loss and grief axiology and the medical model of illness and distress to the wellness model (Hassed, 2005) and the concept of resilience (Bonanno, 2004). This in turn enabled me to link my original area of interest, loss and grief, with the other emerging concepts such as identity disparities.

I have been immersed in these data for more than seven years as I pursued my research part-time. Consequently, while I have endeavoured to commit to “systematic observation, willingness to consider alternative explanation, careful and thoughtful analysis, and clarity of expression” (Lofland et al., 2006, p. 240), I acknowledge that this thesis has definitely been influenced not only by the missionaries’ stories of transition but by my personal transitions in perspective during this journey. The results of this process and the story of these transitions are within the chapters of this thesis.

#### 1.4 The Thesis Argument and Outline

This thesis presents evidence that the psychological distress experienced by re-entering adult Australian missionaries is strongly linked to their loss and grief issues together with certain psychological, social and spiritual characteristics or constructs including identity disparities which determine patterns of resilience. In this thesis, I

integrate the findings of this thesis with a framework for dealing with re-entrants“ psychological distress in the context of a suitable general practice paradigm. The thesis chapters are summarised below to form an outline for the reader to guide their journey (Figure 1).

In Chapter 2, I describe the re-entry literature and the literature about psychological distress during migration with particular emphasis on the loss and grief literature. I identify gaps in the literature in relation to the comprehensive lived experience and care of re-entering adult long term Australian cross-cultural missionaries which led me to the first research question: *What is the nature of the psychological distress of adult Australian cross-cultural missionary workers who are re-entering Australia?* I show that there is no identifiable theoretical framework in the general practice setting for dealing with these issues which led me to the second research question: *What evidence-based theoretical framework will facilitate management of cross-cultural workers' psychological distress in the general practice setting?*

In Chapter 3, I discuss the study design and its links with the research questions to give an overall view. I also discuss the ethical issues in this study.

In Chapter 4, I describe the implementation of the study to answer the identified research questions.

In Chapter 5, I outline the participants“ biographies and briefly discuss the results of the quantitative analysis for all participants. My main findings are that the descriptive statistics show that all participants suffered loss and grief during re-entry including disenfranchised grief.

In Chapter 6, I discuss my qualitative findings and outline the quantitative results for the two identified groups of participants. The results of the qualitative

analysis are described in three published articles. In the first article (Selby, Moulding, Clark, Jones, Braunack-Mayer, & Beilby, 2009), all participants were found to experience re-entry losses which were characterised by multiple varied losses, two loss mechanisms and loss of control; and re-entry grief characterised by common grief phenomena, disenfranchised grief and reactivation of past grief. Self-absorbed disenfranchised grief was identified as a new type of disenfranchised grief. In the second article (Selby, Braunack-Mayer, Moulding, Jones, Clark, & Beilby, 2009), despite their significant loss and grief, two patterns of response for the participants were identified: the resilient and the fragile. The results of the analysis showed that these two groups of re-entrants were distinguished by psychological, social and spiritual constructs. In the third article (Selby, Braunack-Mayer, Jones, Clark, Moulding, & Beilby, 2010), the results of analysis of another psychological construct have been discussed in relation to resilience during re-entry: identity disparities. A new connection between resilience and identity disparities was identified.

In Chapter 7, in an article accepted for publication, I present a new theoretical framework for re-entry loss and grief based on the results of this study. I discuss loss and grief theory including a description of the Dual Process Model (DPM) for loss and grief and deal with common areas of linkage between the results of this study and the DPM to propose an application of the DPM for dealing with psychological distress in re-entering missionaries in the general practice setting. I discuss the clinical applications in General Practice of the results of this study.

Chapter 8 summarises the results of this study and the new findings. I also address suggestions for the receiving communities and sending agencies from the results of this study and suggest further research opportunities.



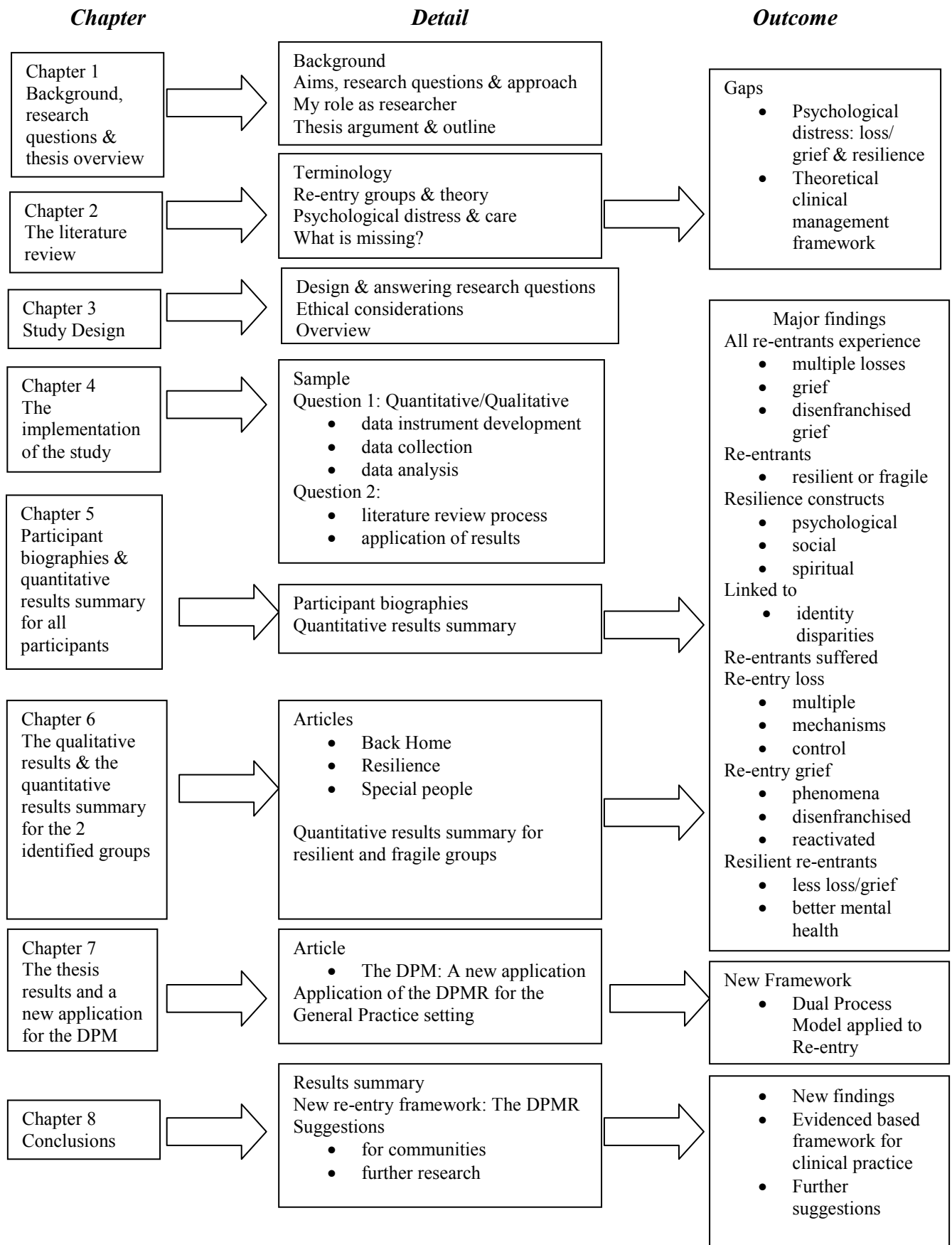


Figure 1. The Thesis Map

## CHAPTER 2: THE LITERATURE AND CULTURAL ADAPTATION: ACCULTURATION AND REACCULTURATION OR RE-ENTRY ADJUSTMENT

### 2.1 Introduction

In this chapter, I introduce the reader to the literature surrounding cultural adaptation, particularly re-entry adjustment, and its effects for groups and individuals who have journeyed back from the cross-cultural experience. I demonstrate the gaps in the literature about psychological distress during re-entry for adult long term cross-cultural workers, especially in the areas of loss, grief, resilience and the general practice setting. I show the need for an appropriate unifying theoretical framework which may be used to improve clinical care.

In section 2.2, I discuss the terminology of cultural adaptation. In section 2.3, I answer the question: *Who re-enters?* and explore the literature about these groups. In section 2.4, I discuss the re-entry adjustment theories and their inability to explain the complex psychological processes of re-entry. In section 2.5, I discuss psychological distress: its meaning, its manifestations during cultural adaptation and its links with loss and grief during re-entry. I also discuss the loss and grief paradigm and the resilience paradigm in the context of psychological distress and re-entry. In section 2.6, I discuss the current care of re-entrants both in the group setting and individually with a detailed discussion of clinical care in Australia. In sections 2.7 and 2.8, I conclude by summarising the gaps in the literature which lead to the formation of the two main research questions in this thesis. The search strategy is described in detail in Appendix 1.

## 2.2 Terminology of Cultural Adaptation

This part of the chapter will discuss the two types of cultural adaptation: acculturation and reacculturation or my preferred term, re-entry adjustment, and show why I have chosen to use this term in my thesis.

The process of moving from one culture to another and adapting to that culture has been described as acculturation (Martin, J. N., 1984). Re-entry adjustment or reacculturation is recognised in the literature as a separate process to acculturation and describes the transition of returning to the home culture from another culture abroad (Adler, N. J., 1981). Other terms associated with re-entry adjustment, aid workers and missionaries are in the Glossary.

### *2.2.1 Acculturation*

Acculturation was initially characterised with the U-curve hypothesis proposed by Lysgaard (1955) in a study of Norwegian Fulbright scholars in the United States which linked cultural adjustment to time since migration. The U-curve depicted four separate linear phases during entry to a new host country: euphoria with elation about the host country environment; culture shock caused by negative experiences; acculturation during which there was learned adaptation to the new host country; and eventually a stable state if there was successful adaptation. Later research has questioned the linear uni-dimensional nature of acculturation (Suinn, 2009), although Lovell-Hawker (2008) defends the U-curve as a useful model, particularly for cross-cultural preparation. Much of the emphasis of the acculturation process in the literature has been in terms of culture shock: “an occupational disease precipitated by

the anxiety that results from losing all familiar signs and symbols of social intercourse” (Oberg, 1960, p. 177). Culture shock has also been described as a set of emotional reactions (Adler, P. S., 1975) and as a behavioural response or adaptation (Berry, 1999; Littlewood, 1985) involving stress and coping mechanisms (Ward, C. & Rana-Deuba, 2000). Berry (1999), amongst others (Adler, P. S., 1975; Bochner, Lin, & McLeod, 1979), has widened the concept of acculturation adjustment from the emotional to include other personal domains such as the cognitive and behavioural. He also noted that assimilation, integration, separation and marginalisation could result from culture shock (Berry, 1999) and some of these outcomes correlate with Littlewood’s observations of “going native” or “jungle madness” (1985). These concepts enable the development of a multilinear model which describes the individual’s position relative to both the old and new culture (Suinn, 2009). This modern concept of acculturation is well summarised as: “Acculturation is both a process and an outcome. As a process acculturation occurs when two or more cultures meet. ... how each individual processes these experiences and makes it their own is unique and far from predictable” (Trinh, Rho, Lu, & Sanders, 2009, p. xi). For the sojourner, acculturation involves complex psychological processes affecting multiple personal domains with variable outcomes (Lovell-Hawker, 2008).

### *2.2.2 Reacculturation or re-entry adjustment*

In parallel with this research, in the early 1960s, re-entry adjustment was identified as a separate process to acculturation (Gullahorn & Gullahorn, 1963). The terms re-entry adjustment (Lester, 2000; Uehara, 1986), re-entry transition (Moore, Jones, & Austin, 1987), repatriation adjustment (Black et al., 1992), reverse bereavement (Foyle, 2001)

and reverse culture shock (Adler, P. S., 1972) have also been used to describe the process of reacculturation. *Re-entry adjustment* will be used in this thesis to describe this process. *Re-entry* more accurately describes the return which may or may not be a result of repatriation or permanent return, while *adjustment* is a broad term which may encompass the terms *transition* and *bereavement*. Using the terms, *reverse culture shock* and *reacculturation* may imply that this process is an inversion of the culture shock process which the literature does not support (Sussman, N. M., 2001). Austin (1986) defined a readjustment period after actual re-entry of 6 to 12 months as normal and I will adopt the period of re-entry adjustment for the purposes of this thesis as 12 months after re-entry. But who is actually experiencing re-entry in the twenty first century?

### 2.3 Who Re-enters?

This part of the chapter reviews the characteristics of groups of re-entrants; I will show that there is a lack of research about adult long term cross-cultural workers who are re-entering.

A number of re-entering groups have been identified in the literature: corporate employees, their spouses, students, missionaries, aid workers, Peace Corps volunteers, diplomats, Third Culture Kids (TCKs), returning migrants, military personnel and multiple re-entrants (Doyle, M. E. & Peterson, 2005; Faizullaev, 2006; Lovell, 1997; Onwumechili et al., 2003; Szkudlarek, 2009). Whilst the corporate employee has been the most extensively researched especially in the area of work-related challenges (Szkudlarek, 2009), their spouses have had significant issues relating to re-establishing family life, employment assistance and cultural

readjustment (Punnett, 1997). Students comprise the second most researched group; however, studies exploring their readjustment patterns have been inconsistent (Szkudlarek, 2009). Although re-entering Third Culture Kids have also been the subjects of extensive research (Pollock & Van Reken, 2001), some researchers have argued that their re-entry was actually expatriation (Szkudlarek, 2008; Wise, 2000) with identity, loss, grief and loneliness being key issues for them (Storti, 2001). Returning migrants, diplomats and multiple re-entrants have been found to have significant identity issues (Faizullaev, 2006; Maron & Connell, 2008; Onwumechili et al., 2003), with a more flexible framework needed to understand these processes widening the linear concept of re-entry, originally proposed (Ley & Kobayashi, 2005).

Austin (1986) alerted the missionary community to the importance of re-entry in 1986. Since then missionary researchers have addressed re-entry and the importance of the family life cycle stage (Huffman, 1989); family dynamics (Stringham, 1993); identity based on a relationship with God (Jordan, 1992); cultural identity (Walling, Eriksson, Meese, Ciofica, Gorton, & Foy, 2006); dealing with transitions (Gardner, 1987); and the role of mental health practitioners and re-entry (Foyle, 2001; Schulz, 2002) with personal accounts in books (Pirolo, 2000) and missionary journals (Hunter, S., 2005) as well as literature discussing psychological distress which will be discussed in Section 2.5. Much of the research about missionary re-entry is around the issues for TCKs (Pollock & Van Reken, 2001). Szkudlarek (2009, p. 10.) has emphasised that “One of the interesting characteristics of the missionary literature is the privileged and comprehensive treatment of the family unit as opposed to the individual-centred analysis favoured by researchers working with other returning groups”.

Despite an enormous amount of research activity since the 1970s in this area, there are some important gaps. Firstly, Szkudlarek's observation that the missionary literature is not individually centred points to one reason why I have chosen to concentrate on individual adult missionaries in this research as there is less comprehensive research about this group during their re-entry in the literature than many others (2009). Secondly, there are no identifiable dedicated studies about re-entering Australian long term missionaries. Thirdly, in clinical practice it is the distressed individual who presents and patient-centred models (Booth et al., 2005; Stevenson, 2002; Sturmberg & Martin, 2006) for clinical practice serve us well to manage this group; however, we need to identify their individual distress before we can appropriately manage this. Before exploring the nature of psychological distress in re-entering missionaries themselves, I will discuss the theories which have been suggested in the literature to explain the concept of re-entry adjustment.

## 2.4 Re-entry Adjustment Theories

Re-entry adjustment theories have been grouped by a number of authors (Martin, J. N. & Harrell, 2004; Szkudlarek, 2009; Ward, C., Bochner, & Furnham, 2001) into three functional categories: affective, behavioural and cognitive – the ABC of re-entry. This grouping addressed the concept of re-entry as a cultural transition (Adler, P. S., 1975; Gardner, 1987; Koteskey & Koteskey, 2003; Martin, J. N. & Harrell, 1996; Onwumechili et al., 2003; Stringham, 1993) which Szkudlarek (2009) argued is consistent with the acculturation model of cultural transition (Ward, C. et al., 2001) as a multifaceted phenomenon affecting these personal domains. While describing re-entry as a “unique phenomenon”, Storti (2001, p 46) described the classical transition

stages of ending (leave-taking and departure from the host country), instability (initial honeymoon stage and stage of reverse culture shock) and reintegration (readjustment). Martin and Harrell (1996) also noted the underlying assumption that the amount of time taken to make the transition is highly individualistic. The Re-entry Systems Theory based on the work of Kim, Martin and Rohrlach (cited in [Martin, J. N. et al., 1996]) suggested that re-entry adjustment was a transition involving a stress-adaptation-growth cycle with the role of communication with others in the re-entry environment being a key element. The importance of communication has been confirmed in a recent study (Cox, 2001). Re-entry theories are discussed below using the three functional categories described above; however, there is some overlap and it is often difficult to completely separate the categories (Geers & Lassiter, 2003).

#### *2.4.1 Affective theoretical concepts*

This category addresses theoretical concepts surrounding emotional transitions during re-entry, particularly involving feelings and responses. Firstly, the stage models of re-entry depict re-entry as stages describing affective transitions, some of which may be distressing. This was originally illustrated by Gullahorn and Gullahorn's W-curve (1963) depicting the four stages of euphoria, culture shock, acculturation, and stable state plotted against time twice to depict both acculturation and re-entry adjustment. These stages were later expanded by Adler (1975) to five stages: contact, disintegration, reintegration, autonomy, and independence. Gullahorn and Gullahorn's W-curve (1963) extended the U-curve to explain the process of re-entry which was assumed to be the same as that of culture shock with the four stages being repeated on return to the home country. Recent literature does not support this theoretical concept.



Sussman (2001) noted that literature reviews and anecdotal stories did not support the relationship between time and severity of distress on re-entry in the W-curve whilst Onwumehili, Nwosu, Jackson and James-Hughes (2003) argued that there was no basis for the assumption that the process of re-entry is the same as acculturation. This is in line with the more recent acculturation literature and the concept of a multilinear model (Suinn, 2009).

Secondly, although, as yet, there is no formal theory of loss and grief for re-entry, affective aspects of loss and grief have been noted in the re-entry literature (Austin, 1986) with Chamove and Soeterik (2006) showing that the intensity of the grief experienced by re-entrants from short-term sojourns may be comparable to that experienced by the bereaved.

#### *2.4.2 Behavioural theoretical concepts*

Some researchers have proposed that behavioural control is a very important aspect of successful readjustment (Black et al., 1992). During re-entry, the re-entrant suddenly confronts their personal and environmental changes during their time away which may be very stressful (Adler, N. J., 1981; Sussman, N. M., 1986). Black, Gregersen, and Mendenhall (1992) have argued that the re-entrant has experienced loss of behavioural routines and control which they seek to re-establish by controlling their behaviour aided by accurate anticipatory expectations, a cognitive aspect of the transition. Sussman (2002) found no simple relationship between cultural adaptation in the host country and cultural repatriation, which suggests that behavioural control may not be an important factor in adjustment. Interestingly, Katzman, Hermans, van

Hoeken and Hoek (2004) have identified a behavioural disorder, anorexia nervosa, as a risk factor for re-entry distress.

### 2.4.3 *Cognitive theoretical concepts*

This category addresses theoretical concepts surrounding cognitive transitions during re-entry, particularly cognitive issues of expectation and identity which may cause re-entry distress.

Firstly, the Expectations Model of re-entry describes different responses to re-entry as a function of the gap between individual expectations prior to re-entry and the actual reality of this transition back to the home country (Adler, N. J., 1981; Black & Gregersen, 1991; Black et al., 1992; Rogers & Ward, 1993). Various authors have described different cognitive processes. Adler (1981) described four re-entry modes or coping styles which were found in 200 corporate and government employees returning after two years abroad: resocialised; proactive; alienated and rebellious. The first two styles, resocialised and proactive, indicated personal growth as part of re-entry adjustment whereas those experiencing more negative cognitions associated with the last two styles, alienated and rebellious, had unmet expectations. No direct relationship between realistic expectations and psychological adjustment, however, was found by Rogers and Ward (1993). As part of the expectations model of re-entry, Black, Gregersen and Mendenhall (1991) proposed a model for re-entry adjustment involving adjustments made prior to returning home (anticipatory adjustments) and adjustments made after arriving home (in-country adjustments) with individual, organisational, job and non-work variables affecting coping responses. Sussman's study (2001), however, measuring re-entry preparedness in forty four American

managers did not support this assumption. More recent research has shown greater readjustment distress for spouses whose re-entry experience was more difficult than anticipated (Maybarduk, 2008) adding weight to the anticipatory model (Black et al., 1992). Storti (2001) proposed that the re-entry transition is particularly distressing due to the changes in the meaning of “home” for the returnee. Sussman (2001) noted that Storti’s model may apply to certain re-entry groups but proposed that “self-concept disturbances and subsequent shifts in cultural identity ... are the critical mediating factors in explaining and predicting psychological responses to these transitions” (p. 362) in line with the cultural identity model discussed below.

The second type of cognitive theory addresses identity. Two theoretical models of cultural identity have been proposed in the literature (Szkudlarek, 2009). Firstly, Sussman (2000) proposed that “as sojourners successfully adapt to the new culture by modifying behaviours and social thought, cultural identity changed as well” p. 365. She suggested four types of identity shifts which were only activated on re-entry: subtractive, additive, affirmative and intercultural. Later studies have shown correlation between the increased distress for those identifying less with the home country or more with the host country (subtractive and additive) than those identifying more with the home country or having a global world view (affirmative and intercultural; Maybarduk, 2008; Sussman, N. M., 2001, 2002).

Secondly, Cox (2001, 2004) confirmed the importance of communication, with its important cognitive aspects, in facilitating re-entry adjustment and he also proposed another model of cultural identity with four intercultural identity patterns: home favoured, host favoured, integrated, and disintegrated. Results from his study of 101 American missionary re-entrants demonstrated that integrated and home-favoured patterns resulted in smoother re-entry adjustment, while disintegrated and host-

favoured patterns had more difficult re-entry adjustments. Szkudlarek (2009) connected the importance of building new cognitive structures in the host-environment demonstrated by Cox (2004) and the development of intercultural sensitivity (Bennett, M. J., 1986) with those who move from an ethnocentric to an ethnorelative stage likely to experience a smoother re-entry (LaBrack, 1993).

As theoretical concepts have continued to be developed, with some such as the W curve being discarded as a result of further research, key concepts of re-entry as a transition with affective, cognitive and behavioural changes have been explored with the importance of the affective and cognitive concepts largely validated, although behavioural concepts also play a role. As previously noted, however, cross-cultural re-entry may be a very psychologically distressing experience which may require further conceptual explanation and there is a lack of a comprehensive unifying theoretical framework (Szkudlarek, 2008) which could be adapted for use in the clinical setting.

## 2.5 What does the Literature Tell Us about Psychological Distress during Re-entry?

This part of the chapter defines psychological distress and discusses its occurrence during cultural adaptation especially re-entry adjustment. I demonstrate the importance of loss and grief as part of this psychological distress and how this paradigm may be an important part in unifying theoretical concepts to enable understanding and further management of this distress. I also discuss the paradigm of resilience and its place in the exploration of psychological distress during re-entry.

### 2.5.1 *What is psychological distress?*

Various models have been employed to explore the concept of *psychological distress*; however, there has been no definitive agreement within these theoretical frameworks and the concept is ill-defined and not clearly articulated (Mabitsela, 2003; Ridner, 2004). The biomedical model (Annandale, 1998) conceptualises psychological distress as an organic disease (Wade & Halligan, 2004); interpersonal theorists emphasise the links between dysfunctional relationships and psychological distress (Bueno, 2009); psychodynamic theorists interpret psychological distress as an intrapsychic process due to outgrown patterns of emotional responses derived from childhood defence mechanisms (Janis, 1958); while cognitive theorists attribute psychological distress to the individual's inappropriately negative view of themselves, their environment and their future (Weinrach, 1988). Whilst there has been this ongoing debate, Ridner's (2004) concept analysis of psychological distress has clarified the meaning of the term and is used in this thesis.

Psychological distress has five defining attributes which occur when the individual experiences a stressor posing a personal threat which results in perceived or actual loss of control and ineffective coping (Ridner, 2004). The five attributes are perceived loss of ability to cope; change in emotional status which involves loss; loss of comfort or discomfort; communication of discomfort and resulting harm which may involve loss of physical or mental health. The outcomes of psychological distress may be viewed as a continuum from permanent harm (e.g. suicide) to temporary harm (e.g. insomnia) and eventually personal growth (e.g. finding meaning).

One aspect of psychological distress that is particularly relevant for re-entering missionaries is spiritual distress. Ridner (2004) acknowledged the existence of

spiritual distress which should be distinguished from psychiatric morbidity (Durà-Vila & Dein, 2009) but which is intricately linked with psychological distress (Guthrie & Stickley, 2008). Villagomez (2005) has usefully analysed the concept of spiritual distress concluding that it may involve impairment or loss of one or more of the seven constructs of a person's spirituality: connectedness, faith and religious belief system, value system, meaning and purpose in life, self-transcendence, inner peace and harmony, and inner strength and energy. Both concepts of psychological distress and spiritual distress are linked with loss which may result in grief. For the purposes of this thesis and because of their intricate links, I will use the term psychological distress to include spiritual distress, unless the discussion requires detailed clarification.

### *2.5.2 Psychological distress associated with migration: acculturation and re-entry adjustment*

Psychological distress associated with migration has been described both in the acculturation and re-entry literature. Psychological distress during migration was first described as part of *acculturation* with the concept of culture shock (Oberg, 1960), which was later explored as acculturative stress (Berry, Kim, Minde, & Mok, 1987). Berry (1987) defined *acculturative stress* as reduction in the health status of individuals including physical, psychological and social changes which were related to the individual's experience of acculturation. This has been documented in such diverse groups as Vietnamese-Canadian students (Lay & Nguyen, 1998); elderly American Hispanics (Krause & Goldenhar, 1992); and Soviet Jewish refugees migrating to the US (Vinokurov, Trickett, & Birman, 2002).

Re-entry adjustment has also been recognised as disturbing in diverse groupings of re-entrants. These include missionaries (Austin, 1986; Foyle, 2001; Gardner, 1987; Moore et al., 1987), aid workers (Lovell, 1997), students (Gaw, 2000; Uehara, 1986), military personnel (Doyle, M. E. & Peterson, 2005), managers (Black & Gregersen, 1991) and wives of Japanese corporate sojourners (Isa, 2000) with researchers suggesting that re-entry adjustment may be even more psychologically distressing than acculturation (Adler, N. J., 1981; Adler, P. S., 1975; Austin, 1986; Chamove & Soeterik, 2006; Gullahorn & Gullahorn, 1963; Martin, J. N., 1984; Storti, 2001). Lovell (1997) has found that 46% of re-entering aid workers reported that they had developed a psychological disorder either while they were working overseas, or, in 82% of these cases, after they returned home. Although psychological distress has been documented during re-entry for missionaries and aid workers, no dedicated instrument for measuring re-entry loss and grief could be identified in the literature.

In two significant areas of research addressing re-entry - exploration of re-entrants' characteristics and exploration of situational variables (Szkudlarek, 2009) - the issue of psychological distress has been addressed with some definitive research but also conflicting results. Firstly, re-entrants who are older, married and have certain personality traits are less likely to suffer distress (Black & Gregersen, 1991; Cox, 2004; Gullahorn & Gullahorn, 1963; Huffman, 1989; Moore et al., 1987; Rohrllich & Martin, 1991; Sánchez Vidal, Sanz Valle, Barba Aragón, & Brewster, 2007). The key role of identity in the re-entry transition has also been acknowledged in the literature (Isogai, Hayashi, & Uno, 1999; Sussman, N. M., 2000; Ward & Styles, 2003). Research about the importance of gender (Brabant, Eddie Palmer, & Gramling, 1990; Sussman, N. M., 2001) has been conflicting with further research needed (Szkudlarek, 2009). Although Brabant et al. (1990) found a significant

relationship between religion and re-entry distress in students from non-western backgrounds, there is also a paucity of literature in this area. Both socioeconomic status and prior intercultural experience and re-entry have been found to have no relationship to re-entry distress, although, again, the research is limited (Brabant et al., 1990; Cox, 2004; Gregersen & Stroh, 1997).

Secondly, situational variables such as length of intercultural sojourn, intercultural distance, time since return, contact with host-country individuals, contact with home-country individuals, attitudes of home-country individuals towards re-entrants and housing conditions have all been explored in the literature in relation to re-entry distress (Szkudlarek, 2009). There has been an association in the literature between decreased re-entry distress and home country connections either by maintaining personal relationships with home-country individuals (Cox, 2004), or by more frequent home visits (Brabant et al., 1990).

Emergency evacuation increased the risk of psychological distress in re-entering Peace Corps workers (Hirshon, Eng, Brunkow, & Hartzell, 1997) and this is also a particular risk for missionaries and aid workers (Donovan, 1991). Housing on re-entry is a significant issue (Black & Gregersen, 1991; Gregersen et al., 1997) with Foyle (1999) confirming significant distress in those who had difficulty accessing suitable accommodation on permanent re-entry. Similarly, increased cultural distance between the host and home culture may increase re-entry distress (Gregersen et al., 1997; Isa, 2000), although negativity towards re-entrants by their home-country communities has not been extensively studied, except in Japan (Szkudlarek, 2009) and the effects of this are unknown. Szkudlarek (2009) noted that the literature is inconsistent in the relationship between re-entry distress and the length of an



international sojourn, the time since return, and the effect of host-country relationships.

Currently, there is no clear link running through the literature about psychological distress during re-entry. However, in view of the key role of loss in the concept of psychological distress itself (Ridner, 2004), the significant incidence of depression and anxiety which may be outcomes of complicated grief (Rando, 1993) in returned aid workers (Lovell, 1997), together with the observation by Chamove and Soeterik (2006) that the intensity of re-entry grief is comparable to bereavement, a clearer link with loss and grief may be discovered. Add to this the overlap of symptoms of cultural adaptation and loss and grief (Clark, 2003; Lovell-Hawker, 2008) which is further discussed in section 2.6.2 and exploration of a loss and grief paradigm including links with the re-entry literature becomes imperative to develop our understandings of re-entry adjustment and its relationship to such distress.

### *2.5.3 Loss and grief and re-entry adjustment*

Loss and grief are among the most significant experiences in the human journey (Miller & Omarzu, 1998). A fundamental assumption about re-entry transition is that, like all transitions, it involves loss and change for individuals, whilst presenting opportunities for personal growth (Martin, J. N. et al., 1996). Interestingly, the nature of these losses and the resultant grief have not been comprehensively explored in the re-entry literature about adults, although re-entry loss and grief issues have been recognised for three decades (Austin, 1986; Fowke, 1994; Foyle, 2001; Huffman, 1989; Lester, 2000; Martin, J. N. et al., 1996; Moore et al., 1987; Onwumechili et al., 2003; Pirolo, 2000; Pollock & Van Reken, 2001; Seiter & Waddell, 1989; Stringham,

1993; Uehara, 1986; Werkman, 1986). Martin and Harrell (1996) suggested that further research in the form of qualitative in-depth studies was needed to extend knowledge about a wide range of returnee groups as did Szkudlarek (2009) who particularly emphasised the need for cross-disciplinary studies incorporating psychological, cultural and socio-political aspects of re-entry.

In discussing loss and grief during re-entry, I have chosen Clark's definitions (Glossary) to describe loss and grief which enables acknowledgement of both death and non-death losses and their resultant grief although death is the most recognised form of loss (Cohen, D. A., 1996).

Werkman (1986) was one of the early researchers who discussed loss and grief in re-entry adjustment and noted that the returnees he had interviewed had left a significant part of themselves behind. He discussed the possibility of re-entry as a grieving process: "The need to abandon intense friendships and cultural supports frequently results in disturbing feelings characteristic of a grieving process" (Werkman, 1986, p. 10). Austin (1986) emphasised a sense of loss as "another prevailing motif of re-entry" p. 126. He included losses for returned missionaries such as the loss of status, underutilisation of field skills and experiences, and loss of some degree of independence.

Various studies have flagged issues of re-entry loss and grief by including them in quantitative instruments employed to measure re-entry adjustment, although recent literature has questioned the validity of these instruments (Rudmin, 2009). Uehara (1986) used seven items which were rated on a five point self-reported scale to test whether re-entry adjustment occurred when American students returned from abroad. This was confirmed statistically by the study and one of the items in the scale was *a feeling of loss*. Moore, Jones and Austin (1987) studied the combined ability of

eight variables to predict reverse culture shock among North American Church of Christ missionaries. Similarly, Seiter and Waddell (1989) measured re-entry shock and three other scales in American tertiary students to explore possible relationships between a number of variables. Both studies used scales to measure reverse culture shock or re-entry shock which included the effect of losses such as friends and culture. Similarly, Huffman (1989) in her study on the impact of the Family Life Cycle (Carter and McGoldrick, 1988 cited [Huffman, 1989]) on the re-entry adjustment of adult missionaries re-entering the United States also measured grief. She used The Homecomer Culture Shock Scale (Fray, 1988 cited in [Huffman, 1989]), which was selected to measure culture shock experienced during the re-entry process and consisted of a 23 item self-report scale, comprising four subscales of which one was grief, although this scale was originally designed for use in college age missionary children (Huffman, 1989). Huffman (1989) observed that “Expatriates who have served overseas for most of their adult life experience severe grief upon re-entry into the United States” p. 24.

Other authors also explained their observations as a part of a grief process. Stringham (1993) discussed the results of his qualitative research of the re-entry adjustment of three missionary families returning to the United States. He proposed that individuals’ experiences during re-entry included grief for the loss of reinforcing events and he also found sojourn outcome was a predictor for grief reaction with favourable sojourn outcomes facilitating adaptive grieving processes. Fowke (1994, p. 16) described the problem of re-entry in the missionary population as being “that people and time have moved on ... More importantly no one is exactly the same person as the one who went overseas, be it a short or a long time ago.” She

emphasised the importance of losses being expressed on returning and noted that health would be maintained if the mourning process was completed.

Although re-entry will trigger a cycle of predictable emotions and reactions whatever the scale of the transition, when a transition is unpredictable or involuntary, the stress is greater (Jones & Jones, 1994). Jones and Jones (1994) noted the following significant issues for missionaries returning permanently: absence of clear role for the future; need to find employment, housing, schooling and new friendships; change in missionary and parent culture; absence of friends or family members who have died while they were away; and lack of interest by the church in their life abroad. They noted there are particular issues for single missionaries, especially females, as they may have worked in a small community abroad with a deep sense of family which has been lost on return. Single women may have had major responsibilities overseas but have no role in the home church where they were often given low status and role. They used the term “bereavement reaction” (Jones & Jones, 1994, p. 35) implying the role of grief in this process.

Other authors have identified loss and grief during re-entry, directly and indirectly. Foyle (2001) devoted a chapter of her book to re-entry stress in missionaries. She defined it as “reverse bereavement”, again implying the role of grief, naming loss of role as one of the most stressful factors (Foyle, 2001, p. 223). Pirollo (2000) recorded a number of short accounts of missionaries’ experiences on re-entry, mainly to the USA, with acknowledgement by some that “there was a lot of grief to work through” p. 91. Donovan (2002) acknowledged the source of her distress after re-entry was grief over a series of major losses which had become apparent following her re-entry to Australia after seventeen years as a missionary in a developing country. More recently Chamove and Soeterik (2006) have found a

significant incidence of grief in re-entering short term student sojourners while Knell (2007) identified loss and grief as important signs of cultural stress on re-entry, although grief was only discussed as an emotional response.

Multiple re-entries may also be associated with loss and grief. Onwumechili et al. (2003) demonstrated that individuals experiencing multiple re-entries have further losses such as progressive weakening of friendship networks in both locations. These authors also identified a gap in the literature in relation to re-entry issues in this group. Onwumechili et al (2003) listed four groups whom they described as intercultural transients i.e. those who frequently alternate between homes in foreign countries and their own country. However, missionaries were not included in this group, although most would qualify.

Lester (2000) provided some key concepts and missing links in re-entry adjustment research. She asked “what is missing?” in re-entry adjustment and answered the question in terms of loss and grief concepts (Lester, 2000, p. 5). She specifically emphasised the need to mourn the loss of cultures and identity, but she also identified the issue of disenfranchised grief (Doka, 2002) for those experiencing re-entry adjustment. Disenfranchised grief (Glossary) may be community disenfranchised grief or self-disenfranchised grief (Doka, 2002). Lester’s proposed re-entry management model acknowledged that one of the key factors in facilitating re-entry adjustment is the legitimising of grief. Lovell (1997) found that 92.9% of returned aid workers who invalidated their feelings reported a history of psychological distress. This finding may link with the concept of self-disenfranchised grief (Kauffman, 2002) which is associated with shame, a powerful cause of psychological distress (Robinaugh & McNally, 2010).

Gardner (1987) and Pirolo (2000) listed symptoms of anxiety and depression and behavioural patterns such as suicide as part of re-entry transition stress which may all be complications of loss and grief (Rando, 1993).

Although loss and grief issues are acknowledged in the literature as being significant in the process of re-entry adjustment, there have been no identifiable studies exploring the specific nature and extent of these issues for long term re-entering missionaries. In view of the importance of the cognitive, affective and, to a lesser extent, behavioural theoretical concepts discussed in section 2.4 for re-entry, a loss and grief paradigm may offer a comprehensive framework which would include the cognitive, affective, behavioural, social, spiritual and physical domains. This paradigm may enable current key issues in re-entry research suggested by Szkudlarek (2009) to be addressed by unifying different re-entry research streams with further exploration of research theory in the social, spiritual and physical domains; enlarging the scope of the populations investigated with cultural responses to loss and grief being acknowledged to enable a more global approach to intercultural research; and addressing the re-entrants' communities' responses to their interactions with the re-entrants as they experience re-entry loss and grief.

#### *2.5.4 The loss and grief paradigm*

Parkes (1988, 1998) and Clark (2003, Clark et al., 2005) have suggested loss and grief (Glossary) as a suitable paradigm for psychosocial issues. Parkes (1988) has described loss and grief as a psychosocial transition while Clark's (2003) concept, based on Corr (1999), is of grief being a process of adaptation to loss over time that may affect the physical, emotional, mental, social, behavioural and spiritual domains of the

individual. Clark (2003) described three features of the paradigm. Firstly, events are unified by a common aetiology (loss), resulting in common effects (grief), complications, and shared management strategies. Secondly, the paradigm recognises each loss has its own unique features and thirdly, the paradigm also recognises that the unique characteristics of the individual concerned and their context contribute to the outcome of the loss. This is addressed in more detail in section 6.2.

Clark (2005) has suggested that the loss and grief paradigm is very suitable for the management of patients in the general practice setting because of the significant incidence of grief from loss in the general practice setting, that members of the general public identify GPs as an appropriate source of help, and that the complications of grief are associated with morbidity and mortality outcomes which are relevant to general practice. This paradigm can address prevention and management issues in the general practice setting (Clark, 2003).

Complications of grief include increased risk for both physical and psychiatric illness (Rando, 1993) with Jones, Bartrop, Forcier and Penny (2010) reporting an overall increase in morbidity of 10-20% in bereaved individuals relative to controls particularly for the cardiovascular system and psychiatric illness. Complications of grief for psychiatric illness include mood disorders such as depressive illness, anxiety disorders including Post-Traumatic Stress Disorder and psychoactive substance abuse disorders (Rando, 1993; Shear & Clayton, 2008). Suicide may also be a complication of grief (Szanto, Prigerson, Houck, Ehrenpreis, & Reynolds, 1997). Prolonged grief disorder (Glossary), which is a form of complicated grief, (Prigerson, 2008) has also been recognised as a risk factor for poor mental health and decreased quality of life (Boelen & Prigerson, 2007).

Disenfranchised grief (section 2.5.3 and Glossary), which may be part of the grief experienced during loss, is very important to recognise. Disenfranchised grief may impair the mourning process as many of the facilitating factors for grief are not present e.g. ability to attend funeral rites and social supports may be unavailable (Doka, 2002). Disenfranchised grief may also lead to the griever experiencing intensification of the feelings of grief, especially anger and powerlessness (Doka, 2002) and may also lead to complicated mourning and poor health outcomes (Rando, 1993). Ambivalent relationships and concurrent crises complicate grief and usually exist in situations of disenfranchised grief which may also lead to the complications of grief (Doka, 2002).

Doka's (2002) five types of societal or community disenfranchised grief (Glossary) demonstrate how individuals may "experience, express, or adapt to loss in ways at variance with the grieving rules" (p. 10-11) for a particular culture or sub-culture with various groups having been identified as experiencing disenfranchised grief including ex-spouses, caregivers, children and the disabled. Kauffman (2002) has expanded the concept of disenfranchised grief to include *self-initiated disenfranchised grief* (Glossary). Kauffman has suggested that *shame* is the psychological force that prevents the individual's experience of grief occurring in disenfranchised grief with liberation from one's psychological distress enabled by receiving permission to grieve.

While loss and grief are richly explored through qualitative methods such as semi-structured interviews which provide complex, interactive and encompassing data (Creswell, 2003), quantitative measures of grief have also been used for more than two decades to assess grief. As part of the process of designing instruments to measure grief, grief phenomena (Glossary) have been identified (Burnett, Middleton,



Raphael, & Dunne, 1994). Clark (2001) has identified three categories of grief phenomena for death and non-death loss (Unreality, Survival, New Life) which may be useful in the assessment of grief and have been incorporated into a clinical tool called *The Grief Map* which has been used in assessment, education and therapy with individuals, groups and families. Horrocks (2006) has reviewed the literature and has discovered 63 grief instruments and five grief-related instruments. Bereavement scales were the most common instrument with Minton and Barron (2008) identifying 12 tools to measure spousal bereavement alone while other commonly used bereavement scales included the Grief Experience Inventory (Sanders, C. M., Mauger, & Strong, 1985) and Core Bereavement Items (Burnett, Middleton, Raphael, & Martinek, 1997). Measurements for specific groups of grievers such as carers (Marwit & Meuser, 2005); and measurements for prolonged grief disorder (Prigerson, Horowitz, Jacobs, Parkes, Aslan, Goodkin et al., 2009; Prigerson, Maciejewski, Reynolds, Bierhals, Newsom, Fasiczka et al., 1995) have also been developed. Despite the importance of non-death losses in all aspects of daily living (Harvey, 1998) and their prevalence in the family practice setting with 80% of losses detected in patients being non-death losses (Clark, 2003), there are few identifiable instruments which detect and measure grief from all types of loss with only one specific instrument for family practice: The Grief Diagnostic Instrument (GDI) (Clark et al., 2005). Thornton and Zanich (2002) have also noted that disenfranchised grief may be assessed both empirically and qualitatively. The GDI (Clark et al., 2005) and the measurement of mental health indices of depression, anxiety and stress including the DASS 21 (Lovibond & Lovibond, 1995) which may be complications of grief are further discussed in section 4.3.

### 2.5.5 *The resilience paradigm*

Although I have discussed the significant re-entry research and the loss and grief paradigm, sections 2.5.2, 2.5.3, and 2.5.4 of the review have focused upon distress and dysfunction with little emphasis about what makes a re-entrant resilient to the challenges experienced in the re-entry environment. The concept of resilience has been extensively discussed in the literature (Bonanno, Wortman, Lehman, Tweed, Haring, Sonnega et al., 2002; Caplan, 1990; Farley, 2007; Jacelon, 1997; Luthar & Brown, 2007; McLaren & Challis, 2009; Smith, 2006). I have adopted Bonanno's definition of resilience to loss and trauma (Glossary). A highly disruptive event or adversity is the main antecedent to the development of resilience (Earvolino-Ramirez, 2007; Luthar et al., 2007) and for the purposes of this research the act of re-entry is a highly disruptive event. Bonanno (2004) also distinguished between resilience and recovery (where normal psychological functioning has been regained after a period of dysfunction) and noted that resilient individuals experienced healthy psychological functioning over time, with only transient dysfunction.

Psychological, social and spiritual constructs associated with resilience have been identified from the literature (Ano & Vasconcelles, 2005; Burkhart & Solari-Twadell, 2001; Chun Bun & McBride-Chang, 2007; Earvolino-Ramirez, 2007; Gu & Day, 2007; Hood, Olson, & Allen, 2007; Luthar & Cicchetti, 2000; Martin, A. J. & Marsh, 2006; McLaren & Challis, 2009; Nakashima & Canda, 2005; Ryan & Deci, 2000; Wilkes, 2002), however, there is no identifiable literature discussing resilience and those experiencing cross-cultural re-entry. In particular, there are gaps in the literature about the relationship of resilience and identity disparities including identity gaps (Jung & Hecht, 2004) and depersonalisation or dehumanisation (Billig, 2002;

Haslam, 2006; Tajfel, 1981) during re-entry. This relationship is important as poor mental health, especially depression which may be a complication of grief, is associated with identity disparities (Barbulescu & Ibarra, 2008; Hunter, E. C. M., Sierra, & David, 2004; Jung & Hecht, 2008; Jung, Hecht, & Wadsworth, 2007). Resilience as a paradigm which may be useful in the exploration of psychological distress during re-entry is explored in detail in the literature reviews in the articles (Selby et al., 2010; Selby, Braunack-Mayer et al., 2009) in Chapter 6.

## 2.6 Psychological Care during Re-entry

There are two main ways that psychological distress during re-entry has been addressed: a broad approach with group Transition Re-entry programs and an individual approach involving access to internet resources, debriefing and clinical care including counselling. Firstly, re-entry transition programs for adult cross-cultural workers returning home have been developed slowly in the last four decades since the concept of re-entry adjustment was identified (Szkudlarek, 2008). They are designed to address the needs of particular groups in both the secular world (e.g. corporate re-entrants) and faith-based communities (e.g. missionaries). Secondly, the importance of individual care has been emphasised more recently and is being addressed in both the general and clinical settings (Hurn, 1999; Klaff, 2002; Lovell-Hawker, 2002; Selby, Jones, Clark, Burgess, & Beilby, 2005).

### 2.6.1 *Group care: re-entry transition programs*

There have been a number of programs designed to facilitate re-entry in the secular and faith communities which have been discussed in the literature. Although the literature has revealed that re-entry is associated with psychological distress which should be addressed, in the secular community there has been a lack of wide-spread implementation of evidence-based models over the past four decades globally (Szkudlarek, 2008). One early re-entry program was at The East-West Centre on the campus of The University of Hawaii for Asian students returning home in the early 1970s. Brislin and Van Buren (1986) designed a program of four interactive reorientation seminars dealing with issues of friends and relations; short-term adjustments; professional relations; non-western perspective; playing the role; nonverbal behaviour and keeping in touch. Over the years, a number of researchers such as Werkman have recommended programs such as organising recognised events within the re-entrants' communities to reintroduce and validate their place in their communities and "transition groups" with guides and mentors who would aid in the readjustment process (1986). Similarly Isogai, Hayashi and Uno (1999) proposed the creation of a widely available program in Japan for re-entry training of returnees with a focus on the issue of identity. However, they noted that in Japan, where there has been an awareness of "adjustment education" through the Japan Overseas Educational Services since the 1980s, that „formal re-entry training for adult returnees seemed to be almost non-existent" (Isogai et al., 1999, p. 498). Several authors have discussed the lack of programs in the USA. Sussman (1986) noted that there were only two programs in the USA for returning American students and a similar lack of business training re-entry models. She stated: "One of the major flaws in the re-entry field is

the lack of integration of empirical research with training design and implementation” (Sussman, N. M., 1986, p. 240). She suggested re-entry workshops include awareness of change; understanding of the cultural adaptation process and the ability to make personal adjustments to home/work environments.

More recently, Martin and Harrell (1996) noted that re-entry training using systematic professional programs was only a fairly recent development in the USA; however, they have remedied this situation themselves with their detailed publications for re-entry training (Martin, J. N. et al., 1996; Martin, J. N. et al., 2004). However, implementation of such programs has been slow. Even by 2001, Storti (2001) commented that, although over two thirds of companies in the USA offered some kind of orientation for employees leaving for a post abroad, only 28 % had a re-entry program for returnees and that “if you want to get the kind of help and attention you need during readjustment, personally and professionally, you have to take the initiative” p.79. Newton (2007) found that, although 71% of various corporate Australian organisations had some form of repatriation policy, the programs gave priority to taxation and financial assistance rather than readjustment issues.

In the most recent detailed investigation of re-entry training services in the international Human Resource field, Szkudlarek (2008) found that the affective, cognitive, and behavioural aspects of re-entry were poorly addressed in line with her observation that there was “big discrepancies between re-entry theory and conducting training practices” p. 13.

Like the growth of secular interventions over the past four decades, faith based organisations serving the missionary community have also addressed the need for Re-entry Transition Programs. The International Student Ministry of the Intervarsity Christian Fellowship has updated a comprehensive guide by Espineli-Chin (2000) for

returnees leaving the USA, which was originally published in 1984. This is a workbook with chapters covering topics on identity, supports, and potential re-entry problems and coping responses as well as chapters on spiritual guidance for re-entry, although there is no detailed discussion of loss and grief issues.

A number of organisations offer opportunities for retreats and courses for missionaries who are re-entering. These are mainly based in the USA e.g. Missionary Training International; the UK e.g. Equip and New Zealand e.g. Cancare. Re-entry Seminars for returned missionaries are run twice a year in Australia through Missions Interlink and one of the sessions explores loss and grief in a group setting with explanatory material about these issues and the opportunity to share in groups of two. However, there has been no identifiable assessment of these programs in the literature and I suspect that translating research into practice may also be a stumbling block for these agencies as has been described in the secular world (Szkudlarek, 2008).

### *2.6.2 Individual care: non-clinical and clinical*

With recent literature emphasising the value of individual sessions with a counselor during re-entry (Hurn, 1999; Klaff, 2002), the importance of appropriate individual debriefing (Lovell-Hawker, 2002) and clinical care (Selby et al., 2005), there has been an increasing awareness of the value of individual approaches in dealing with re-entry distress in both the general and clinical settings. In the non-clinical setting, approaches designed to assist individual re-entrants deal with their psychological distress include the development of internet resources and the increasing use of debriefing.

A large number of *internet sites* provide educational material about re-entry for both secular (Fruity Solutions, 2010; La Brack, 2003; Pandora Web Box, 2009; Pascoe, 2006; Thornton & Zanich, 2002) and faith based communities (Global Connections, 2010; Koteskey & Koteskey, 2004-2008; McKay, 2007). The Headington Institute provides an on-line self-study unit for coping with travel and re-entry stress (2009) and opportunity for self-referral. There is, however, no identifiable literature which evaluates the effect of these sites in addressing psychological distress during re-entry.

Individual *debriefing* after re-entry may be Operational (work-related), Personal (individual experience) or Critical Incident Debriefing (CID) in response to trauma (Lovell-Hawker & Emmens, 2004). Personal debriefing is recommended as a form of social support during re-entry (Sharpe & Lankester, 2008). Operational and Personal debriefing may be done in a non-clinical setting by trained debriefers, however, Sharpe and Lankester (2008), emphasise that CID should only be carried out by trained practitioners in clearly defined circumstances. Regel has noted that: “Psychological debriefing ... should be viewed as a form of social and organisational support, and not an intervention to prevent PTSD.” (2010, p. 18).

The effectiveness of debriefing is a controversial topic, particularly CID for primary victims of trauma, and further research is needed to clarify this topic. Mission organisations in older sending countries have recognised the importance of formal debriefing during home leave; however, newer sending countries have undeveloped re-entry arrangements, particularly debriefing (Bloecher, 2005). There is little research about the effectiveness of re-entry debriefing, despite its use in the older sending countries.

The *clinical care* of re-entering missionaries was discussed in the literature as early as 1913 (Price, 1913) with Peppiatt and Bypass (1991) emphasising the role of the GP. Although there has been a move to globally shared care of missionaries since 1995 (Gardner, 2002), the need for improved clinical care was flagged by Lovell (1997) two years later. She found that only 30% of re-entering British aid workers reported that they had been debriefed or received professional help on their return and suggested that: “Health professionals (such as GPs) could also be encouraged to look out for potential difficulties when visited by returned aid workers, who might not mention psychological difficulties unless specifically asked. Aid workers are more likely to feel „understood“ by professionals who are well-informed about this topic” (Lovell, 1997, p. 159). Gaw (2000) examined the re-entry experiences of 66 overseas-experienced American college students and found that if their reverse culture shock was significantly stressful they may not seek help through available student support services. Although further research is necessary to confirm this pattern in other groups, this finding is significant as it is possible that the visit to the GP may be the only opportunity to address psychological issues on re-entry.

The travel medicine literature has more recently addressed the clinical care of the re-entering sojourner as an important topic with emphasis upon a combined physical and psychosocial approach (Sharpe & Lankester, 2008). Organisations such as InterHealth (Dogstar, 2008) in the UK have accepted the challenge of offering comprehensive health care for returning missionaries and aid workers for a number of years. However, globally, including in Australia, the situation is closer to that described by Szkudlarek (2009) in her comprehensive literature review: “Taking into consideration the range of articles documenting psychological distress upon return, re-



entry assistance needs to appear higher on the agendas of both researchers and practitioners.” p. 13.

In Australia, re-entering Australian missionaries and aid workers still have limited access to health services which address all aspects of re-entry including psychological distress compared to their American and British counterparts. Cross-cultural workers will often present to their GPs as their first point of contact with the health system on re-entry. Australian GPs provide the majority of mental health care in Australia (Harrison & Britt, 2004), in contrast to the USA (Wang, Lane, Olfson, Pincus, Wells, & Kessler, 2005), with missionaries often having a routine medical appointment on re-entry. There may be a number of medical issues to address and this is an opportunity to detect re-entry psychological distress, particularly loss and grief issues which may be complicated by mental illness such as depression if they are not addressed (Rando, 1993).

Translating the results of research through suitable models is very important in the management of psychological distress. These models must provide for the GP being aware that loss and grief are everyday experiences which demand a broader view (Conway, 2007) while addressing the positive and negative outcomes of grief (Kellehear, 2007). The somato-psycho-socio-semiotic (Sturmberg & Martin, 2006) paradigm addresses these issues and may be a suitable basis for dealing with re-entrant distress, especially loss and grief issues. It addresses five of the six personal domains which are affected by loss and grief. It is patient-centred; evidence-based; and allows for the influence of other aspects of health care to be included in management at the macro; meso; micro and nano level. A number of health issues have been identified as being related to loss experiences and their resultant grief

requiring a comprehensive paradigm such as the somato-psycho-socio-semiotic (Sturmberg & Martin, 2006).

Any model to be used in general practice to translate research findings into clinical practice will need to be one which engages with all the re-entrants' domains, enables patient-centred and evidence-based assessment and treatment, whilst facilitating prevention of complications of grief and mental health disorders. Key elements of patient-centred care are: full assessment of patient concerns; getting to the heart of the problem; delivering diagnostic information; developing treatment plans; and educating and motivating patients (Larivaara, Kiuttu, & Taanila, 2001). The model will also need to be flexible enough to facilitate the GP's involvement with the re-entrants' communities if necessary, to facilitate management and to educate these communities.

Any model for use in general practice also needs to address the five key domains of general practice: the doctor patient-relationship; applied professional knowledge and skills; population health and the GP context; professional and ethical roles; organisational and legal dimensions (Kidd & Watts, 2006); and be accessible, clinically appropriate, timely and affordable (Booth et al., 2005). These issues are central to the care of the re-entering cross-cultural worker as they are a subpopulation who may be disadvantaged financially (Wilson, M., 2004) and in need of accessible and clinically appropriate care (Peppiatt & Byass, 1991) requiring an interactive doctor-patient relationship.

The Quality Framework for Australian General Practice (Booth et al., 2005) addresses these issues and may be a suitable model for dealing with re-entrant distress, especially loss and grief issues in the Australian General Practice setting. It is patient-centred, evidence-based, and allows for the influence of other aspects of

health care to be included in management at the four levels of care: consultation, setting of care, regional and national.

A number of health issues have been identified as being related to migration as well as loss experiences and their resultant grief. These issues require a comprehensive framework such as the Quality Framework for Australian General Practice (Booth et al., 2005). Lovell-Hawker (2008) and Clark (2003) explore these issues. Lovell-Hawker (2008) gives a comprehensive list of symptoms in the physical, emotional, behavioural, cognitive and spiritual/philosophical domains which are associated with the stress of cultural adaptation. Clark (2003) identifies identical domains and also includes a social domain as she summarises the main grief phenomena. There is significant overlap in these symptoms and phenomena suggesting that loss and grief is at the core of cultural adaptation. It is also very likely that those suffering from these symptoms will seek medical assistance and may present to their GP with physical symptoms e.g. palpitations, headache and vomiting; emotional symptoms, e.g. mood fluctuations, suicidal thoughts; cognitive symptoms, e.g. poor memory and concentration; or behavioural symptoms, e.g. sleeplessness and increased substance abuse. It is therefore very important that the GP has an understanding of the re-entry process (Selby et al., 2005).

Morbidity as an outcome of the grief process is supported by a large body of literature from the studies of the effects of bereavement (Stroebe, W. & Stroebe, 1987). Rando (1993) lists physical, psychological and behavioural symptoms as potential outcomes of loss and complicated mourning with diagnosable mental and physical disorders being further outcomes. If this concept is extended to the effects of loss and grief for the re-entering missionary or aid worker, there is an opportunity for the GP not only to prevent poor health outcomes but also to recognise the other causes

for physical symptoms, manage somatisation appropriately and minimise unnecessary investigations and referrals.

## 2.7 What is missing?

Hall and Schram (2002, p. 19) in their overview of mental health issues for missionaries, emphasise that there is a “need for a more sophisticated research foundation for clinical work in a missions context”. My literature review has identified a number of gaps in the literature. Research in these areas may lead to more appropriate clinical management.

Firstly, there appear to be no studies in the re-entry literature for adult long term cross-cultural workers, including Australian missionaries, who are re-entering in relation to the comprehensive identification through qualitative in-depth research of their psychological distress, especially their loss and grief. The significance of disenfranchised grief in this group also needs further evaluation. There is also a need for the exploration of the concept of resilience in this group and links between the psychological, social and spiritual constructs of resilience and psychological distress during re-entry. Loss and grief issues can cause significant health issues and assessment of the loss and grief issues for these cross-cultural workers, including spiritual loss, on re-entry needs to be undertaken. At present there are no dedicated tools to assess re-entry loss and grief. Secondly, Australian GPs in their *gatekeeper role* (Catchlove, 2001), like their colleagues in the UK and the Netherlands (Verhaak, Van Den Brink-Muinen, Bensing, & Gask, 2004), are ideally placed to institute the detection, treatment and prevention of psychological distress including loss and grief issues, however there are currently no identifiable theoretical frameworks to inform

an intervention to manage these issues in general practice. Finally, exploration of a loss and grief paradigm and a resilience paradigm as appropriate launching pads to address the currently identified gaps in the re-entry research literature may enable the identification of a unifying thread in re-entry literature and enable improved care of these valuable sojourners.

## 2.8 Conclusion

In this chapter, I have explained the terminology of cultural adaptation, identified groups affected by re-entry and discussed re-entry theories. I have also discussed psychological distress, particularly loss and grief, and its links with migration, especially re-entry. I have demonstrated the current management of this psychological distress, including clinical practice, and identified the importance of the GP's role. I have shown that there are a number of gaps in the literature. Firstly, there is a gap in the description of the nature of the lived experience of psychological distress of re-entering adult long term cross-cultural workers, including missionaries especially their loss and grief issues. Links between psychological distress during re-entry and resilience constructs need further exploration. Secondly, there is a lack of an evidence-based unifying theoretical framework which may form the basis of a management plan for these valuable re-entrants in clinical practice. How these issues will be addressed will be discussed in the following chapters about the design and implementation of the study.

## CHAPTER 3: THE STUDY DESIGN

### 3.1 Introduction

In this chapter, I describe the development of the research questions and the study design while in the following chapter I describe the implementation of this study. In line with the satellite analogy, this chapter will give a broader view of the study, whereas, Chapter Four will describe the day to day implementation of the methods used in this study. The separation of these two chapters resulted because of the evolving nature of this study. In many ways this study has reflected the re-entry journeys of the participants as I repeatedly re-entered the data to answer the emerging research questions which were generated by the analysis (Figure 2). In section 3.2, I show how the study design developed iteratively. In section 3.3, I give a detailed description of the mixed methods<sup>b</sup> used in answering the first research question. In section 3.4, I explain the development of the framework for clinical use, involving another literature review and the application of the study results. In section 3.5, I discuss the ethical considerations. In section 3.6, I give an overview of the study design (Figure 3) showing the interaction between the findings and the research questions and how the subsidiary research questions developed. I summarise this chapter in section 3.7.

---

<sup>b</sup> This study was designed as a mixed method study; however, as a result of the generation of further research questions the analysis and results are largely qualitative. I have retained the “mixed method” label because this is what I did; however, the presentation is predominantly qualitative with the quantitative results summarised in the body of the thesis and the detailed descriptions in the Appendices.

### 3.2 Following the Research Questions: My Evolving Journey

Initially, I intended to explore the stories of re-entrants to paint a rich picture of their experiences. So a qualitative methodology seemed to be the best approach. However, I was also very conscious of choosing a method which would not only gather data but could also be eventually used as a quantitative instrument to aid in the assessment of these patients in the time-poor setting of general practice (Chew, 2005).

I then considered the “third methodological movement” (Doyle, L., Brady, & Byrne, 2009, p. 184) as an approach. This mixed method approach, combining qualitative and quantitative approaches as “they suggest, discover and test hypotheses [and research questions]” (Borkan, 2004, p. 4) seemed to fit my aims. This would “give new insights on complex phenomenon ... allow the investigator to address practice and policy issues from the point of view of numbers and narratives; ... add rigor.” (Borkan, 2004, p. 4).

As I proceeded with both the quantitative and qualitative approaches of this study, I discovered that reflection upon the broad term of psychological distress included addressing not only loss and grief issues and mental health disorders such as depression and anxiety, but also, reflection upon the nature of resilience. The mixed-method approach changed the way I viewed the data and my first research question (Figure 2). This method enabled the detailed exploration of loss and grief issues and clarified participants’ responses. As I answered this research question and discovered differences in the responses of participants to these issues, further research questions addressing the characteristics of the participants emerged (Figure 2). These subsidiary research questions were about the pattern of these differences for participants, how these differences emerged, and the nature of these differences. As I reflected upon

these results I realised, in some ways I had come the full circle: the loss and grief paradigm seemed to be the starting point to explore models for a theoretical basis for an intervention for clinical care. This led to the development of the second research question. As I was following these paths, I was also engaging with the literature surrounding the methodological issues which were continually emerging as a result of the generation of other research questions. I will describe in detail the mixed methods approach, its theoretical basis and rationale for use in this study.



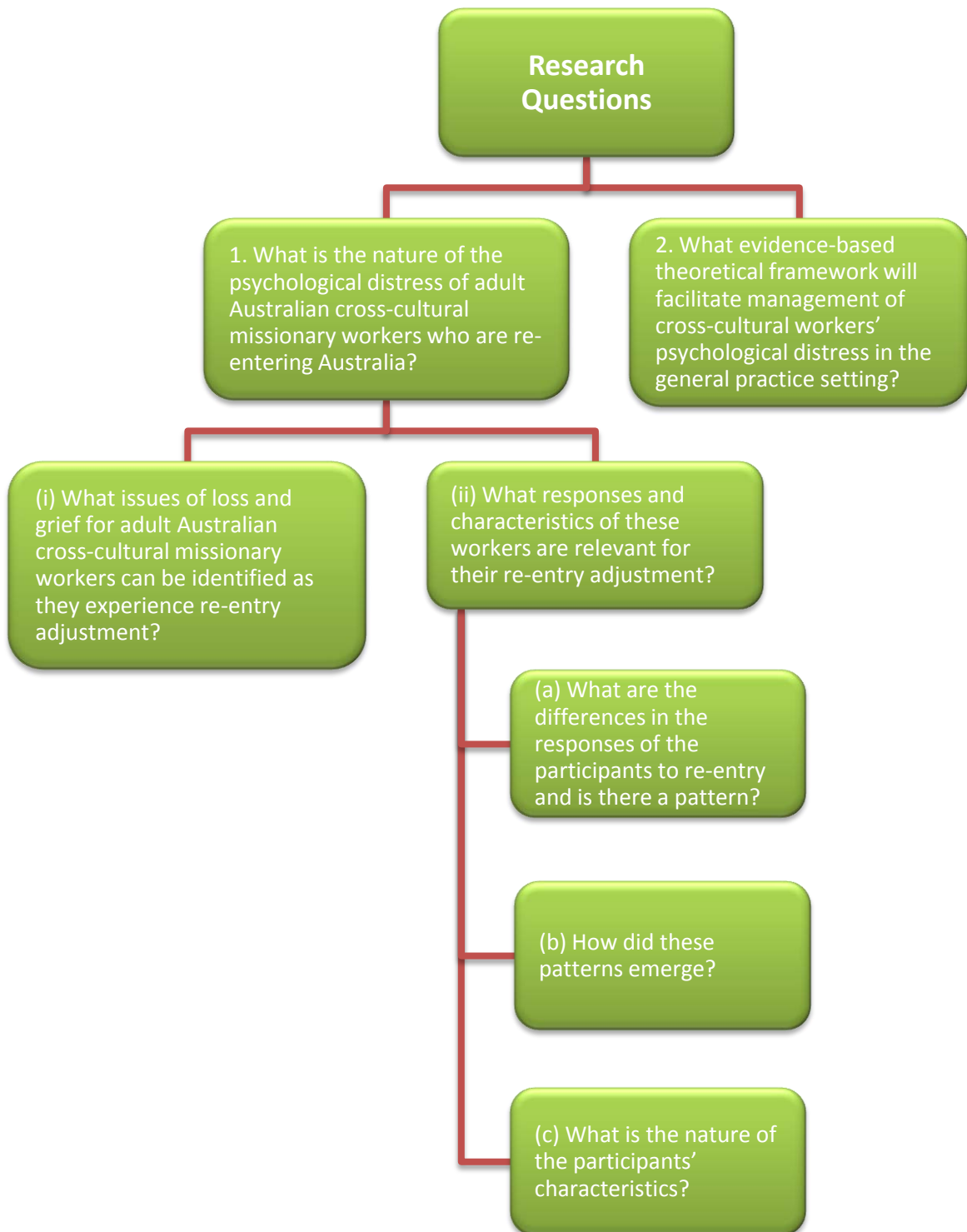


Figure 2. Research Questions

### 3.3 Answering Question 1: Mixed Methods

Mixed methods research has been defined as “research in which the investigator collects and analyzes data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study or a program of inquiry” (Tashakkori & Creswell, 2007, p. 4). In the same editorial the authors caution that this is an emerging field and the definition may be further developed. Although Creswell traced the origins of mixed methods to Campbell and Fiske’s study in 1959 (2003), it is only in the past decade that this has become a dominant framework for design in health care research (Doyle, L. et al., 2009). There has been much debate about combining the two differing ontological and epistemological stances of qualitative and quantitative research (Bryman, 2007; Howe, 1985; Sandelowski, 2000; Yanchar & Williams, 2006); however, researchers have developed procedures for this research which is now considered an acceptable third methodological movement (Doyle, L. et al., 2009; Tashakkori & Teddlie, 2003). Other published studies (Barg, Huss-Ashmore, Wittink, Murray, Bogner, & Gallo, 2006; Bennett, I., Switzer, Aguirre, Evans, & Barg, 2006; Hroschikoski, Solberg, Sperl-Hillen, Harper, McGrail, & Crabtree, 2006; Rabago, Barrett, Marchand, Maberry, & Mundt, 2006; Solberg, Crain, Sperl-Hillen, Hroschikoski, Engebretson, & O’Connor, 2006; Sussman, A. L., Williams, Leverence, Gloyd, & Crabtree, 2006) have demonstrated the advantages of mixed method design to inform and complement research (Stange & Gotler, 2006).

### 3.3.1 *Theoretical basis and rationale*

The mixed methods strategy I have chosen for this study was first described by Creswell (2003) as a Sequential Transformative Strategy and dealt with my issues of the implementation sequence, priority of data collection, integration of the findings and the application of overall theoretical perspectives. It required two distinct data collective phases – the quantitative phase used first followed by the qualitative phase. Priority was assigned to the qualitative phase as the dominant method and the results were integrated during the data interpretation. The method also enabled the use of a theoretical perspective to guide the study which included the loss and grief paradigm and the resilience paradigm (sections 2.5.4 and 2.5.5). This method has subsequently been described in a typology of mixed methods design as a partially mixed sequential dominant status design (Leech & Onwuegbuzie, 2009) and I will use this recent terminology.

There are a number of advantages of the mixed method approach (Denzin, 1978; Doyle, L. et al., 2009; Greene, Caracelli, & Graham, 1989) which are applicable to this study: *triangulation* which allows for greater validity by seeking corroboration between quantitative and qualitative data; *completeness* with two approaches providing a more comprehensive picture including complementary emergence of different facets of the participants' psychological distress; *developmental informing* of the second research question by the previous questions as described above and expansion of the scope and breadth of the study such as the development of further subsidiary research questions; *offsetting* the weaknesses of the two approaches by each other and providing stronger inferences; and *explanation* of the findings where one method is useful in explaining the results of the other. Further

explanation about the rationale for using mixed methods will be discussed in relation to both the quantitative and qualitative methods used in this study.

### 3.3.2 *The survey: the less dominant quantitative method*

I chose quantitative methods to be used in this study as the basis for the secondary source of data. Quantitative methods are based on the positivist paradigm, the basis of biomedicine, which assumes there is a single objective reality which may be tested by the scientific method (Bowling, 2002). A three part survey combined with specific quantitative data from the interviews (the number of disenfranchised griever and the frequency of grief phenomena) enabled the collection of the quantitative data. Specifically, the three instruments in the survey were developed to create a valid instrument to gather the quantitative data about loss and grief from this study, to enable correlations with mental health indices and to gather relevant demographic information.

The constructivist/interpretivist paradigms for the dominant qualitative method are in contrast to empiricist epistemology (Sarantakos, 2005) which informs the positivist paradigm, containing a realist/ objectivist ontology of a singular, verifiable reality and truth (Patton, 2002) which is quantifiable. Whilst the constructivist/interpretivist paradigms are of particular value in this study as described in section 3.3.3, GPs have been used to the positivist paradigm of the biomedical model (Annandale, 1998), in particular, in the use of various measures of psychological distress in patient management (Clark et al., 2005; Henry & Crawford, 2005; Hickie, Andrews, & Davenport, 2002; Terluin, van Marwijk, Ader, de Vet, Penninx, Hermens et al., 2006). Therefore, in the process of knowledge translation

(Leahey & Svavarsdottir, 2009), a positivist paradigm within this research may enable GPs to work within the biomedical model, whilst facilitating the move towards the integration of evidence-based medicine (positivist paradigm) (Sackett & Rosenberg, 1996) and the patient centered model (constructionist/interpretivist paradigm) (Booth et al., 2005; Sturmberg & Martin, 2006) as the second research question addressing the theoretical framework is answered.

While there are challenges in the mixed method design, such as the requirement for the researcher to be familiar with both forms of research and the need for extensive data collection (Creswell, 2003), I chose to pursue a pragmatic approach in my use of mixed methods (Tashakkori & Teddlie, 2003). Consequently, I have used a modified form of this mixed method strategy with a much smaller quantitative sample than usual to provide limited descriptive quantitative data. This is balanced by the extensive analysis of the qualitative data in response to the emergence of subsidiary research questions (1(ii) a, b, c; Figure 2) with the nature of the questions lending themselves to qualitative methods.

### *3.3.3 The semi-structured interview: the dominant qualitative method*

Qualitative research methods were chosen as the primary data source in this thesis in line with their uses described by Strauss and Corbin (1998) and Rice and Ezzy (2005): “Qualitative methods can be used to explore substantive areas about which little is known ... [and] to obtain the intricate details about phenomena such as feelings, thought processes, and emotions that are difficult to extract or learn about through more conventional research methods.” (p. 11). Rice and Ezzy (2005) emphasised that “the basic aim of qualitative research is to gain a thorough understanding of particular

phenomena within certain contexts” (p. 28). Evidence from the literature in Chapter 2 has confirmed that the phenomenon of re-entry adjustment may be a complex distressing transition for missionaries who are cross-cultural workers. Using qualitative methods in this thesis enabled me to gain an intricate understanding of the missionaries’ psychological distress in the context of re-entry.

Semi-structured interviews were the dominant qualitative method in this study, facilitating sensitive exploration of the re-entry issues to enable rich detail and information about *what* and *how* research questions in this study (Armstrong & Grace, 2000; Silverman, 2001). Semi-structured interviews have been described as “guided, concentrated, focused, and open-ended communication events” (Crabtree & Miller, 1992, p. 16) and may enable psychological distress and particularly loss and grief issues to be richly explored (Clark, 2003). They have also been used to research psychological distress in diverse groups (Ray & Street, 2007; Wilson, K. G., Curran, & McPherson, 2005).

This study was informed predominantly by constructionist ontology (Sarantakos, 2005) as I engaged with participants in the research process. The constructionist ontology answered the question of the nature of reality for re-entering cross-cultural workers by assuming that the research focused on the construction of their meanings of their re-entry distress. This emerged out of their own reflections as well as their descriptions of interactions with their communities (Sarantakos, 2005) and myself as the researcher in a participatory, collaborative role (Hansen, 2006), co-constructing meaning with the participants (Ponterotto, 2005). The answer to what kind of knowledge is being discovered about psychological distress for re-entering missionaries is given by the epistemological/ interpretivist view of socially constructed multiple realities (Patton, 2002) which highlights the individual

participant's realities, particularly in the area of loss and grief on re-entry using reflective assessment (Sarantakos, 2005). I have found that Crotty's (1998) observation that ontological issues and epistemological issues tend to merge together is helpful so my use of the terms is reflected in this.

The paradigm or conceptual model for this study's design employed a constructivist/interpretivist view in line with the functional purpose of the research to collect "open-ended, emerging data with the primary intent of developing themes from the data" (Creswell, 2003, p. 18). The set of assumptions on which the enquiry was originally based (Bowling, 2002) and which underpinned the data collection was a loss and grief paradigm (section 2.5.4). As the study progressed, this paradigm broadened the concept of psychological distress (Ridner, 2004) to include the literature about resilience (Bonanno, 2004, section 2.5.5).

The loss and grief paradigm is useful in that it is a simple diagnostic and management framework common to the vast range of otherwise disparate psycho-spiritual-social issues encountered in family practice. It may be appropriate for those with psychological distress arising during re-entry who need individual assessment (Lovell, 1997; Selby, Jones, Burgess, Clark, Moulding, & Beilby, 2007) or those re-entrants with undifferentiated presentations in family practice (RACGP, 2005).

The second research question was also addressed by a research paradigm for the primary health care setting so that the qualitative results could inform the theoretical framework. The second paradigm which was useful in underpinning knowledge translation to clinical applications was the somato-psycho-socio-semiotic (Sturmberg & Martin, 2006) paradigm of patient care. Patient care is central to the Qualitative Framework for Australian general practice (Booth & Snowdon, 2007) which was flagged in Chapter 2. This approach enabled the most appropriate

theoretical positions to be utilised in this study which Patton described as “methodological appropriateness” (Patton as cited in [Hansen, 2006, p. 17]).

Much of the previous work on re-entry has been done with an ethnographic approach, emphasising the importance of culture (Sussman, N. M., 2000). Although this approach has given valuable insights and theories around the process of re-entry, it does not always explore the experience of the individual which is vital in determining the nature of the psychological distress for this group. There is also a large body of literature which focuses upon corporate re-entry with an organisational paradigm focusing on results, clarity and order (Szkudlarek, 2008); however, this was not an appropriate paradigm for this thesis and the qualitative nature of the research questions.

#### 3.3.4 *Reliability, validity and rigour*

I discuss the issues of reliability, validity and rigour in this section. Determining issues of truth in methodology has been controversial especially for qualitative research (Cohen, D. J. & Crabtree, 2008) and this has been reflected in the terminology. For the purposes of this thesis simple definitions will be used in applicable contexts. *Reliability* and *validity* are usually used in the context of quantitative research. Where they have been applied to qualitative research, inappropriate conclusions have sometimes ensued (Hansen, 2006). The term *reliability* refers to the reproducibility and consistency of the instrument used in quantitative studies (Bowling, 2002) while the term *validity* refers to “the extent to which a test or instrument measures what it claims to measure” (Hansen, 2006, p. 47). In contrast the term *rigour* refers to the thoroughness and appropriateness of the use



of research methods (Kitto, Chesters, & Grbich, 2008) and is mainly used to describe qualitative research (Rice & Ezzy, 1999). I will use the term *rigour* when discussing the qualitative data or the mixed methods in this thesis; however, in the explanations of the quantitative analysis, I will also discuss *reliability* and *validity*.

Creswell (2003) and Hansen (2006) have detailed methods which establish rigour in mixed method studies for both data collection and analysis. Of these data collection methods, I have used specific identification of the type of data collected in both the survey and the semi-structured interview with clearly documented techniques. Purposive sampling increased the rigour of the semi-structured interview (Hansen, 2006) and I have related the procedures to the visual model in Figure 3. During the analysis of a mixed method study, Creswell (2003) emphasised that the process of analysis occurred both within the quantitative and qualitative approaches and between the two approaches. All three processes have occurred during this study to establish rigour by means of data transformation, exploring outliers, examining data on multiple levels, multiple triangulation, modified respondent validation of the transcripts, transparency of method and reflexivity (Caracelli & Greene, 1993; Hansen, 2006; Tashakkori & Teddlie, 1998). Although Barbour (2001) warned against the use of checklists in improving rigour, I have embedded the processes described above in the context of the rationale of this study. For example, processes such as multiple triangulation evolved from the emerging research questions during the four types of analysis employed: Framework, Typology, modified Consensual Qualitative Research, and Descriptive Statistical analysis.

I have used audit trails, keeping records of what was done, particularly in the initial analysis as recommended by Lincoln and Guba (1985) to enhance *rigour*. However, as I proceeded, I found that I was drawing on intuitive knowledge which no

doubt arose from my immersion in the data and gave me some sympathy with the argument that audit trails do not necessarily establish credibility (Cutcliffe & McKenna, 2004).

I have also reported the process in detail so that the readers themselves may discern the rigour of the process and hopefully reach the same conclusions (Silverman, 2005). As the reader reviews the methodology of this study and assesses both the processes used to enhance rigour and their own response to the data presented, the trustworthiness of the findings will be tested.

### 3.4 Answering Question 2: Developing a Framework for Clinical Use

The results from the answers to Question 1 and its subsidiary questions in this study enabled comprehensive assessment of the nature of psychological distress for re-entering participants. This, in turn, was able to inform the development of a theoretical framework to manage their psychological distress. I undertook a further literature review which is described in Chapter 7 to discover concepts and models which could be useful in addressing the results of my study. The most appropriate theoretical model was identified and the study results applied to the design of a framework which would enable management of this psychological distress in the clinical setting.

### 3.5 Ethical Considerations

This part of the chapter describes how I approached ethical considerations in this study. Ethics approval was sought and granted from the Human Research Ethics

Committee of the University of Adelaide (Appendix 2). The question of ethics for the participants in this study revolved around the “value of advancing knowledge against the value of non-interference in the lives of others” (Neuman, 1997, p. 445). This needed to be balanced with the acknowledgement that the risks attached to this study could be construed as minimal (Council for International Organizations of Medical Sciences, 1999). Braunack-Mayer (2002) noted that the issues of risks, benefits and altruism are complicated by the pain and distress of recalling past experiences, the opportunity to gain information and the various stakeholders’ views. She also noted, however, that Scott, Valery, Boyle and Bain (2002) indicated that benefits were gained by participants in their study despite the pain of talking about distressing events. This was evident in my study as three of the participants volunteered, in subsequent correspondence, that their participation had been a helpful process. The main ethical issues for this project are beneficence and respect for persons which have been outlined in The National Statement on Ethical Conduct in Research Involving Humans (National Health and Medical Research Council).

### *3.5.1 Beneficence*

The National Health and Medical Research Council (1999, p. 11) described how to address beneficence in the research setting:

“Researchers exercise beneficence in several ways: in assessing and taking account of the risks of harm and the potential benefits of research to participants and to the wider community; in being sensitive to the welfare and interests of people involved in their research; and in reflecting on the social and cultural implications of their work.”

I assessed the most significant risk of harm as the causation of further psychological distress as the participants reflected upon their past experiences during the interview. The interview was further complicated by the difficulty in responding to body language and giving visual non-verbal encouragement as 13 of the 15 interviews were done by telephone. I managed these issues in two ways: exclusion of certain participants and management of distress. Firstly, very distressed participants were excluded as part of the criteria for the sampling (section 4.2). Secondly, I was skilled enough to undertake the interviews and detect their distress (Berglund, 2001) and was able to employ a number of strategies to manage this distress. My clinical experience in the area of general practice and mental health had equipped me with interviewing skills which I was able to employ in the research process. I determined to offer closure of the interview at the first sign of their distress so the participants had control of the interview procedure. I also had strategies to deal with their distress which I could implement as necessary. These strategies included questioning skills such as the appropriate use of silences, neutral utterances and continuers, reflection and echoing; and relationship building skills such as the emotion handling skills of naming and labelling, understanding and validation, respect and praise, and support and partnership (Tierney & Henderson, 2005). Information about their cultural background from the survey prior to the interview was also helpful in interviewing participants appropriately. Finally, the participants were offered the opportunity to have follow-up counselling if required.

In this study, the participants were informed that they were unlikely to benefit from the research but that it would benefit others. There was no evidence from the literature that this sample was an *over-researched* group. Sampling was not

discriminatory except in so far as it satisfied the project's purpose and selection criteria.

The interviews were conducted so that the participant was not compromised in the search for knowledge. The interviews were a process of appreciative enquiry with the aim of empowering the participant to tell their story. Six participants (including the pilot study participants) expressed emotional distress during the interview to the point of crying or sobbing and being unable to continue temporarily. They were given the opportunity to stop the interview at that time and they had been previously informed that they could cease the interview at any time and that follow-up counselling was available (Appendix 3). Interestingly, none of the participants wished to cease the interview.

### 3.5.2 *Respect for persons*

The other significant ethical issue in this thesis is respect for persons. Respect “involves recognising that each human being has value in himself or herself, and that this value must inform all interaction between people. Such respect includes recognising the value of human autonomy – the capacity to determine one's own life and make one's own decisions. But respect goes further than this. It also involves providing for the protection of those with diminished or no autonomy, as well as empowering them where possible and protecting and helping people wherever it would be wrong not to do so.” (National Health and Medical Research Council, 1999, p. 11)

This study ensured respect for persons by obtaining informed consent and excluding those who were unable to give such consent, and ensuring confidentiality. The participants were provided with comprehensive information about the purpose, methods, tasks, benefits and possible outcomes of the research including publication, the voluntary nature of the participation and their right to withdraw at any time in the Participation Information Sheet and the Consent form (Appendix 3 and 4). They signed a consent form (Appendix 4) and I also acknowledged the process. The subjects were also offered a copy of their transcript and the conclusions of the research (Appendix 3). They kept copies of the Participant Information Sheet and the consent form (Appendix 3 and 4).

Participants who were not competent to consent were not initially invited by the mission. Participants with severe anxiety or depression would also have fitted this category and would have been excluded from the interview process by identification using the DASS 21 (Lovibond & Lovibond, 1995) which was part of the survey completed prior to the interview (Appendix 5).

To ensure confidentiality, the participant's identifying data was not stored with the research data and the participant was identified by a code and a pseudonym known only to myself. Any data in the transcribed tape which may have led to identification was de-identified. The sending organisations did not know who had responded to the invitations they had sent so the participants' confidentiality was maintained.

### 3.6 Overview of Study Design

In response to the evolution of the research questions and the ethical issues in this study, a two part design based on answering the first and second research questions was adopted as described in sections 3.2, 3.3 and 3.5. Figure 3 illustrates the overview of the study design.

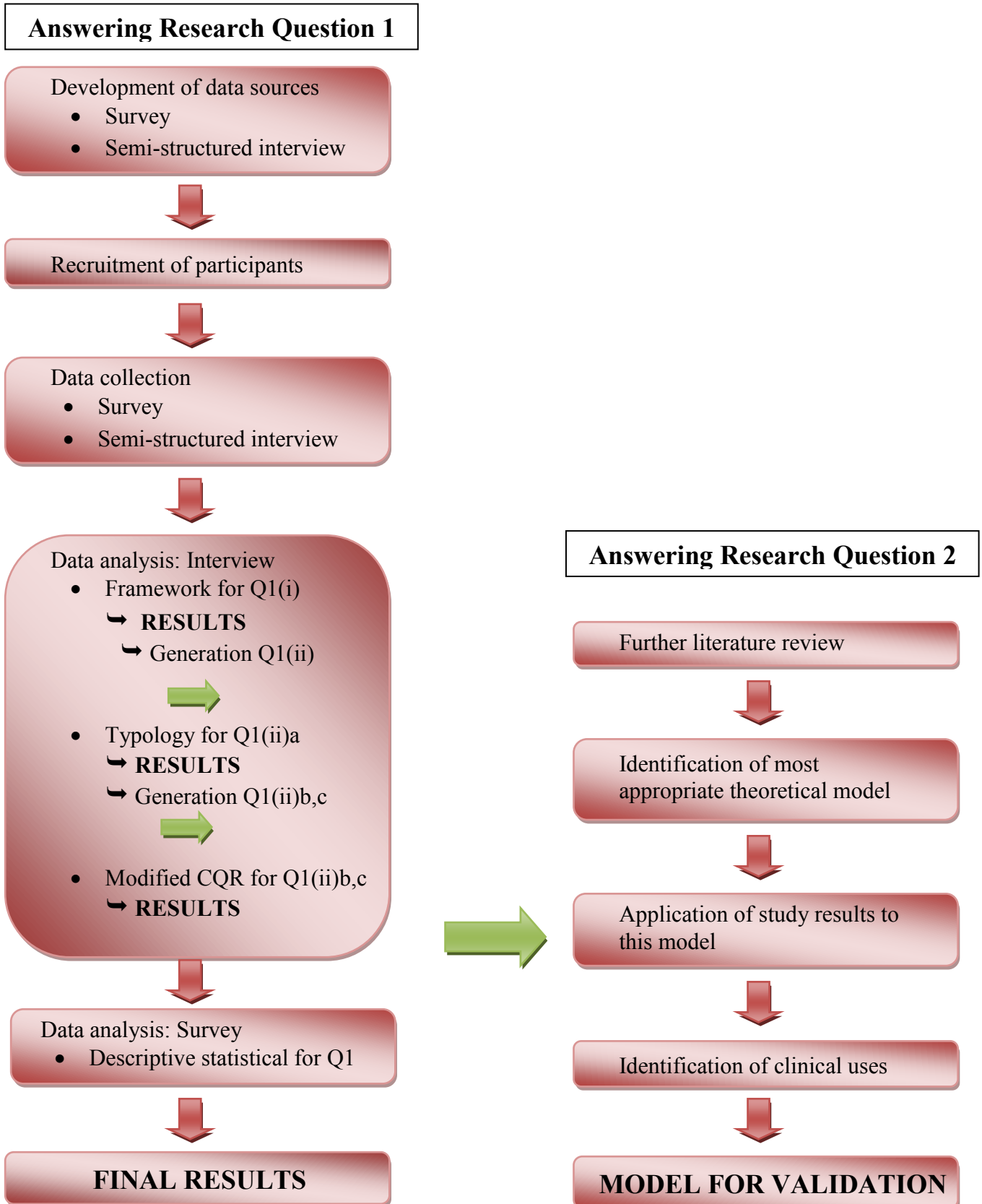


Figure 3. Study Design



### 3.7 Conclusion

In summary, this chapter has broadly addressed the study design of this thesis and its evolution in response to the two main research questions. The methods used to answer the first research question explored the nature of the participants' psychological distress and the methods used to answer the second research question and build a theoretical framework have been described. The theoretical basis of the study design and issues of reliability, validity and rigour have been addressed. These descriptions link the centrality of the research questions to this thesis and the generation of further research questions during the analysis of the data. In the next chapter, I will outline the implementation of this study.

## CHAPTER 4: THE IMPLEMENTATION OF THE STUDY

### 4.1 Introduction

In this chapter, I describe the implementation of this study and the associated methodological issues. In section 4.2, I discuss the rationale for the participant sample, the inclusion criteria and their recruitment. In sections 4.3, 4.4 and 4.5, I describe the methods used to address the first research question and its subsidiary questions to investigate the nature of the participants' psychological distress: the development of the data collection instruments, the collection of data, and the analysis of the data. In section 4.6, I describe the methods used to address the second research question of the study to develop a theoretical framework to address psychological distress during re-entry. I summarise this chapter in section 4.7.

### 4.2 Sample

This part of the chapter will discuss the rationale of the sampling method, the inclusion criteria which enabled the research questions to be answered and the recruitment methods for the participants. In summary, the sample comprised adult Australian Christian missionaries who had re-entered Australia between one and 12 months previously, after at least two years out of the past three being spent in a non-western country.

#### 4.2.1 *Rationale*

The technique I chose for sampling was purposive sampling with the participants selected from a previously identified subgroup, re-entering adult Australian Christian missionaries, because only they could inform the research process (Bowling, 2002; Rice & Ezzy, 2005). I wished to obtain detailed information in the areas of “meanings, interpretations, processes and theory” (Rice & Ezzy, 2005 p. 46) from participants about their psychological distress on re-entry, particularly loss and grief issues, as “the logic and power of purposive sampling lie primarily in the quality of information obtained per sampling unit, as opposed to their number per se.” (Sandelowski, 1995, p. 52)

#### 4.2.2 *Inclusion criteria*

In order to answer the first research question, organisations and individuals who satisfied the criteria in the question needed to be identified. Three missionary organisations were chosen because their administrators were known to me due to prior links through work and personal connections. Another organisation was approached on the recommendation of their medical officer but did not reply after further information was sent and interestingly I had had no direct connections with this group. A fourth organisation asked to be included after they were contacted as one of their missionaries indicated their interest in the study as a result of an approach by a friend who knew of the study.

In my clinical experience, missionaries who were considered long term, as opposed to short term, seemed to have more difficulty with re-entry so, I decided to

sample the long term group. There is, however, some inconsistency in the literature about the definition of *long term* (Szkudlarek, 2009). After discussion with the four participating organisations about the definitions of short term and long term assignments, it was decided to define *long term* as assignments lasting for two years or more as this definition was generally used by the organisations. As the pilot studies proceeded, however, it was evident that very few participants had been away for two years continually with short trips being made back to Australia most often for personal reasons such as family occasions. Therefore, for the purposes of this study, the definition of long term was changed to absence from Australia for an assignment for not less than two years out of the previous three years.

Adult participants were chosen because the issue of re-entry adjustment has been well studied in children and adolescents (Pollock & Van Reken, 2001). To avoid overlap with issues which were relevant to adolescence, an adult was defined as being between the ages of 25 and 70. After discussion with an adolescent psychiatrist about when adolescence ends, 25 years was chosen as the cut-off age.

Australian participants were chosen as the research question addresses the care of these participants in the Australian General Practice setting. There are no identifiable studies in this area using Australian participants. Most of the studies focus on missionaries from the United States (Bagley, 2003; Barnett, Duvall, Edwards, & Hall, 2005; Coschignano, 2000; Cox, 2001; Huffman, 1989; Moore et al., 1987; Stringham, 1993; Walling et al., 2006; Windus, 1999) or the United Kingdom (Jones & Jones, 1994; Lovell, 1997; Peppiatt & Byass, 1991) and this Australian group was of clinical interest and accessible.

To ensure the missionaries came from cross-cultural situations, those chosen were returning from a non-western country<sup>c</sup> and they participated in this study between one and 12 months after their return as this has been defined as the period of re-entry adjustment (Austin, 1986). Missionaries who were permanently returning and those on furlough were all included in the study as there are differences in the psychological stressors for each group (Foyle, 2001) and I wanted to capture the broad range of responses during re-entry.

Participants who were severely affected by anxiety or depression as assessed by the DASS 21 questionnaire (Appendix 5, section 4.3.1) were excluded from the study as these health issues may have impeded interview structure and content in this group. There are various reasons for this. Firstly, those with mild depression often find relief at being able to vent their feelings and this is the best form of therapy for this group (Jureidini & Tonkin, 2006); however, those with severe depression may find little or no benefit in sharing their experience (Bloch and Singh, 1999 cited in [Moyle, 2002]). Secondly, depression has been associated with reduced linguistic complexity (Emery & Breslau, 1989) which may decrease the participant's ability to describe and reflect on their experiences, decreasing the richness of the interview (Moyle, 2002). Those with severe depression have difficulty with concentration and memory (Gelenberg & Hopkins, 2007) and this would have extended the interview (Moyle, 2002). Depression may also act as a confounding factor for those experiencing grief with Joynt and O'Connor (2005) emphasising that a normal grief reaction is sometimes clinically indistinguishable from mild depression.

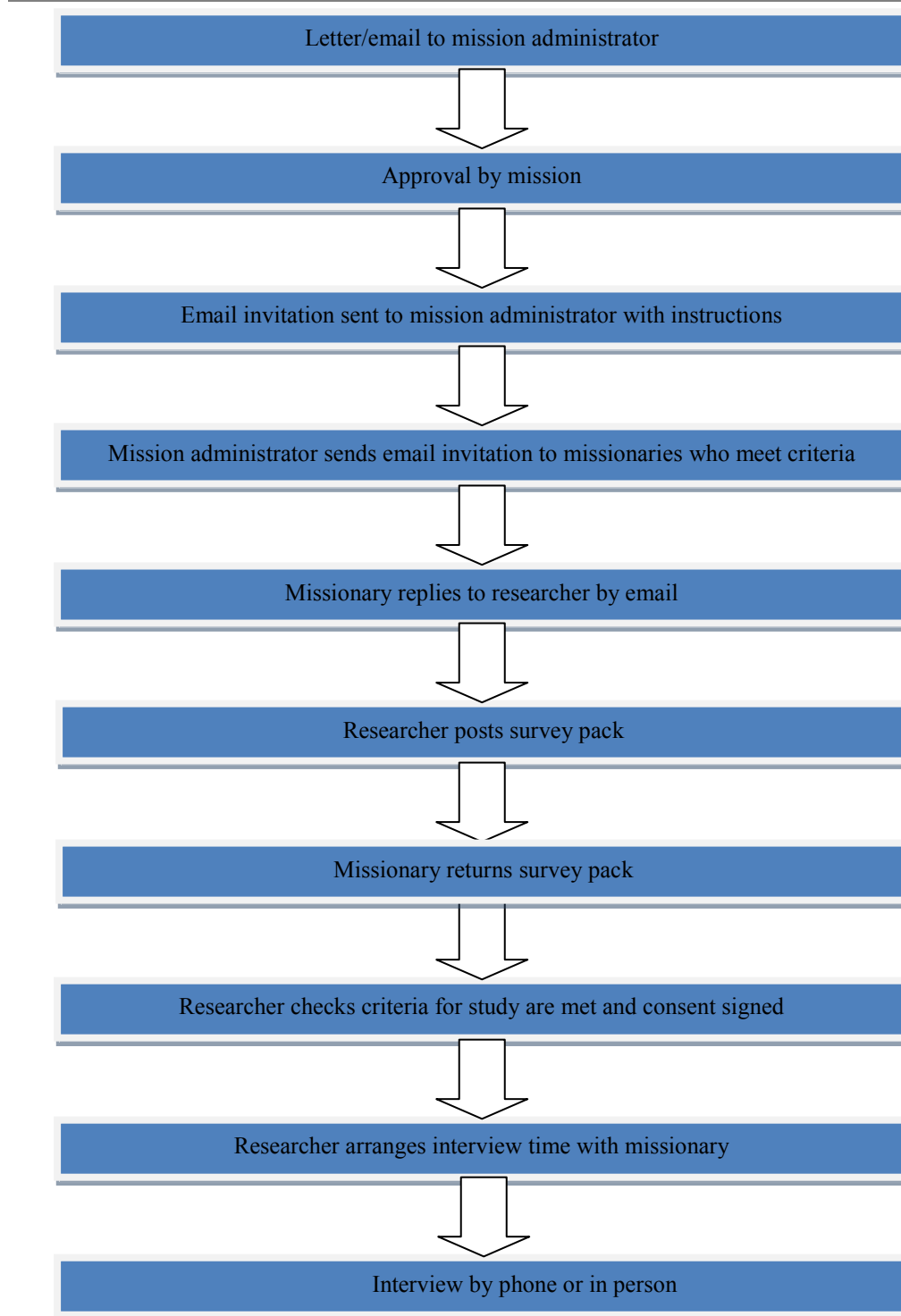
---

<sup>c</sup> *Non-western country* describes a country which is poorer and has less advanced industries, especially in Africa, Latin America or Asia (Cambridge University Press, 2010).

### 4.2.3 Recruitment

In terms of deciding the number of interviews, Crabtree and Miller (1992) have noted that various authors have shown that 12-20 data sources are usually needed when looking for deviant cases or trying to achieve maximum variation in qualitative research. Therefore, 15 participants were considered to be a sufficient initial sample with an option to increase the sample size if necessary. Twelve to fifteen participants also enabled subdivision of the sample into more homogeneous subgroups during analysis (Hill, C. B. et al., 2005).

The process of the participants' entry into the study is described in Figure 4. An example of the letter/email to the mission administrator is given in Appendix 6. The participants' entrance into the study was initiated with email contact by the missionary in response to an email from their sending organisation (Appendix 7) and the sending of a survey pack. The survey pack consisted of an invitation to the participant (Appendix 8), a participant information sheet (Appendix 3), a consent form (Appendix 4) and the three part survey (Appendix 5). Five out of six participants who indicated they would like further information were included in the pilot study and 15 out of 22 participants who indicated they would like further information were included in the main study. Unfortunately, no follow-up was designed to discover why those with initial interest did not participate. Fifteen participants completed the study answering the first research question described below.



*Figure 4. The Process of Participant Entry to the Study*

### 4.3 Answering the First Research Question<sup>d</sup>: Development of Data Collection Instruments

In this section of the chapter, I will describe the development of the instruments – the survey and semi-structured interview - used to collect the data to answer the first research question (*What is the nature of the psychological distress of adult Australian cross-cultural missionary workers who are re-entering Australia?*) and the subsidiary questions (Figure 2, section 3.2).

#### 4.3.1 *The survey*

The survey consisted of three parts:

- the Re-entry Demographics Questionnaire (RDQ) also known as The Demographics Questionnaire (Appendix 5A)
- The Re-entry Grief Diagnostic Instrument (RGDI), also known as The Loss and Grief Questionnaire for Re-entry to Australia (Appendix 5B)
- the DASS 21 (Appendix 5C)

The survey was developed to gather relevant demographic information (RDQ), to collect quantitative data about loss and grief from this study (RGDI) and to enable correlations with mental health indices (DASS 21) and the qualitative data. The RDQ and RGDI were developed for use in this study as there were no identifiable instruments in the literature (section 2.5.2). The DASS 21 is a reliable and validated

---

<sup>d</sup> *The first research question* refers to the broad question: What is the nature of the psychological distress of adult Australian cross-cultural missionary workers who are re-entering Australia? (Figure 2, section 3.2) unless otherwise stated.



instrument for measuring depression, anxiety and stress and is described later in this section.

### *The Re-entry Demographics Questionnaire*

I chose to design a separate demographics questionnaire as the importance of demography is well recognised in any discussion about international migration (Zlotnik, 1987). This questionnaire was originally called the *Demographics Questionnaire* but is now referred to as the *Re-entry Demographics Questionnaire* (RDQ) in this thesis. Data from this questionnaire gave background information to inform the interview in accordance with the mixed method development design where sequential gathering of information starting with the survey enables sample selection and informs the analysis (Greene et al., 1989). After reviewing the literature, the questionnaire was modified from the work of Jensma (1995) and Clark (2003). Further modifications were introduced after review of the Census Dictionary of the Australian Bureau of Statistics (ABS; Australian Bureau of Statistics, 2001). Table 1 presents the development of the demographics questionnaire. The Appendices contain the first (Appendix 9) and final versions (Appendix 5) of the questionnaire. Further descriptions are available in Chapter 6.

Table 1. Development of the Re-entry Demographics Questionnaire

Question Area	Schedule 1	Final Schedule	Reason For Change
Personal information	Q1-4	Q1-8	
	<ul style="list-style-type: none"> <li>describe gender, age, country of birth , nationality</li> </ul>	<ul style="list-style-type: none"> <li>Q2 was changed to year of birth</li> </ul>	<ul style="list-style-type: none"> <li>to aid in coding and consistent with ABS usage</li> </ul>
		<ul style="list-style-type: none"> <li>Q5,6 added</li> </ul>	<ul style="list-style-type: none"> <li>to identify cultural background to ascertain cultural losses</li> </ul>
		<ul style="list-style-type: none"> <li>Q7,8 added</li> </ul>	<ul style="list-style-type: none"> <li>to aid in interview in areas of spirituality and role</li> </ul>
Re-entry	Q5-8	Q9-13	
	<ul style="list-style-type: none"> <li>describe timing, circumstances of field work, re-entry future plans</li> </ul>	<ul style="list-style-type: none"> <li>Q10 rephrased</li> </ul>	<ul style="list-style-type: none"> <li>2 participants gave total number of years of service instead of time since last return</li> </ul>
		<ul style="list-style-type: none"> <li>Q12 modified with clearer instructions and change of headings to give more accurate time frame and reason for return</li> </ul>	<ul style="list-style-type: none"> <li>participants found the question confusing and it was altered to give more relevant information</li> </ul>
		<ul style="list-style-type: none"> <li>Q13 modified so more than one answer could be given</li> </ul>	<ul style="list-style-type: none"> <li>2 participants noted they had more than one reason for re-entry</li> </ul>
Role at home	Q9	Q13	
	<ul style="list-style-type: none"> <li>plans for the future changed</li> </ul>	<ul style="list-style-type: none"> <li>changed to plans for the next 12 months</li> </ul>	<ul style="list-style-type: none"> <li>more specific and using period of time associated with re-entry adjustment</li> </ul>
Educational Attainment	Q10		
	<ul style="list-style-type: none"> <li>documented educational attainment</li> </ul>	<ul style="list-style-type: none"> <li>deleted</li> </ul>	<ul style="list-style-type: none"> <li>information not necessary for this study</li> </ul>
Family	Q11-13	Q14-16	
	<ul style="list-style-type: none"> <li>describes marital status on re-entry and currently</li> </ul>	<ul style="list-style-type: none"> <li>Q14, 15 categories altered</li> </ul>	<ul style="list-style-type: none"> <li>fitted with ABS categories</li> <li>other category increased accuracy of information</li> </ul>
	<ul style="list-style-type: none"> <li>describes number of children and ages on re-entry</li> </ul>	<ul style="list-style-type: none"> <li>Q16 Added including adult children</li> </ul>	<ul style="list-style-type: none"> <li>2 participants thought it only meant dependent children</li> </ul>
		<ul style="list-style-type: none"> <li>last re-entry was changed to present re-entry</li> </ul>	<ul style="list-style-type: none"> <li>to clarify time-frame</li> </ul>
General Changes	<ul style="list-style-type: none"> <li>no cover sheet</li> </ul>	<ul style="list-style-type: none"> <li>cover sheet</li> </ul>	<ul style="list-style-type: none"> <li>clarify data collection</li> </ul>
	<ul style="list-style-type: none"> <li>repatriation used to describe return</li> </ul>	<ul style="list-style-type: none"> <li>repatriation was changed to re-entry</li> </ul>	<ul style="list-style-type: none"> <li>participants commented this was a better term and did not mean final re-entry to them</li> </ul>
	<ul style="list-style-type: none"> <li>instructions</li> </ul>	<ul style="list-style-type: none"> <li>instructions more specific and consistent</li> </ul>	<ul style="list-style-type: none"> <li>clarify data</li> </ul>
	<ul style="list-style-type: none"> <li>format</li> </ul>	<ul style="list-style-type: none"> <li>format changed</li> </ul>	<ul style="list-style-type: none"> <li>for ease of completion of questionnaire</li> </ul>

### *The Re-entry Grief Diagnostic Instrument*

The Re-entry Grief Diagnostic Instrument (RGDI; Appendix 5) was developed in two stages: firstly, a *literature search* was done to identify a suitable instrument which could be modified for re-entry; secondly, initial *modifications* of this instrument were undertaken after further literature review; and thirdly, this instrument was further modified with the aid of a *pilot study* to develop the final RGDI.

A *literature search* (section 2.5.4) identified the GDI (Clark, 2003; Clark et al., 2005; Appendix 10) as the most suitable instrument to measure loss and grief in the general practice setting for both death and non-death loss. Clark et al (2005) validated the GDI as a concise, reliable and sensitive measure which detects a broad range of losses, measuring their combined effect and the resultant grief. It may be used as a research tool or a clinical screening tool. Its research uses include exploring coexisting losses in specific populations; exploring differences as well as commonalities of loss among populations affected by the same loss in order to identify individuals at risk; and measuring and comparing grief for different losses. The GDI consists of three sections: a demographic review (section A); the loss review (section B); and a grief measure (section C; Appendix 10). The loss review (section B) with fourteen categories of loss including one open item response category detects the presence or absence of loss in participants and determines the categories of loss events causing grief. The grief measure (section C) measures the extant state of grief resulting from the losses detected by the loss review (section B). It consisted of 16 items which measured validated grief phenomena (Clark et al., 2005) on a 4-point Likert scale. Scores for the item response options of section C were: never (score = 0); a little bit of the time (score =1); quite a bit of the time (score = 2); and a lot of the

time/continuously (score = 3). The range of possible item scores was 0-3 with the maximum possible score of 48. A score for the whole of the grief measure (section C) was obtained by summing the scores for all items. The maximum possible score was 48 (16 items x 3) with validated categories being: mild grief = 1-17; moderate grief = 18-22; severe grief = >22. Permission to use the GDI in this thesis was given by Dr Sheila Clark (Appendix 11).

The *GDI modifications* initially resulted in three changes. The demographic review (section A) of the GDI was discarded and replaced by the separate RDQ (section 4.3.1.). The loss review (section B) of the GDI was modified after the literature search (section 2.5.3) identified supplementary questions relevant to re-entry. It was then renamed the loss review (section A) of the RGDI and the final questions are listed in Table 2. The grief measure (section C) of the GDI was used unchanged from the original GDI (Clark et al., 2005) and renamed the grief measure (section B) of the RGDI with Table 3 listing the items. Therefore, the first version of the RGDI consisted of the loss review (section A) and the grief measure (section B; Appendix 10). The loss review (section A) of the RGDI was further developed during a pilot study which resulted in the final version (Appendix 5).

*Table 2. Loss Categories for the Loss Review (Section A) of the Re-entry Grief Diagnostic Instrument*

<p><b>General losses<sup>1</sup></b></p>	<ol style="list-style-type: none"> <li>1. Fear of your own death</li> <li>2. Loss of someone through separation, divorce, child leaving home, disagreements with family members or friends etc, death</li> <li>3. Serious illness or death of a pet, or separation from a pet</li> <li>4. Loss of freedom e.g. being a carer, retirement of spouse, gaol, etc</li> <li>5. Job loss e.g. retirement, redundancy, unemployment, illness, birth of a baby etc</li> <li>6. Loss of opportunity e.g. missed career choice, promotion, an unfulfilled dream or life choices being different from those you expected etc</li> <li>7. Financial or property loss e.g. disaster, collapse of financial company, burglary etc</li> <li>8. Loss of quality of life e.g. illness, disability, aging, injury etc</li> <li>9. Loss of personal integrity e.g. domestic violence, rape, incest, war etc</li> <li>10. Losses through adoption/ fostering e.g. giving up, being or caring for an adopted or fostered child</li> <li>11. Loss or lack of pregnancy e.g. infertility, miscarriage, abortion, sterilisation, stillbirth etc</li> </ol>
<p><b>Losses associated with re-entry<sup>2</sup></b></p>	<ol style="list-style-type: none"> <li>12. Loss of control of assignment outcome e.g. project terminated</li> <li>13. Loss of closure on field e.g. unable to farewell colleagues</li> <li>14. Loss of family cohesiveness on the field</li> <li>15. Loss of role on field</li> <li>16. Loss of home culture e.g. loss of familiar landmarks, terms of speech</li> <li>17. Loss of host culture e.g. foods, smells</li> <li>18. Loss of identity</li> <li>19. Loss of spiritual beliefs</li> <li>20. Any other losses since this re-entry to Australia?- Please list:</li> </ol>

<sup>1</sup>Alteration of three questions from the Grief Diagnostic Instrument (Table 3)

<sup>2</sup>All questions added to the Grief Diagnostic Instrument (Table 3)

*Table 3. Development of the Loss Review (Section A) of the Re-entry Grief Diagnostic Instrument*

<b>Question areas</b>	<b>Grief Diagnostic Instrument</b>	<b>Re-entry Grief Diagnostic Instrument</b>	<b>Reason for Change</b>
Introduction	<ul style="list-style-type: none"> <li>losses required were in the last 2 weeks</li> <li>affected self and others</li> </ul>	<ul style="list-style-type: none"> <li>instructions were modified to make it clear that the losses required were those experienced since the current return to Australia</li> <li>affected self only</li> </ul>	<ul style="list-style-type: none"> <li>participants in pilot were confused which losses were being assessed and the time frame</li> </ul>
Question construction	<ul style="list-style-type: none"> <li>date of first awareness of loss</li> </ul>	<ul style="list-style-type: none"> <li>deleted</li> </ul>	<ul style="list-style-type: none"> <li>re-entry time frame given in the instructions so this was no longer relevant</li> </ul>
	<ul style="list-style-type: none"> <li>no description</li> </ul>	<ul style="list-style-type: none"> <li>description of the loss requested</li> </ul>	<ul style="list-style-type: none"> <li>to enable further exploration in the interview</li> </ul>
	<ul style="list-style-type: none"> <li>no grading scale</li> </ul>	<ul style="list-style-type: none"> <li>a grading scale for these losses was added</li> </ul>	<ul style="list-style-type: none"> <li>to assess distress caused by a particular loss</li> </ul>
General loss questions	<ul style="list-style-type: none"> <li>Q2 and 4–14 used unchanged</li> </ul>	<ul style="list-style-type: none"> <li>Q1 (loss through death) added to Q4 (loss through separation)</li> </ul>	<ul style="list-style-type: none"> <li>to reduce the number of questions and help the participants view loss more generally, not as only being related to death</li> </ul>
	<ul style="list-style-type: none"> <li>Q3</li> </ul>	<ul style="list-style-type: none"> <li>Q3 (loss through migration) deleted</li> </ul>	<ul style="list-style-type: none"> <li>The whole questionnaire was about re-entry migration</li> </ul>
	<ul style="list-style-type: none"> <li>Q14</li> </ul>	<ul style="list-style-type: none"> <li>Q14 (other losses) became Q20</li> </ul>	<ul style="list-style-type: none"> <li>Final question</li> </ul>
Re-entry questions	<ul style="list-style-type: none"> <li>Not formulated</li> </ul>	<ul style="list-style-type: none"> <li>Q11–19 added to schedule</li> </ul>	<ul style="list-style-type: none"> <li>Evidence from literature search and pilot studies</li> </ul>

*Table 4. Items from the Grief Measurement (Section B) of the Re-entry Grief Diagnostic Instrument*

1. Have thoughts of your loss made it difficult for you to concentrate, remember things or make decisions?
2. Have you experienced images of the events surrounding the loss?
3. Have you found yourself longing for what is or will be lost?
4. Have reminders of the loss such as people, photos, situations, music, places etc caused you to feel longing for what is or will be lost?
5. Have thoughts or reminders of the loss caused you to feel guilt?
6. Have thoughts or reminders of what is or will be lost caused you to feel sick or ill in any way (e.g. generally unwell, loss of energy, headaches, dizziness etc)?
7. Have thoughts of the loss come into your mind whether you wish it or not?
8. Have you felt distress by the reality of the loss?
9. Have thoughts or reminders of the loss caused you to feel dread of the future?
10. Have thoughts of your loss caused you to be more irritable with others?
11. Overall how much have thoughts and feelings about your loss or losses distressed you?
12. Have people or familiar objects (photos, possessions, rooms etc) reminded you of the loss?
13. Have thoughts or reminders of the loss caused your emotions to feel numb?
14. Have you found yourself imagining that the loss has/will not occur?
15. Have reminders of the loss such as people, photos, situations, music, places etc cause you to feel sadness?
16. Have thoughts or reminders of the loss caused you to feel anger?

*The pilot study* with five participants was undertaken after the initial modifications of the GDI. The development of the loss review (section A) of the RDGI from these pilot studies is described in Table 3. The loss review (section A) commenced with an introductory paragraph explaining its purpose. It consisted of 20 categories of loss, which were designed to be mutually exclusive and included a free response item to capture losses not included in the previous categories (Table 2). Examples were given within categories for clarification. As in the GDI, questions were constructed for each category asking subjects whether they were experiencing distress about loss in relation to that category. In contrast to the GDI, they were asked to include any losses they had had since their return to Australia including those which were a direct result of re-entry. Participants were asked to respond by ticking a *Yes* or *No* box for each category. For each *Yes* box selected participants were also requested to complete a 5-point Likert scale by circling a grade in numbers from 1 (mild distress) to 5 (severe distress) for each loss and space was provided for the description of two losses for each category. Scores for the loss review (section A) were obtained by adding the number of endorsed loss categories. The maximum score was 20. Losses detected by the questionnaire were cross-checked at the end of the interviews (methods triangulation) to enhance the dependability of the findings (Hansen, 2006).

The grief measure (section B) of the RGDI (Appendix 5) was used unchanged from the grief measure (section C) of the GDI (Appendix 10) and is described in section 4.3. This grief measure has been shown to have acceptable levels of criterion and item validity as well as test-retest reliability with internal consistency; its construct validity has been supported and it was satisfactory in its brevity, format and content (Clark et al., 2005).



The final version of the RGDI (Appendix 5) consisted of two sections: the loss review (Section A) and the grief measure (section B) in contrast to the GDI with three sections (A, B and C; Appendix 10).

### *The DASS 21*

The final instrument of the survey was the DASS 21 (Appendix 5; Lovibond & Lovibond, 1995) which was chosen because of its usefulness in the clinical setting (Ng, Trauer, Seetal, Callaly, Campbell, & Berk, 2007) and its use in Australian general practice (Capricornia Division of General Practice Ltd, 2007). This quantitative instrument is the short form of a 42 item self-report measure of depression, anxiety and stress (DASS 42; Lovibond & Lovibond, 1995) which has been validated for the general population (Clara, Cox, & Enns, 2001; Henry et al., 2005). I chose it as a further measure of psychological distress including the dimensions of depression, anxiety and stress, with each of these subscales also tapping a more general dimension of psychological distress (Henry et al., 2005) in a given sample. The DASS 21 was chosen to give reliable quantitative values for these dimensions which could be compared to the RGDI grief score. Grief and depression need to be differentiated as they may have similar presentations, for example, loss of concentration, loss of energy, episodes of crying and somatic symptoms such as fatigue (Strada, 2009). The short form of the DASS 21 (Lovibond & Lovibond, 1995) was chosen to increase response rates (Cartwright, 1988) and with a view to using it as a part of a clinical tool in the general practice setting. However, the authors of the supporting website (Psychology Foundation of Australia, 2003) have suggested that in general, the full DASS is often preferable for clinical work, and the DASS 21 is often

best for research purposes. The DASS 21 measurements also served an ethical purpose as they enabled identification of participants who should be excluded according to the criteria approved by the Human Research Ethics Committee, The University of Adelaide (section 3.3.2).

#### 4.3.2 *The semi-structured interview*

The semi-structured interview was developed in three stages. Firstly, important broad areas for questioning about psychological distress, particularly loss and grief, were identified from *the literature search* (Chapter 2), with subsequent modification after more detailed exploration of the literature. Secondly, a *further literature search* was undertaken to explore the optimal style of questions for the semi-structured interview and identify suitable schedules. Finally, a *pilot study* was conducted to develop the interview schedule (Table 5).

*The literature search* (Chapter 2) enabled the initial broad construction of questions with more detailed questions being added after further exploration of the literature. Examples of this were the questions about disenfranchised grief which were not included in the first schedule but were added subsequently (Table 5).

A *further literature search* identified how to construct the semi-structured interview. Kvale (1996), Grbich (1999) and Bowling (2002) have outlined criteria for the semi-structured interview. These included the use of open-ended shorter questions so material could be fully explored without prior assumptions which was important in the identification of psychological distress, particularly loss and grief reactions; the opportunity for more complex questioning if necessary and obtaining more in-depth information to explore the nature of the distress and particular issues such as

disenfranchised grief; and the opportunity to check the responses for meaning which is vital in obtaining reliable data. Kvale (1996), Grbich (1999) and Bowling (2002) also required that the researcher was experienced in interview technique. I met this criteria as I had had extensive clinical experience in interviewing and had studied research methods. Kvale (1996) further emphasised that the participant be given permission to engage in ongoing interpretation of their answers which may result in a self-contained story. Suitable questions and probes formulated in accordance with Fielding's principles on how to design an interview schedule (2001) were constructed to enable this. The first schedule of the semi-structured interview guide was developed (Appendix 13).

*A pilot study* was undertaken with five participants to further develop the interview schedule (Table 5). Participants gave feedback directly after the interview and I made field notes during and after the interview. The final schedule was the result of five modifications after each pilot study (Table 6). Although part of question 14 asked participants to indicate their level of distress on a Likert scale, in the final version, this question was deleted during the study as it was very difficult for me to explain clearly in telephone conversations.

Table 5. Development of the Semi-structured Interview Schedule

Question Categories	First Schedule	Final Schedule	Reason for Change
Introduction	<ul style="list-style-type: none"> <li>used <i>re-entry</i> or <i>repatriation</i></li> </ul>	<ul style="list-style-type: none"> <li>used only <i>re-entry</i></li> <li>added <i>this last time</i></li> </ul>	<ul style="list-style-type: none"> <li>participants thought <i>re-entry</i> was a better term as <i>repatriation</i> meant to them the final return</li> <li>to clarify time frame</li> </ul>
Introductory Questions	<p>Q1-4</p> <ul style="list-style-type: none"> <li>explored circumstances of return, role in Australia and feelings</li> </ul>	<p>Q1-3</p> <ul style="list-style-type: none"> <li>one of the questions was deleted</li> <li>the order was changed</li> </ul>	<ul style="list-style-type: none"> <li>it was repetitive</li> <li>to facilitate the flow of the interview</li> </ul>
Culture	<p>Q5,6</p> <ul style="list-style-type: none"> <li>explored change and loss related to the host and home culture</li> </ul>	<p>Q4,5,6</p> <ul style="list-style-type: none"> <li>Q5 was expanded</li> <li>Q6 was clarified</li> </ul>	<ul style="list-style-type: none"> <li>to explore the nature of relationship losses and disenfranchised grief</li> <li>so the comparison was with previous re-entry experiences</li> </ul>
Personal Change	<p>Q7</p> <ul style="list-style-type: none"> <li>the participants were given a general question on personal change</li> </ul>	<p>Q7</p> <ul style="list-style-type: none"> <li>the question was changed to specific questions about personal changes in 4 of Corr's domains for grief (the other 2 domains were addressed in separate questions)</li> <li>examples of behaviour changes were given</li> </ul>	<ul style="list-style-type: none"> <li>the participants found the general question very hard to answer; after the changes using Corr's domains one participant commented on what a good question this was and answers were much more detailed</li> <li>to clarify</li> </ul>
Family Issues	<p>Q9</p> <ul style="list-style-type: none"> <li>explored loss in this area</li> </ul>	<p>Q9</p> <ul style="list-style-type: none"> <li>no change</li> </ul>	<ul style="list-style-type: none"> <li>explored issues adequately</li> </ul>
Personal Relationships	<p>Q10</p> <ul style="list-style-type: none"> <li>explored loss in this area</li> </ul>	<p>Q10</p> <ul style="list-style-type: none"> <li>no change</li> </ul>	<ul style="list-style-type: none"> <li>explored issues adequately</li> </ul>
Spiritual Issues	<p>Q11</p> <ul style="list-style-type: none"> <li>explored changes in spirituality</li> </ul>	<p>Q11</p> <ul style="list-style-type: none"> <li>an introduction was added</li> <li>more specific questions were asked about beliefs and values</li> </ul>	<ul style="list-style-type: none"> <li>to prepare participants for these questions</li> <li>participants were not giving very detailed answers so more specific questions were asked to explore this domain</li> </ul>
Particular Incident	<p>Q12</p> <ul style="list-style-type: none"> <li>no change</li> </ul>	<p>Q12</p> <ul style="list-style-type: none"> <li>no change</li> </ul>	<ul style="list-style-type: none"> <li>explored issues adequately</li> </ul>
Multiple Re-entry	<p>Q13</p> <ul style="list-style-type: none"> <li>no change</li> </ul>	<p>Q13</p> <ul style="list-style-type: none"> <li>no change</li> </ul>	<ul style="list-style-type: none"> <li>explored issues adequately</li> </ul>
Questionnaire Review	<ul style="list-style-type: none"> <li>not in original schedule</li> </ul>	<p>Q14</p> <ul style="list-style-type: none"> <li>review of losses in questionnaire</li> <li>Likert scale to measure distress (deleted during study)</li> </ul>	<ul style="list-style-type: none"> <li>to enable losses noted in the questionnaire to be clarified</li> <li>to help in assessment</li> </ul>
Disenfranchised Grief	<ul style="list-style-type: none"> <li>not in original schedule</li> </ul>	<p>Q15,16,17,18</p> <ul style="list-style-type: none"> <li>were added to explore areas of disenfranchised grief</li> </ul>	<ul style="list-style-type: none"> <li>for clarification of disenfranchised grief and to quantify</li> </ul>

Table 6. Questions in the Final Semi-structured Interview Schedule

<b>Introductory Questions</b>	
1	Can you explain the circumstances of your return?
2	How did you feel when you returned? What sort of support would be useful in helping with this?
3	Now that you have returned, what is your role in Australia?
<b>Cross-cultural issues and relationships</b>	
4	Now you have returned, what do you miss? Can you give me some specific examples? How do you feel about this?
5	Do you miss any of the relationships you had with the nationals overseas? What sort of relationship did you have? How do you feel about this? Do you miss any other relationships now you are back? What sort of relationship did you have? How do you feel about this? Do you think loss of the relationships you had overseas have been recognised here by: friends and family, the church, the sending agency
6	After your return, have you noted things in the Australian way of life that are different? Can you give me some specific examples? How did you feel about this?
<b>Personal Change</b>	
7	Now that you have returned, can you tell me about areas of change in you as a person? <ul style="list-style-type: none"> <li>• Have you had any changes in physical function since returning? How do you feel about this?</li> <li>• Have you had any changes in your emotional makeup since returning? How do you feel about this?</li> <li>• Have you had any changes in the way your thought processes are functioning since returning? How do you feel about this?</li> <li>• Have you had any changes in behaviour since returning e.g. things that you would normally do that you are not doing or things that you wouldn't do that you are doing? How do you feel about this?</li> </ul>
<b>Social Issues: (Identity, Family Issues, Personal Relationships in Australia)</b>	
8	How do you think others see you since your return? How do you feel about this?
9	How is the family since your return? How do you feel about this? What sort of support would be useful in helping you at this time?
10	Since your return to Australia are there significant personal relationships that have changed? How do you feel about this? What sort of support would be useful in helping you at this time?
<b>Spiritual Issues</b>	
11	Has your relationship with God changed since your return? Have your beliefs changed since your return? Have your values changed since your return? How do you feel about this? What sort of support would be useful in helping you at this time?
<b>Particular Incident</b>	
12	Can you pick one day or experience that has stuck in your mind since your return? Can you tell me about it? How did you feel? What made it a positive/negative experience?
<b>If multiple re-entries</b>	
13	You have been back and forth a number of times. What differences has this made to you compared with your first re-entry? How do you feel about this? What sort of support would be useful in helping you this time?
<b>Survey Review</b>	
14	After looking at the Questionnaire, can you tell me more about the following losses ....
<b>Disenfranchised Grief</b>	
15	We have discussed a number of losses. During re-entry: <ul style="list-style-type: none"> <li>• Do you feel your losses have been acknowledged by those close to you e.g. friends and family? Can you tell me about this? What would help in this situation?</li> <li>• Do you feel your losses have been acknowledged by the sending agency? Can you tell me about this? What would help in this situation?</li> <li>• Do you feel your losses have been acknowledged by your church? Can you tell me about this? What would help in this situation?</li> <li>• Do you feel you have acknowledged your losses? Can you tell me about this? What would help in this situation?</li> </ul>
16	Do you feel that you have been given the opportunity to grieve for these losses? If no, why don't you think you have had the opportunity?
17	Have you been able to express your grief? If yes, how?

#### 4.4 Answering the First Research Question: Data Collection

This section will discuss the two methods of data collection: the survey and the semi-structured interview. In line with the partially mixed sequential dominant status design (Leech et al., 2009) of this study, the survey, which is the less dominant secondary source of data, was collected first followed by the semi-structured interview which is the dominant primary source of data.

##### *4.4.1 The survey*

The survey enabled collection of demographic data from the RDQ and quantitative data from the RGDI and DASS 21. The quantitative data from the survey consisted of loss category scores and grief scores from the loss review (section A) and grief measure (section B) of the RGDI and depression, anxiety and stress scores from the DASS 21. The survey was collected from 22 participants; however, two were excluded as they did not meet the criteria of being within 12 months of re-entry. Five participants were surveyed for the pilot study to develop the data collection instruments as discussed in section 4.3.1, with two final survey schedules being redone by two of these missionaries as a final check. Fifteen missionaries who had not been involved in the pilot studies were surveyed for the main study. Survey packs were posted to the participants with stamp addressed return envelopes included so the participant could return the consent form (Appendix 4) and the three part survey (Appendix 5; see section 4.2.3).

#### 4.4.2 *The semi-structured interview*

The semi-structured interview enabled collection of the qualitative data (Creswell, 2003) and limited quantitative data: the number of identified loss categories for each participant, the number of disenfranchised participants identified by their interview responses (Appendix 14), and the frequency of grief phenomena for participants by means of manual counts and quantifying NVivo 2.0 codes for grief phenomena (section 4.5.2). The same 15 missionaries who were surveyed were interviewed for the main study.

I conducted the interviews face-to-face, one-on-one, in the participants' homes or by telephone because of distance (Creswell, 2003). Two interviews were conducted in the participants' homes, while thirteen interviews for the study were conducted by telephone. Interviews took between 45 and 90 minutes. The interview schedule was flexible with opportunities for clarification by both me and the participants (Lofland & Lofland, 1995). Interviews were audio-taped with participant consent checked at the beginning of the interview (Lofland et al., 1995). Field notes were also made during the interview (Lofland et al., 1995). At the completion of the interview I offered to arrange counselling if the participants wished to have this in line with the ethical considerations (section 3.5). I spent time after the interview reflecting on the process: any difficulties experienced, the main points, and interesting aspects of the interview (Lofland et al., 1995). I have described the nature of each interview including these reflections in the biographical descriptions of the participants in Chapter 5.

I employed two transcribers who undertook the initial transcription of the interviews into Microsoft Word. I then corrected and de-identified the transcripts,

checking and rechecking transcripts two or three times. One interview was only partially taped due to a technical difficulty; however, I had made adequate field notes about the missing section. Non-verbal behaviour such as weeping was included in the transcription as a description within brackets to facilitate verbatim transcription (Lofland et al., 1995). All participants had been invited to receive a copy of the transcript (Appendix 4) but only seven out of 15 accepted this offer. Six received the transcript and made no comment while one was not contactable and it was not able to be sent. The transcriptions were imported into NVivo 2 (QSR International Pty Ltd, 2002), a computer qualitative analysis program which was used to help manage the data. Descriptions of the data collection methods are also found in Chapter 6 (Selby et al., 2010, p. 4; Selby, Braunack-Mayer et al., 2009, p. 705; Selby, Moulding et al., 2009, p. 22).

#### 4.5 Answering the First Research Question: Data Analysis

In this section of the chapter, I will explain the methods of data analysis for the survey and the semi-structured interview. This discussion will show how further subsidiary research questions for Question 1 were generated from the analysis of the data: Questions 1(ii) a, b, and c (Figure 2, section 3.2; Figure 3, section 3.6).

##### *4.5.1 The survey*

The analysis of the quantitative results of the survey will be described in two parts: the RGDI and the DASS 21. A preliminary analysis of the quantitative data is available in a published article (Selby et al., 2007; Appendix 14). As the number of



participants was small (N=15), descriptive statistics were used in the analysis.

Analyses were performed in SAS® Version 9.2 (SAS Institute Inc, Cary, NC, USA).

Demographic data from the RDQ was gathered and informed the analysis by enabling comparison of the identified groups of participants (Chapter 6, Selby, Braunack-Mayer, et al., 2009); however, because of the small sample no statistical analysis was performed for the demographic data.

#### *Re-entry Grief Diagnostic Instrument*

This *loss review (section A)* and *grief measure (section B) analysis* of the RGDI was conducted to gather data about losses and to measure grief experienced during re-entry. Analysis was also performed to check the reliability and validity of the loss review (section A) of the RGDI.

The *loss review (section A) analysis* of the RGDI commenced with the entry of the number of loss categories for each individual participant. The data were examined for the incidence of loss, multiples of loss categories, mean scores for loss categories and frequencies for each loss category. The data for categories of participants identified during the Typology Analysis (section 4.5.2) were also compared. The Likert scales used to detect distress in the final version of the survey were not analysed as they had not been assessed for reliability and validity.

Cronbach's alpha (Trochim, 2007) was used to assess the reliability of the loss review (section A) of the RGDI by checking the internal consistency of the data. Convergent validity was used to assess validity of the RGDI by demonstrating if the measures of loss categories in the loss review (section A) of the RGDI correlated with the grief measure (section B) of the RGDI (Armstrong, Calnan, & Grace, 1990). Multiple losses are a risk factor for severe grief and complicated grief (Rando, 1993) so one

would expect grief scores to be higher as the number of losses increase. This validity was concurrent as the corroborative measure (section B) was established at the same time as the original measure (section A). Construct validity (Trochim, 2007) was unable to be assessed as the loss review (section A) of the RGDI was used only in this study with its small sample.

The *grief measure (section B) analysis* of the RGDI commenced with calculation of the incidence of participants with mild, moderate and severe grief<sup>e</sup> (section 4.3.1, p. 13) and mean grief scores for categories of participants identified by Typology Analysis (section 4.5.2). Cronbach's Alpha (Trochim, 2007) was calculated to determine the reliability of items in the grief measure (section B) of the RGDI. A t-test (Trochim, 2007) was also performed to determine if there was a significant difference in the mean grief score between the categories of participants identified by the Typology Analysis (section 4.5.2).

### *DASS 21*

Descriptive statistics were calculated for all participants' depression, anxiety and stress scores from the DASS 21 instrument and also for the categories of participants identified by Typology Analysis (section 4.5.2). Cronbach's alpha (Trochim, 2007) was calculated to determine reliability of the items in the DASS 21.

---

<sup>e</sup> In the preliminary analysis (Appendix 14), categories for grief were used based on an early version of the GDI. The *mild* category used in the rest of this thesis includes the *minimal* category described in this article.

#### 4.5.2 *The semi-structured interview*

Quantitative data and qualitative data were analysed from the semi-structured interviews. Quantitative data about the frequency of losses from the interviews were collated in the same loss categories as the loss review (section A) of the RGDI and examined in the same way using descriptive statistical analysis. The number of participants who experienced any type of disenfranchised grief (Glossary and section 2.5.4) and the frequency of the participants' grief phenomena listed from the grief map including phenomena emerging from the data (Appendix 20, section, 2.5.4) were counted manually assisted by NVivo 2 (QSR International Pty Ltd, 2002) using quantitative content analysis (Sarantakos, 2005). The qualitative data were analysed by three different methods: Framework Analysis, Typology Analysis and modified Consensual Qualitative Research (CQR).

Framework analysis is a deductive method, designed specifically by a group of British researchers for applied health research (Ritchie & Spencer, 1993). It allows inclusion of *priore concepts* to enable objectives such as answering the research question (Pope, Ziebland, & Mays, 2000). Framework analysis involves five steps: familiarisation or immersion in the data to list key ideas and themes; identifying a thematic framework by which all the key ideas, concepts and themes may be indexed; indexing or coding of the framework by data annotation which may involve a management tool such as NVivo (QSR International Pty Ltd, 2002); charting with comparison of the data to produce synthesised summaries; and mapping and interpretation to "find associations between themes with a view to providing explanations for the findings" (Pope et al., 2000, p. 116). Framework Analysis is also described in Chapter 6 (Selby, Moulding et al., 2009, pp. 22-23).

Typology analysis involves “typologizing ... to call attention to existing but unnoticed patterns [in the data]” (Lofland et al., 1995, p. 126) by classification across two or more ideas or concepts, each typically with two values such as *present* or *absent* which may involve the use of tables (Lofland et al., 2006). Typology Analysis is also described in Chapter 6 (Selby, Braunack-Mayer et al., 2009, pp. 706-707).

CQR was designed by a group of American researchers to integrate the best features of qualitative research methods into a rigorous learnable process (Hill, C. E., Thompson, & Williams, 1997) and may also include deductive processes (Hill, C. B. et al., 2005). It has five components: use of open-ended questions in a semi-structured data collection technique to allow consistent collection and in-depth examination of individual experiences; several judges throughout the data analysis process to foster multiple perspectives; consensus to arrive at judgments about meaning of data; at least one auditor to check the work of primary team judges; and developing domains, constructing core ideas and building categories in the cross-analyses during the data analysis (Hill, C. B. et al., 2005). Modifications to this process in the CQR analysis were adopted for this study: there was no formal auditor, no formal training and no stability check to check existing data categories, although this is not now considered necessary providing there is an adequate sample and evidence of trustworthiness in the analysis (Hill, C. B. et al., 2005). Modified CQR analysis is also described in Chapter 6 (Selby et al., 2010, pp. 4-5; Selby, Braunack-Mayer et al., 2009, p. 707).

All methods involved constant immersion in the data with reading and rereading of the transcripts to determine categories and coding. Coding was done manually using tables with headings for *priore* concepts, themes, categories and memos about data (Lofland et al., 1995). Transcripts were then transferred to NVivo 2 as the manual coding was completed and further codes were developed as more

transcripts were coded. Early transcripts were then recoded to account for the development of new codes. Concept mapping was also used to develop theory (Daley, 2004). A concept map is “a schematic device for representing a set of concept meanings embedded in a framework of propositions” (Novak, 1984, p. 15). I used these maps to reduce data and analyse themes (Daley, 2004).

As I describe in more detail the three qualitative analyses of this study, Framework, Typology and modified CQR, I will show the reader how my analysis generated further research questions which led to further analysis resulting in the different methods used.

Framework Analysis (Figure 5), the first qualitative analysis of the semi-structured interviews was designed to answer research question, Q1(i): *What issues of loss and grief for long-term adult Australian cross-cultural workers serving as missionaries can be identified as they experience re-entry adjustment?* (section 3.2). I followed the five steps of framework analysis. Firstly, I familiarised myself with the data by repeated reading and re-reading. Secondly, I identified a thematic framework initially using the *priore* concepts from the literature search of loss, grief and disenfranchised grief (section 2.5.3) after consultation with my supervisor (SC). Thirdly, I developed the coding of the framework using NVivo 2 (QSR International Pty Ltd, 2002) with sub-themes and categories with checking by my supervisor (NM) so that consensus were reached (Table 7). Fourthly, I charted and compared data and finally, I mapped concepts (Daley, 2004; Figure 5). As I reflected on the results of this analysis and reviewed the literature (Chapter 2; Selby, Braunack-Mayer et al., 2009, p. 702), I wondered why some participants seemed less distressed than others, although they had all experienced re-entry loss and grief. This *puzzlement* (Lofland et al., 1995) led me to a further subsidiary research question, Q1(ii): *What*

*characteristics and responses of these workers are relevant for their re-entry adjustment?* (Figure 2, section 3.2).

As I reflected on the data and discussed my questions with my supervisors, I realised that to investigate this further research question it would be helpful to identify any patterns in the responses of the participants to their re-entry. This led to a further subsidiary research question, Q1(ii)a: *What are the differences in the responses of the participants to re-entry and is there a pattern?* Typology analysis specifically addresses this type of question (Lofland et al., 1995). After repeated reflective reading and rereading of the transcripts, two categories of participants were identified from the data according to Lofland's rule of mutual exclusiveness (Lofland et al., 2006). This process is described in detail in Chapter 6 (Selby, Braunack-Mayer et al., 2009, p. 707).

After identifying the two groups of participants, two further research questions emerged, Q1(ii)b: *How did these patterns emerge?* and Q1(ii)c: *What is the nature of the participants' characteristics for particular patterns?* I conducted further analysis of the data using modified CQR which was used to explore these questions by providing categories which could then be explored in relation to the participants' patterns of re-entry. By using modified CQR, I was also able to use *prior*e concepts to inform developing domains and then construct core ideas and build categories (Hill, C. B. et al., 2005).

Firstly, five domains were derived from a start list (Hill, C. B. et al., 2005) which emerged from the data and the literature relevant to the concepts of resilience and identity disparities (Selby et al., 2010, pp. 2-4; Selby, Braunack-Mayer et al., 2009, pp. 701-703): psychological, social, spiritual, personal/relational identity gaps and depersonalisation/dehumanisation. After immersion in the data and with the use

of computer-assisted technology, NVivo 2 (QSR International Pty Ltd, 2002), and manual methods, I coded the qualitative data sets for each participant under categories which contained the core ideas for the five domains with attention to outliers. I discussed the coding with my supervisors, with particular checking by two supervisors at different times (NM and ABM), and consensus was reached. I undertook cross-analyses by exploring the relationship between the identified domains and categories and the two patterns of grouping which had emerged from the typology analysis, including the application of frequency descriptors to each category for each of the participant groupings identified in the Typology analysis. Frequency descriptors were *general*, *typical*, *variant* or *absent* and are described in Chapter 6 (Selby et al., 2010, p. 7; Selby, Braunack-Mayer et al., 2009, p. 707).

Both the analyses of the survey and the semi-structured interviews provided a comprehensive set of results which answered the first research question and the subsidiary questions generated by the analysis.

*Table 7. Thematic Analysis of the Semi-structured Interview*

<b>Major themes</b>	<b>Sub-themes</b>	<b>Categories</b>
Loss on Re-entry	Multiple varied losses	Personal
		Social
		Spiritual
	Mechanisms of loss	Vicious loss cycle
		Concurrent loss
	Loss of control	Personal
		Social
		Spiritual
	Grief on Re-entry	Grief phenomena
Disenfranchised grief (DG)		Doka's 5 types of community-initiated DG
		Kaufmann's self-initiated DG
Reactivation of past grief		Re-entry as a trigger



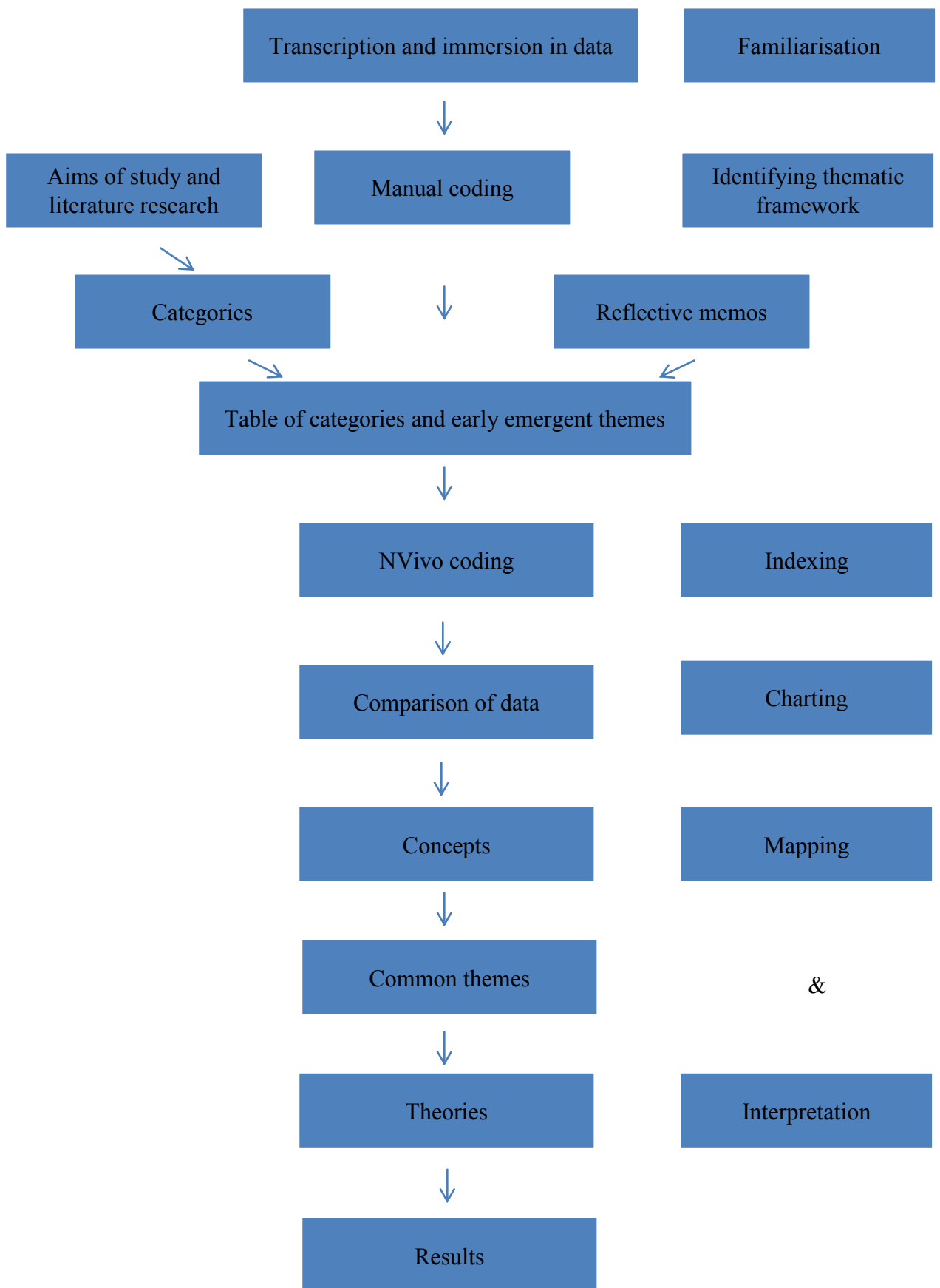


Figure 5. Framework Analysis

## 4.6 Answering the Second Research Question

This part of the chapter will describe the methods used to answer the second research question which arose out of the results from the analysis of the first research question and its subsidiary questions: *What evidence-based theoretical framework will facilitate management of cross-cultural workers' psychological distress in the general practice setting?* (Figure 2, section 3.2). The methods included a literature review with identification of a suitable framework for addressing psychological distress, the modification of this framework, the application of the study results, and the identification of possible clinical applications.

Although the data analysis generated a number of subsidiary research questions, the continuing predominant themes of re-entry loss and grief resulted in my searching for a theoretical framework or model applicable to death loss which was suitable for adaptation to the non-death loss of re-entry. I undertook a further literature review which is described in Chapter 7 and this review resulted in the identification of a suitable model. A search was carried out of national and international published literature in September 2009 with continuing searches during the course of the study and a final search reviewing databases in June 2010. The literature search was done using key words including those in MeSH categories. The search terms were loss, grief, psychological distress, theory and theories. The data bases used were Academic Search Premier, CINAHL, Health Source: Nursing/Academic Edition, PsycARTICLES, Psychology and Behavioral Sciences Collection and PsycINFO. The reference lists of identified articles which were relevant after review of title, abstract and text were also searched.

As I read and reread the literature and understood how the identified model worked for death loss, I was able to apply the parameters of the model to re-entry losses and to describe the stressor categories within the parameters of the model to re-entry. I then reworked the diagram of the model replacing the parameters and stressors for death with those for re-entry. Once the model had been applied to re-entry, I was then able to fit my results into the model as facilitators or barriers to the adaptation to re-entry grief. This is further described in section 7.2.

Possible clinical applications of the findings of this thesis were identified by examining areas of linkage with the application of this model for re-entry loss and grief and the Quality Framework for Australian General Practice (Booth et al., 2005) identified in the literature search (section 2.6.2). This is described in section 7.3.

#### 4.7 Conclusion

In summary, this chapter has described the methodological issues in this thesis including the sample, the development of data collection instruments, data collection and data analysis to answer the first research question and its subsidiary questions; and the process of answering the second research question. These descriptions link the centrality of the research questions to this thesis with the generation of further research questions during the analysis of the data. In the next chapter, I will introduce the participants in this study in the context of their re-entry journey and outline the quantitative results for all participants.

## CHAPTER 5: BIOGRAPHIES AND THE QUANTITATIVE RESULTS

### SUMMARY FOR ALL PARTICIPANTS

#### 5.1 Introduction

In this chapter, I describe the 15 participants' stories in detail and my interaction with the participants. These stories are the background for the results described in Chapter 6. Demographic details of the participants from the RDQ are described in Appendix 15 including participants in the pilot study, as quotes from two of these participants appear at the beginning of this thesis and the article in Chapter 6. I also outline the quantitative results for all the participants in this study and refer the reader to Appendix 16 for further detail. I show that all participants suffered multiple losses, grief and disenfranchised grief.

In section 5.2, I describe the participants' stories in the context of their re-entry to Australia and my interaction with the participants. In section 5.3, I outline the quantitative results for all the participants, which are described in detail in Appendix 16. In section 5.4, I discuss the limitations of the quantitative data.

In section 5.5, I conclude this chapter and show how I have set the participants in their re-entry context to enable the discussion of the qualitative results in Chapter 6.

#### 5.2 The Study Participants: Their Re-entry Context and Our Interaction

The 15 missionaries I interviewed for the main study re-entered from a variety of locations with rich and diverse backgrounds. They ranged in age from late twenties to early sixties, with the largest groups being in their forties and fifties. Nine of the

missionaries were female and six were male. All were Australian citizens and 14 came from Anglo-Saxon cultural backgrounds. Greta also included her background as being part Mestizo/Mexican and Trudy also included her background as being part Dutch. Lily described her cultural background as Chinese. The last placement location for 14 of the group was Asia or Africa, while one had served in the Pacific. Their time on the field as a missionary ranged from two to 15 years. All were Protestant. The time of the interview from their actual re-entry to Australia was between 3 and 11 months. Eleven missionaries were returning permanently for the foreseeable future, whilst three were planning to return to the field. Twelve were married, two were single and one was widowed. Two had four children, seven had three children, one had two children, one had one child and four had no children. Although eight of the missionaries were couples, their individual stories were very diverse. I have given a brief biographical account of each missionary below to enable the reader to place the missionary in their re-entry context and to understand my interaction with each missionary as the researcher.

### *5.2.1 Neil*

Neil, born in 1957, was a doctor from an Australian cultural background, who had a planned permanent return with his wife and three children after serving as a missionary in an African country for the past 12 years. His immediate past role had been in a senior administrative position interacting with host country government officials and he had been living in a larger town. He and his family had returned to a large Australian city near some of their extended family. He gave his religious affiliation as Christian. At the time of the interview, he was still in transition eight

months after his actual return, with no permanent housing or job. He also needed to establish new faith community links. His links with the sending agency had just ceased as he had finished his six months of deputation. He gave his plans for the next 12 months as: *Resign* (from the mission). This was my first interview and was conducted by phone from our respective homes as Neil lived interstate. There were technical difficulties and I needed to transcribe the tape by hand as it was difficult to hear. Initially, I felt rather intimidated when Neil disclosed he also had a medical background, was doing research; however, as the interview progressed we developed rapport. He was very open and did not try and control the process; however, I must have still felt a little intimidated at the end of the interview as I failed to recommend that he could have access to counselling if he needed this and I emailed this provision to him. He had returned permanently for the sake of his children's education after a long term assignment during which he and the family had returned on furlough every 2–3 years, on three occasions. He described ambivalent feelings and internal conflict about his return which was complicated by a concurrent problem's with his son's health which also distressed him. At times I found the interview challenging as he expressed his distress and his feelings of hopelessness. My role of researcher and carer was blurred as I wondered if he was moderately depressed, although I did not express this, and my only care consisted of empathic listening. Neil was married to Jenny, another participant.

### 5.2.2 Jenny

Jenny<sup>f</sup>, born in 1966, was a social worker who had also had roles as an educator, researcher and lay church leader on the field. She was from an Australian cultural background, married to Neil, and had returned, as planned, permanently with him and their 3 children after 12 years in Africa. She had returned every two to three years on furlough with the family. She and her family had returned to a large Australian city from a large East African town. She gave her religious affiliation as Christian. At the time of the interview, seven months after her actual return, she had a part-time job but still had no permanent housing. She also needed to establish new faith community links, although part of her extended family was in the same city. Her links with the sending agency had just ceased as she had finished her six months of deputation. She gave her plans for the next 12 months as: *Other: part-time work and part-time research and study*. This second interview was also conducted by phone as Jenny lived interstate. She was married to Neil so I had some grasp of their situation; however, I let her tell her own story. She was very keen to talk. The interview lasted an hour and a half and her final comments were not recorded as we ran out of tape. We had good rapport; however, she did not always answer the questions. There were technical difficulties as the tape was hard to hear and I had to transcribe it by hand before it could be typed. Interestingly, she was very aware of re-entry adjustment but had definite ideas about the sources of her stress. Nevertheless, she became very emotional as she described her own re-entry distress. Once again the role of carer and researcher was blurred, however, despite my suggestion we cease the interview she wished to continue.

---

<sup>f</sup> Jenny's interview lasted 30 minutes longer than the time indicated on the participant information sheet as it would have been inappropriate to finish earlier and she wished to continue.

### 5.2.3 Alan

Alan, born in 1943, was a houseparent for missionary children attending school in an Asian city. He was from an Australian cultural background and had returned permanently to a small Australian city, as planned, after 15 years on the mission field, having returned nine times during those years. His religious affiliation was Christian (Anglican). He had three adult children who lived in Australia and extended family in the same city. He needed to establish new church community links and was completing deputation work for the sending organisation. He gave his plans for the next 12 months as: *Resign and Other: mix of retirement and Christian-church-home office of mission-voluntary service*. Alan had had to be evacuated from his first host country due to a terrorist attack after working there for a number of years and this re-entry was from the second host country he had worked in. This interview, four months after his actual return, was conducted face to face with Alan at his home. He was open and thoughtful and tried to lighten up the interview with light hearted banter. We developed good rapport, and he was delighted to show me the furniture he was assembling in their new home. He had retired but was considering becoming very involved with his sending organisation on a voluntary basis. He was married to Pam who was interviewed separately.

### 5.2.4 Pam

Pam, born in 1948, was a houseparent for missionary children attending school in Asia in an Asian city. She was from an Australian cultural background and had returned permanently to a small Australian city, as planned, after 15 years on the



mission field, having returned nine times during those years. Her religious affiliation was Anglican. She had three adult children who lived in Australia and her extended family was in the same city. She needed to establish new church community links and was completing deputation work for the sending organisation. She gave her plans for the next 12 months as: *Resign*. She had also been evacuated from her first host country after working there for a number of years due to a terrorist attack and this re-entry was from the second host country she had been transferred to. This interview was conducted face to face with Pam at her home, four months after her actual return. Pam was very easy to interview and although there was an initial reticence, she was very open about her thoughts and feelings as the interview progressed. She gave her answers a lot of thought, although she did become emotionally distressed during the interview as she described her feelings and events. She was given the opportunity to cease the interview but wished to continue. Once again, I needed to juggle my role as researcher and carer by making sure she had permission to cease the interview if she wanted. She wished to continue. Although there was some background noise, there were no technical difficulties.

#### 5.2.5 Joan

Joan, born in 1957, returned on a planned furlough. She had been secretary to the head of the mission in a Pacific country, having been on the mission field for 13 years. She had re-entered twice during that time. Her religious affiliation was Christian (Pentecostal) and she came from an Australian cultural background. She had three adult children and she was also settling her youngest child into tertiary training, having previously done this for her older two children who were studying in

Australia, although not in the same city. She had returned to her own home on Christmas Eve which had been rented in a large Australian city to find it had not been well cared for by tenants. She continued to work for the mission as a secretary at the Australian headquarters while she was on furlough. She returned to her supporting faith community and her extended family lived in the same city. She gave her plans for the next 12 months as: *Home Assignment then return to overseas mission field*. I interviewed her by phone, eight months after actual re-entry as she lived interstate. We quickly established rapport and she was easy to interview. She was apologetic about not having a lot of distress; however, I missed a couple of cues she gave about a very distressing issue for her – the death of her husband on her previous long furlough. She was keen to discuss this when I finally recognised the cues. After his death in an accident in Australia, she had returned to work as a missionary in the host country as a single parent with her three children. This was an unusual situation; however, she was fully supported by the organisation although her extended family had not wanted her to return. She did not become distressed during the interview and had a sense of humour which she used to help her describe her adjustment. Although she had had a previous significant loss, I had no blurring of my role as researcher and carer, although my unwillingness to acknowledge her cues about her loss may have been related to my lack of confidence of how to handle this in the research setting as she was only my third interview. I suspect, however, it was more about my trying to get through the interview schedule as my previous interview with Jenny had been very long and rambling.

### 5.2.6 Chas

Chas, born in 1957, had returned permanently, as planned, from Africa with his wife, Greta, and three teenage children after serving for 15 years. He had re-entered four times during that time. He had been an administrator for the mission working as a language program facilitator. His cultural background was given as white/Scottish and his religious affiliation was Baptist. He had returned to work in the sending organisation's Australian headquarters and lived in a home with his family at this complex. He needed to establish links with a new faith community as he was not living in his home town. Information was not collected during the interview about the location of his extended family. He gave his plans for the next 12 months as *Other: Home assignment with a brief visit to host country every two years, but eventually return to host country when our children have finished school and are settled in Australia*. The interview was conducted by phone, nine months after his actual return, as Chas lived interstate. We established good rapport although he was hesitant about expressing his feelings and needed encouragement to do so. The tape was interrupted at one stage because the dog was scratching on the door; however, this did not result in any loss of data. Chas had returned permanently from the field with his wife and children for his children's education. Like Neil, he had ambivalent feelings about this. He had immediately transferred to the headquarters of his sending organisation where he lived with his wife and three children and had only been briefly able to visit relatives and friends in his home town. I felt very sorry for him as I listened to his story of leaving the best part of his life behind to return for the sake of his children, although he described his own limitations about expressing his feelings. My role as a

researcher and carer was not blurred and I was able to listen to him empathically. He was married to Greta who was interviewed separately.

### 5.2.7 Greta

Greta, born in 1960, had been involved in mission administration and home schooling. She had returned permanently, as planned, from Africa with her husband, Chas, and three children for the children's education after 15 years of service. She had re-entered four times during that time. She described her cultural background as Mexican/Australian and her religious affiliation as evangelical Christian. She had returned to work in the sending organisation's Australian headquarters and lived in a home with her family at this complex. She was unable to continue her anticipated job in Australia due to conflict with another worker. She needed to establish links with a new faith community as she was not living in her home town, although her original sending faith community was very supportive. Information was not collected during the interview about the location of her extended family. She gave her plans for the next 12 months as *Other: work with our mission in Australia till the kids finish school*. She was interviewed by phone, nine months after her actual return, as she lived interstate. The interview was relaxed and we developed good rapport, although at one point she became very distressed and broke down. I felt concerned about her level of distress and suggested we cease the interview; however, she insisted on continuing. I used silences, giving her space to recover, and she was able to complete the interview. Once again, my role as researcher and carer was blurred as loss and grief were explored. She had returned to work in the mission's home base but a breakdown in the relationship with her immediate superior resulted in the loss of her expected role with

the organisation in Australia. Greta was very articulate and was able to describe her thoughts and feelings in great detail. Although this was a challenging interview because of Greta's significant distress, it gave a very rich picture of the difficulties during re-entry. Interestingly, she emailed me when I sent her the transcript and said: "I think the only comment I can make is that I'm out of the tunnel; and that talking to you helped me identify a lot of the problems."

#### 5.2.8 Sam

Sam, born in 1976, had returned permanently with his wife, Trudy, as planned, from living in an Asian city for two years after holding an administrative position at a school for children of aid workers. He had had no other re-entries. He described his cultural background as Australian and his religious affiliation as Christian. He returned to the workforce in Australia. He lived in the same area and rejoined his supporting faith community in a large Australian city. Extended family also lived nearby. He gave his plans for the next 12 months as *Other: no current plans to return overseas but remaining open to the possibility*. He was interviewed by phone, as he lived interstate, six months after his actual return. The interview was easy to conduct and he tried to give thoughtful and accurate answers. Unfortunately, we were interrupted at one point by the dog scratching on the door and barking but this did not result in any loss of data. He was married to Trudy and during re-entry they had experienced the concurrent loss of their pregnancy at 15 weeks due to a severe foetal abnormality. However, he did not become distressed during the interview and in fact displayed very little emotion although, eventually, he admitted to a deep sense of sadness. There was no blurring of my role of carer and researcher as he told his story.

### 5.2.9 Trudy

Trudy, born in 1976, returned as planned from an Asian city after two years as a teacher at a school for aid workers' children. She returned with her husband to their home city in Australia. She had had no other re-entries. She described her cultural background as Australian/Dutch and her religious affiliation as Christian. However, her re-entry was complicated by the concurrent loss of her pregnancy at 15 weeks due to a severe foetal abnormality. She and her husband, Sam, decided to terminate the pregnancy after medical advice. After this, she returned to part-time work with the sending organisation in Australia. She returned to live in the same area and rejoined her supporting faith community in a large Australian city. Extended family also lived nearby. She gave her plans for the next 12 months as *Other: settle in Australia, at least for a while*. She was interviewed by phone, six months after her actual re-entry, as she lived interstate. While the interview was easy to conduct as she was easy to talk with and keen to answer the questions comprehensively, during the process she became very distressed and I offered to cease the interview. Once again, my role of researcher and carer was blurred. Nevertheless, she wished to continue the interview and found the process helpful as she indicated in a note sent after the interview. I was again challenged in my role as a researcher, especially in relation to the ethical principal of beneficence.

### 5.2.10 *Felicity*

Felicity, born in 1946, had returned to Australia with her husband, as planned, after service in an Asian city as a teacher. She had left her first Asian host country after a terrorist attack and had transferred to the second country via Australia. After serving in the second host country, she had returned to Australia permanently. During her three years of service she had re-entered four times, with two of these re-entries being unplanned evacuations due to security issues. She had two adult children living in Australia and returned to the same Australian city, faith community and friendship group. Her faith community was not functioning very well as there had been a leadership problem. She described her cultural background as Australian and her religious affiliation as Anglican. She gave her plans for the next 12 months as *Retire*. She was interviewed by phone, 11 months after her actual re-entry, as she lived interstate. Felicity was easy to interview and we developed good rapport. There were minor difficulties such as background noise and I failed to restart the duplicate tape for side two, however the first tape was of good quality. This was a very rich interview as she was able to describe her thoughts and feelings comprehensively. Felicity had a concurrent loss during her re-entry with the breakup of her daughter's marriage on a background of domestic violence, so while she was dealing with her own re-entry stress she was also required to deal with her daughter's loss and grief. This was the point at which she had a psycho/social/spiritual crisis which resulted in the need for counselling. During the interview, she said that she had also been diagnosed with PTSD; however, she had ceased active treatment and felt she had recovered. She was always in control of her thoughts and emotions during the interview and appeared to take the opportunity to review her re-entry story. She wrote

to me afterwards and said: “I was encouraged to ... realise how much recovery I have experienced over the last 2–3 months.”

### 5.2.11 *Carrie*

Carrie, born in 1967, had returned on a planned furlough from a very stressful situation as a nurse/evangelist in an African village for the previous three years. She was single and spent the first three months of leave having a complete break in her home town. She was supported by her family and the mission organisation. She returned to her supporting faith community. She described her cultural background as Australian and her religious affiliation as Protestant. She had previously re-entered once. She described her plans for the next 12 months as: *Home assignment then return to the overseas mission field*. She was interviewed by phone, ten months after her re-entry, as she lived interstate. We developed good rapport and she was easy to interview and keen to talk. The interview tape was not complete as I failed to start the tape recorder correctly and about half the tape of the interview was lost. However, I had made comprehensive notes of her interview as well. She had a concurrent loss as she had recommenced a relationship which may have led to marriage; however, this did not eventuate. She also had significant issues with her local church and society as a whole. Her family, however were very supportive and caring and she was very capable in describing her thoughts and feelings giving very thoughtful analyses of her situations. I was always the listener and the roles of researcher and carer were never blurred.



### 5.2.12 Lily

Lily, born in 1966, returned as planned from two years in an Asian country where she had been involved in language study, cultural training and evangelism. Although she was similar in appearance to the host country inhabitants she did not identify with them culturally and had no language. She was an Australian citizen but her cultural background was Chinese and she described her religious affiliation as Christian. She was single and returned to her home city although this was not the city she had left from; however, her family were there. Her sending faith community was in the Australian city she had left from so she needed to find a new faith community on re-entry. She did not continue involvement with the sending agency after returning. She had had no previous re-entries. She described her plans for the next 12 months as: *Other: study counselling and seeking paid work.* Lily was interviewed by phone as she lived interstate, seven months after re-entry. This was a very difficult interview as she was very reticent at first about discussing her experience. Although she spoke reasonable English, at times she was a little hard to understand. She slowly became more confident and trusting, enabling disclosure, as the interview progressed. Her main issue on re-entry was the unresolved loss of a relationship with a co-worker on the field. The co-worker had been her best friend prior to their overseas work but while overseas another co-worker had formed a friendship with her best friend and Lily had had a psycho/social/spiritual crisis. She described this loss in terms of major trauma, which it was to her, and she was very angry about the organisation's lack of member care in this situation which made the interview more difficult to conduct as she expected me to side with her and condemn the other players. I did not enter into the role of carer or supporter, maintaining my researcher role. She had received

professional counselling. There was some technical difficulty with a noisy line and outside noise but a satisfactory recording was obtained.

### 5.2.13 Grant

Grant, born in 1973, returned for a planned furlough with his wife and child, having been on the field for six years in an Asian country. He was a teacher but also had some administrative and leadership roles. He returned to his home city and sending faith community. During furlough, he had participated in deputation. He described his cultural background as Australian and his religious affiliation as Christian. He had had two previous re-entries and described his plans for the next 12 months as: *Home Assignment and then return to overseas mission field*. Grant was interviewed by phone three months after his actual return. The interview flowed well and Grant tried very hard to give thoughtful, accurate answers. There were some technical difficulties; however, these problems did not interfere with the quality of the data. This was the first interview where the spiritual issues were extensively explored, possibly because his losses involved his core spiritual support network – the local faith community. He had seen a counsellor. Grant described his distress very vividly and was very open about his psycho/social/spiritual crisis. The role of carer and researcher was not blurred, although he did suggest, with tongue in cheek, that I consider a career in listening to distressed missionaries.

#### 5.2.14 *Bernie*

Bernie, born in 1956, had returned earlier than expected from his administrative role in an African country with his wife and four children as a result of his own health problems and the educational needs of one of his children. Bernie described a loss of closure with a close African colleague who had disappeared in the internal conflict in the country. He described his cultural background as Australian and his religious affiliation as Baptist. He had had three previous re-entries. He described his plans for the next 12 months as uncertain. The interview by phone seven months after re-entry was easy to conduct and there were no technical difficulties. Bernie was thoughtful and honest in his answers and was also able to reflect on his experiences. He showed great courage describing his anticipation of death after his heart problems were diagnosed. He also had a concurrent loss, the death of a relative, and he returned to a faith community that was not functioning well. He was invited to be part of the faith community's leadership team, which enabled him to assist the community. He expressed his satisfaction in being able to do this.

#### 5.2.15 *Helen*

Helen, born in 1968, returned permanently as planned after 5 years working as a doctor in an Asian country with her husband and four children. She returned to her home city and her own home and extended family. Her sending faith community was in another city; however, she visited them on returning. She described her cultural background as Australian and her religious affiliation as Christian. She had had three previous re-entries. She described her plans in the next 12 months as: *Resign*. This

interview was conducted by phone from our respective homes as Helen lived interstate, four months after re-entry. Helen was medically qualified, easy to interview, very frank with her answers and did not try to control the process. She did give very detailed answers which made me feel pressured regarding the time taken for the interview, especially as I could hear the children in the background and at one stage her son disconnected the phone and she was interrupted to attend to the family's needs. She was, however, very keen to persevere and completed the interview.

These summaries have set in context each participant's re-entry and described my interaction with the participants during the interviews. Although some of the participants became distressed during the interview and the role of researcher and carer was blurred, I was able to respond appropriately as a result of my clinical experience over many years.

### 5.3 Quantitative Results for All Participants from Loss Review (Section A) and Grief Measure (Section B) of RGDI

The 15 participants described above all completed the survey and the semi-structured interviews which enabled descriptive statistical analysis of the quantitative results (sections 4.5.1 and 4.5.2). The results are given in Appendix 16 and the following section summarises the analysis of the quantitative results for all participants.

All 15 participants in this study experienced multiple losses, grief and disenfranchised grief during their re-entry adjustment. Losses were found in all loss categories for the loss review (section A) of the RGDI except for *personal integrity* and *adopt/foster*. Losses were found in all loss categories for the interview, except for

*adopt/foster*. All participants suffered loss in three or more loss categories for the loss review (section A) of the RGDI and four or more loss categories for the interview (Appendix 16, Table 16.1). The interview detected more losses than the survey, in line with the previous literature (Clark, 2003) and this result adds to the evidence for the disenfranchisement of the participants' grief (section 4.4.2) which is discussed below. All participants suffered from grief (mild, moderate or severe) which was measured as part of the grief measure (section B) of the RGDI (Appendix 14).<sup>g</sup>

All participants suffered from disenfranchised grief with all five categories of community disenfranchised grief and self- initiated disenfranchised grief (section 2.5.4) being represented. These quantitative results are described in detail in Appendix 14 and Appendix 16.

#### 5.4 Limitations of the Quantitative Data

Limitations of this survey include the small sample size and purposive selection of the participants which limits the generalisability of the study. Only descriptive statistics were able to be used in the analysis of the RGDI and DASS 21 due to the small sample size. Although the loss assessment of the RGDI (section A) was found to have validity for this sample (Appendix 16), further testing is necessary to check construct validity and reliability in larger, more diverse samples of re-entrants. Quantitative measures of loss, grief and depression, anxiety and stress for fragile participants may have been lowered by previous therapy as three of the fragile participants had had

---

<sup>g</sup> There was a change in one of the additions for the items of a grief score for the article due to an inaccurate addition (Appendix 14) which resulted in the score for one participant being altered from the mild range to the moderate range in the final results presented in this thesis. Grief scores in the article were also described as minimal, mild, moderate and severe from an earlier scoring version of the GDI (Clark, 2003), however, the minimal category is part of the mild category in this thesis.

counselling prior to completing their surveys which may have decreased their scores (Gibbard & Hanley, 2008).

## 5.5 Conclusion

In this chapter, I have described the stories of the participants in the context of their re-entry to Australia and my interaction with them as a researcher with boundaries which were sometimes blurred. This section has shown how the context of their re-entry is linked with their responses in the interviews which are described in the articles reporting the qualitative results in Chapter 6. I have also outlined the quantitative results for all participants and shown that they all experienced multiple losses, grief and disenfranchised grief. The following chapter will describe the qualitative results which will give an in-depth view of the participants' lived experiences.

---

## CHAPTER 6: THE QUALITATIVE RESULTS IN THREE ARTICLES

### 6.1 Introduction

In this chapter, I present the qualitative results as three published articles and describe the supporting evidence for these results from the quantitative results. I show how the three types of qualitative analysis – framework analysis, typology analysis and modified consensual qualitative research – and the quantitative analysis of the DASS 21 assessment answer the first research question: *What is the nature of the psychological distress of adult Australian cross-cultural missionary workers who are re-entering Australia?* and its subsidiary research questions (Figure 2, section 3.2).

In section 6.2, I answer the first subsidiary research question: *What issues of loss and grief for adult Australian cross-cultural missionary workers can be identified as they experience re-entry adjustment?* and present the results for the framework analysis in the first article. In sections 6.3 and 6.4, I answer the second subsidiary research question: *What responses and characteristics of these workers are relevant for their re-entry adjustment?* I answer the further subsidiary questions: *What are the differences in the responses of the participants to re-entry and is there a pattern? How did these patterns emerge?* and *What is the nature of the participants' characteristics?* by presenting the results from the typology analysis and the modified consensual qualitative research in the second and third articles.

In section 6.5, I summarise the supporting evidence for the qualitative findings from the quantitative findings. In section 6.6, I summarise the results.

## 6.2 Back Home: A Qualitative Study Exploring Re-entering Cross-cultural Missionary Aid Workers' Loss and Grief

The first article, *Back home: A qualitative study exploring re-entering cross-cultural missionary aid workers' loss and grief* (Selby, Moulding et al., 2009), describes the results of the framework analysis of the 15 semi-structured interviews which answers the research question *What issues of loss and grief for long-term adult Australian cross-cultural workers serving as missionaries can be identified as they re-enter?* (section 3.2). These results show that all participants experienced re-entry loss with multiple varied losses in personal, social and spiritual domains; mechanisms of loss which exacerbated distress – vicious loss cycles and concurrent losses; and perceived loss of control. All participants also experienced re-entry grief with common grief phenomena being a sense of loss, isolation and anger; community and self-disenfranchised grief and reactivation of past grief. The article also describes a new type of self-disenfranchised grief – *self-absorbed disenfranchised grief*.



OMEGA, Vol. 59(1) 19-38, 2009

**BACK HOME: A QUALITATIVE STUDY EXPLORING  
RE-ENTERING CROSS-CULTURAL MISSIONARY AID  
WORKERS' LOSS AND GRIEF\***

**SUSAN SELBY**

*The University of Adelaide*

**NICOLE MOULDING**

*The University of South Australia*

**SHEILA CLARK**

*The University of Adelaide*

**ALISON JONES**

*Royal Australasian College of Physicians*

**ANNETTE BRAUNACK-MAYER**

**JUSTIN BEILBY**

*The University of Adelaide*

Selby, S., Moulding, N., Clark, S., Jones, A., Braunack-Mayer, A. and Beilby, J.  
(2009) Back Home: A qualitative study exploring re-entering cross-cultural  
missionary aid workers' loss and grief.  
*Omega: Journal of Death and Dying*, v. 59 (1), pp. 19-38, 2009

NOTE: This publication is included in the print copy of the thesis  
held in the University of Adelaide Library.

It is also available online to authorised users at:

<http://dx.doi.org/10.2190/OM.59.1.b>

This first article has answered the research question: What issues of loss and grief for long-term adult Australian cross-cultural workers serving as missionaries can be identified as they re-enter? (section 3.2). These results show that all participants experienced multiple losses and grief in line with the findings in the quantitative data (section 5.4, Appendix 14, 16). All experienced multiple varied losses involving vicious loss cycles, concurrent losses, and loss of control. It is suggested that the nature of these losses may also be part of a sub-type of non-finite loss (Bruce & Schultz, 2001) found in re-entry. All participants experienced grief expressed most frequently as a sense of loss, isolation and anger, with participants describing community and self-disenfranchisement of this grief and reactivation of past grief. New findings included description of the vicious loss cycles and the identification of a new type of self-disenfranchised grief: self-absorbed disenfranchised grief. These findings are important as multiple losses, loss of control, disenfranchised grief and incomplete grief are risk factors for complications of grief and poor health outcomes (Boelen & Prigerson, 2007; Bruce & Schultz 2001; Rando, 1993).

### 6.3 Resilience in Re-entering Missionaries: Why Do Some Do Well?

The second article, *Resilience in re-entering missionaries: Why do some do well?* (Selby, Braunack-Mayer et al., 2009), describes the results of the typology analysis and the modified consensual qualitative research analysis of the 15 semi-structured interviews as well as the descriptive statistics for the DASS 21 assessment. These analyses answer the research question: *What characteristics of these workers are relevant for their re-entry adjustment?* (section 3.2). The typology analysis and the descriptive statistical analysis answer the research question: *What are the categories*

*of participants identified from the data?* The modified Consensual Qualitative Research analysis answers the research question: *How did this happen or what made the resilient group so?* The results from the typology analysis show that two categories of participants emerged. The results from the descriptive statistics of the DASS 21 complemented the qualitative typology analysis and showed a relationship between good mental health and resilience. The results of the modified CQR analysis demonstrated the characteristics of the two categories of participants which emerged from the data in the three domains affecting resilience in this study: the psychological, the social and the spiritual.

Selby, S., Braunack-Mayer, A., Moulding, N., Jones, A., Clark, S. and Beilby, J.  
(2009) Resilience in re-entering missionaries: why do some do well?  
*Mental Health, Religion and Culture*, v. 12 (7), pp. 701-720, November 2009

NOTE: This publication is included in the print copy of the thesis  
held in the University of Adelaide Library.

It is also available online to authorised users at:

<http://dx.doi.org/10.1080/13674670903131868>

Copyright of *Mental Health, Religion & Culture* is the property of Routledge and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.

This second article has answered the research question: *What characteristics of these workers are relevant for their re-entry adjustment?* (section 3.2). The typology analysis and the descriptive statistical analysis answered the research question: *What are the categories of participants identified from the data?* These analyses have shown that two categories of participants emerged from the data: the resilient with good mental health and the fragile with poorer mental health. The modified Consensual Qualitative Research analysis answered the research question: *How did this happen or what made the resilient group so?* This analysis has shown that characteristics of the participants in three domains are important in determining resilience. The characteristics in the psychological domain are: *used flexibility in response to re-entry distress; described high expectancy with a sense of purpose or achievement; used self-determination or reinvention of self with internal locus of control to manage re-entry distress; used denial with minimisation as a method of dealing with re-entry distress; and enjoyed good mental health as described by their lack of psychosocial and /or spiritual crises.* The characteristics in the social domain are: *provided with social support from two or more groups and described positive reintegration.* The characteristic in the spiritual domain is: *described a positive sense of connection to God.*

New findings were the emergence of the two categories for long term re-entering adult missionaries: the resilient and the fragile with certain characteristics such as *denial with minimisation and personal spiritual connection* not previously described in the literature for the resilient group. These findings are important as assessment of re-entering missionaries to detect if they are resilient or fragile may be appropriate to prevent and manage morbidity. The results may also be used to implement programs which include spiritual and social content to develop resilience

during re-entry. Finally, these results show that good mental health is important during re-entry and appropriate assessment and management of mental health issues during this adjustment may prevent further psychological distress.

#### 6.4 Special People? An Exploratory Study into Re-entering Missionaries' Identity and Resilience

The third article, *Special People? An exploratory study into re-entering missionaries' identity and resilience*, describes the results of the modified CQR analysis from the 15 semi-structured interviews. This analysis also answers the subsidiary research question: *What is the nature of the participants' characteristics?* Further research questions emerged from the data and the literature in response to the subsidiary research question 1(ii)c (Figure 2, section 3.2). These questions were: *What are the nature and frequency of identity gaps in the resilient and fragile groups of re-entering participants?* and *What are the links between their described depersonalisation/dehumanisation, identity gaps and resilience?* The results of this analysis show that two types of identity disparity emerged from the data for participants: personal/relational identity gaps and depersonalisation/dehumanisation. Resilient participants were shown to experience fewer identity disparities and less depersonalisation than fragile participants.



Selby, S., Braunack-Mayer, A., Jones, A., Clark, S. Moulding, N. and Beilby, J.  
(2010) Special people? An exploratory study into re-entering missionaries; identity  
and resilience.

*Journal of Religion and Health*, v. 50 (4), pp. 1007-1023, December 2011

NOTE: This publication is included in the print copy of the thesis  
held in the University of Adelaide Library.

It is also available online to authorised users at:

<http://dx.doi.org/10.1007/s10943-010-9337-8>

This third article has answered the research question: *What characteristics of these workers are relevant for their re-entry adjustment?* (Figure 2, section 3.2). The modified CQR analysis answered the further research question: *What are the nature and frequency of identity gaps in the resilient and fragile groups of re-entering participants?* The results have shown that three types of personal/relational identity gaps emerged from the data: *personal/family and friendship community*, *personal/faith community* and *personal/sending organisation community*. Resilient participants described fewer identity gaps in all categories than fragile participants. The modified CQR analysis also answered the last research question: *What are the links between their described depersonalisation/dehumanisation, identity gaps and resilience?* The results have shown that two types of *depersonalisation/dehumanisation* emerged from the data: as inert objects and automata. Resilient participants described less *depersonalisation/dehumanisation* than fragile participants.

New findings were the identification of personal/relational identity gaps in re-entering adult missionaries and the relationship of identity disparities to resilience during re-entry. These findings are important because identity disparities have been shown to be linked to poorer mental health in this group and to depression in the literature, so there needs to be assessment of these disparities to enable the clinician to undertake appropriate management. There has been no identifiable literature linking resilience and identity disparities for other groups in the literature.

## 6.5 Supporting Evidence for the Qualitative Data from the Quantitative Data

The quantitative results have confirmed the qualitative findings describing the two groups of participants: the fragile and the resilient. The resilient group has been shown to have lower loss category scores, lower grief scores and lower mean scores for depression, anxiety and stress than the fragile group. A detailed description is found in Appendix 17.

## 6.6 Conclusion

This chapter has drawn together three papers to describe the qualitative results of this study which have been supported by the quantitative results. The results which have been presented have answered the first research question: *What is the nature of the psychological distress of adult Australian cross-cultural missionary workers who are re-entering Australia?* and the subsidiary research questions (Figure 2, section 3.2)

The qualitative results have shown that adult Australian cross-cultural missionary workers re-entering Australia experienced re-entry losses including multiple varied losses with mechanisms of vicious loss cycles and concurrent losses, and loss of control. These losses resulted in re-entry grief with common grief phenomena, disenfranchised grief and reactivation of past grief. Further analysis of the data, identified two categories of participants: the fragile, with poorer mental health and the resilient, with better mental health. Characteristics of the fragile and resilient participants were identified in the psychological, social and spiritual domains and links with identity disparities were determined. The quantitative results for resilient and fragile participants confirmed these findings.

New findings from this study include description of the vicious loss cycles and the identification of a new type of self-disenfranchised grief: *self-absorbed disenfranchised grief*; the emergence of two categories for long term re-entering adult missionaries: the resilient and the fragile with certain characteristics not previously described in the literature for this group; the identification of personal /relational identity gaps in re-entering adult missionaries and the relationship of identity disparities to resilience. This is also the first identifiable study which has linked grief scores with mental health indices, particularly for depression, in this sample.

These findings have enabled the nature of psychological distress for re-entering adult missionaries to be clarified and demonstrated the importance of loss and grief issues during re-entry. The following chapter will explore the construction of a theoretical framework to manage this distress in the clinical setting.

## CHAPTER 7: THE STUDY FINDINGS: A NEW APPLICATION FOR THE DUAL PROCESS MODEL

### 7.1 Introduction

In this chapter, I answer the second research question: “What evidence-based theoretical framework will facilitate management of cross-cultural workers’ psychological distress in the general practice setting?” I present the results of the further literature review which identified a suitable theoretical model which could be applied to form a framework for addressing psychological distress during re-entry. I also present the application of the results of this study to this new application for the model in an article which has been accepted for publication in *Omega*, the *Journal of Death and Dying*: Cross-cultural re-entry for missionaries: A new application for the Dual Process Model.

### 7.2 Cross-cultural Re-entry for Missionaries: A New Application for the Dual Process Model

This article reviews the current literature about models to address psychological distress in the loss and grief paradigm and positions the findings of my research in a theoretical framework. The Dual Process Model (DPM) was identified as a useful framework for addressing loss and grief. With reference to the findings of this study, all the parameters of the DPM have been shown to be appropriate for the proposed re-entry model, the Dual Process Model applied to Re-entry (DPMR). Possible clinical

applications are also discussed. I also discuss the application of this model in the Australian general practice setting.

**Cross-cultural re-entry for missionaries: A new application for the Dual Process Model**

Susan Selby

The University of Adelaide

Sheila Clark

The University of Adelaide

Annette Braunack-Mayer

The University of Adelaide

Alison Jones

The University of Adelaide

Nicole Moulding

The University of South Australia

Justin Beilby

The University of Adelaide

Selby, S., Clark, S., Braunack-Mayer, A., Jones, A., Moulding, N., and Beilby, J.  
(2010/11) Cross-cultural re-entry for missionaries: a new application for the Dual  
Process Model.  
*Omega: Journal of Death and Dying*, v. 62 (4), pp. 329-351, 2010/11

NOTE: This publication is included in the print copy of the thesis  
held in the University of Adelaide Library.

It is also available online to authorised users at:

<http://dx.doi.org/10.2190/OM.62.4.b>



### 7.3 Application of the Dual Process Model Applied to Re-entry in the Australian General Practice Setting

In line with the Quality Framework for Australian General Practice (Booth et al., 2005) discussed in Chapter 2, section 2.6.2, the DPMR may be useful in addressing psychological distress in re-entering adult missionaries at the *Consultation, Setting of care, Regional and National* levels (Table 8).

At the *Consultation* level, the DPMR may provide the basis for a patient-centred approach which has resulted from evidenced base research. This approach recognises the importance of re-entry loss and grief and its various presentations. It will include serial assessments of distressed re-entrants in order to detect concurrent losses, vicious loss cycles and disenfranchised grief which may increase distress and lead to the complications of grief. The DPMR may be used to develop clinical guidelines for management of psychological distress in re-entering missionaries and aid workers which will aid GPs in decision making. The identified facilitators and barriers will promote open disclosure and also facilitate the development of guidelines. Further development of the DPMR may enable its use in the development of individual training programs for general practitioners in the management of psychological distress during re-entry using Cognitive Behavioural Therapy(CBT) or Narrative Therapy. Such groups may increase capacity and promote reflective learning. As the re-entrant discusses losses, financial needs may be addressed including the barriers to adequate re-entry care.

At the *Setting of care* level the DPMR, together with other tools such as the RGDI (Appendix 5B) and the DASS 21 (Appendix 5C), will enable clinical decisions to be made by the GP with appropriate referrals. The GP may need to act as an

advocate for the missionary with their sending organisation or faith community. As the DPMR is developed and used more widely in other clinical settings such as psychology, it may aid in the development of other clinical decision tools such as an assessment for prolonged grief disorder due to non-death loss such as re-entry. The practice will be able to monitor the capacity to accept new patients who are seeking management of re-entry distress, particularly if a number are returning for serial assessment and management.

At the *Regional level*, the DPMR may be useful in the interdisciplinary setting involving other health professionals, particularly psychologists, grief therapists and spiritual advisors. The DPMR may be useful as an educational tool to explain re-entry distress to sending organisations, faith communities and family and friends. Peer mentoring of those employing the model may also facilitate capacity which in turn may enable the development of regional training programs in partnership with universities, the Royal Australian College of General Practitioners and other professional bodies. Further research with different re-entering groups may enable the DPMR to be used with other aid workers, returning military personnel and also those in the corporate sector, students and third culture kids.

At the *National level*, the DPMR may address health inequalities for re-entering missionaries and aid workers, promote further research and clinical guideline development for this group, enable training of GPs in the recognition and management of psychological distress in this group, enable capacity building and reduce the morbidity of this group and subsequent health costs to the nation. National curriculums addressing psychological distress in re-entrants may become part of GP training programs with national standards of care for re-entrants.

In summary, this research, and especially the development of the DPMR, will enable improved care for re-entering missionaries and aid workers. It promotes a patient-centred approach, knowledge and information management, competence for the GP, the development of capacity in the management of psychologically distressed re-entering missionaries with benefits also in the areas of professionalism and financing at all levels of the Quality Framework for Australian General Practice (Table 8).

#### 7.4 Conclusion

In this chapter, I have answered the second research question: “What evidence-based theoretical framework will facilitate the management of cross-cultural workers’ psychological distress in the general practice setting?” The results of this study have enabled the development of a new theoretical framework to manage psychological stress during re-entry adjustment: The Dual Process Model applied to Re-entry. I have discussed the possible uses of this model in the Australian general practice setting.

The final chapter will give a broad satellite view of the journey the reader and I have taken through this thesis and I will suggest areas for further research.

Table 8. *Suggested Mapping for the Care of Psychologically Distressed Re-entrants as Part of the Quality Framework for Australian General Practice (modified from Booth et al., 2005)*

NOTE:

This table is included on page 232 of the print copy of the thesis held in the University of Adelaide Library.

## CHAPTER 8: THE JOURNEY, THE FINDINGS AND THE FUTURE

### 8.1 Introduction

This thesis set out to explore the psychological distress of re-entering Australian cross-cultural missionary workers such as Phil (section 1.1) and to facilitate their management in the general practice setting by the design of an evidence-based theoretical framework. In answering and generating the research questions, this thesis has addressed the psychological distress for re-entering adult Australian cross-cultural missionaries associated with loss, grief, and poor mental health, and explored the links with resilience and identity disparities. The findings of this thesis have enabled a suitable model to be applied as an evidence-based theoretical framework to facilitate the management of this distress in the general practice setting. The results of this study have confirmed that the loss and grief paradigm has been central to the understanding of psychological distress during re-entry. These results support Kellehear's assertion: "But above all, suffering appears to be characteristically about grief and loss." (2009, p. 389).

Although I started this research with an emphasis on the loss and grief paradigm, as I reviewed the participants' re-entry experiences, it became clear that to fully address psychological distress on re-entry, I also needed to listen to the participants' stories about their resilience in dealing with re-entry to further inform the nature of their experiences of psychological distress. As I explored these aspects of re-entry, I found that the old models addressing psychological distress during re-entry did not adequately deal with the resulting dilemmas in the re-entry process found in this study. A new model was needed. The Dual Process Model applied to Re-entry has

been developed from the evidence in this study and the literature and is proposed as a suitable framework for clinical practice.

This thesis has dealt with three areas which need to be addressed in the answering the research questions proposed in Chapter 1: the loss and grief paradigm for re-entry; the role of resilience in re-entry; and the proposed theoretical framework for re-entry which has resulted from the findings of this thesis.

## 8.2 The Loss and Grief Paradigm for Re-entry

This thesis has demonstrated the importance of loss and grief issues during re-entry adjustment and their links to the psychological distress of re-entrants. My findings are important because they demonstrate the importance of recognising the nature of the participant's loss and grief to enable improved management of these workers by clinicians. All participants experienced loss and grief, including disenfranchised grief, during re-entry. Re-entry losses were multiple varied losses in personal, social and spiritual domains with loss mechanisms involving vicious loss cycles and concurrent losses and a significant perception of loss of control. Re-entry grief was most commonly expressed as *sense of loss*, *isolation*, and *anger* while re-entry also triggered reactivation of past grief which may be *maturational* or *complicated*. Community disenfranchised grief was experienced by all participants. The five types of community disenfranchised grief, defined by Doka (Glossary) and applied to re-entry, were all described by the participants: no acknowledgement of loss of host country relationships and changed home country relationships; no acknowledgement of the social significance of re-entry losses for participants; no acknowledgement of the participants as being capable of grief due to their depersonalisation; no

acknowledgement that the process of re-entry involves loss; and no support from the communities for the participants' expression of grief. Self-initiated disenfranchised grief (Glossary) was also described with participants denying their re-entry grief themselves.

A new type of self-initiated disenfranchised grief was described: *self-absorbed disenfranchised grief* in which the participant recognises their disenfranchisement by the community and absorbs the grief themselves, taking responsibility and blame for the disenfranchisement. This study is the first identifiable study which has measured loss categories, grief scores and depression, anxiety and stress scores for re-entrants who have returned after long term service overseas.

The importance of these findings for the re-entering missionary is in the association between their lived experience and risk factors for maladaptive grieving. Because of the known association between multiple losses, loss of control, disenfranchised grief, reactivation of past grief and the complications of grief, these findings demonstrate the re-entrant is at risk from the complications of grief such as depression, anxiety and prolonged grief disorder. Disenfranchised grief may also be associated with complicated mourning and poor health outcomes and result in anger which was a common grief phenomenon in this study. Frequent, intense and enduring anger is associated with impairment in a person's physical, emotional, social and behavioural domains (Tafrate, Kassinove, & Dundin, 2002). Reactivation of past grief is also a risk factor for developing prolonged grief disorder. The importance of these findings for re-entering missionaries is also in the area of individual and community education about the nature of re-entry loss and grief which may enable *liberation* or permission to grieve and lessen the incidence of self-initiated disenfranchised grief.

These findings are important for the clinician, particularly the Australian GP. Re-entrants who are missionaries or aid workers may present with symptoms of loss and grief which are undifferentiated and somatic; mental health issues and/or substance abuse resulting from the complications of grief including depression, anxiety and prolonged grief disorder; or poor health outcomes associated with anger, perceived loss of control and prolonged grief disorder. The clinician has an important role in the recognition of the complexity of the re-entrant's presentation, the need to permit expression of their grief with appropriate education, and appropriate management and referral. This may not only involve other health professionals such as psychologists and grief therapists, but also spiritual advisors.

The importance of these findings for the communities interacting with the re-entering missionaries which include family/friends, faith communities and sending organisations is the need for education of these groups so that community disenfranchised grief is recognised and the re-entering missionary's grief is enfranchised.

### 8.3 The Role of Resilience in Re-entry

This thesis has demonstrated the importance of resilience during re-entry adjustment. It has shown the links between psychological, social and spiritual constructs of resilience and psychological distress in participants during re-entry adjustment. It has also shown links between identity disparities and resilience. Although all of the participants in this study experienced loss, grief and disenfranchised grief during their re-entry adjustment, just under half of the participants were identified by the typology analysis as experiencing psychological distress and these were the fragile participants



who were less resilient. These fragile participants described psychological constructs with less use of flexibility, less expectancy and sense of purpose, less self-determination with an external locus of control, less use of denial with minimisation and poorer mental health; social constructs with social support from only one or no community group and less positive reintegration; and the spiritual construct of decreased or fluctuating personal connection to God. The role of denial with minimisation in promoting resilience in this group is a new finding. Although the other characteristics of resilience have not been specifically identified for this sample, they have been identified as promoting resilience in other groups. The fragile participants also described personal/relational identity gaps with their family and friendship community, faith community and sending organisation community and depersonalisation/dehumanisation more often than resilient participants.

The relationship between resilience and identity disparities is a new finding as there is no identifiable literature about this phenomenon. My finding about the importance of the association between identity gaps, depersonalisation and resilience is also important as it will enable these issues to be recognised and addressed at every level of care by the clinician, sending organisation, faith and family/friendship communities.

The importance of these findings for the re-entering missionary is in the area of self-care with education around the importance and development of good mental health, social and spiritual support. Education about identity and identity disparities may also enable the re-entrant to self-determine their own identities and recognise depersonalisation.

These findings emphasise for the clinician, once again, the importance of attending to mental health. For the re-entering missionary presenting with depression,

the role of identity gaps needs to be explored. These findings may also point to the advantages of therapies which restore a sense of coherence (Antonovsky, 1996) such as the narrative approach (Barbulescu et al., 2008).

For the participants' communities these findings are important because they point to the need for communities to be educated about the significance of social support during re-entry, the role of social identity and the dangers of fostering a pedestal effect. Faith communities need to be alerted that re-entering missionary's personal spiritual connection to God cannot be assumed. Permission needs to be given to explore this with a trusted spiritual advisor or spiritual director (Palmer, 1999). Sending organisations may need to review their care of re-entrants to enable detection of barriers to resilience, with serial assessments during their 12 month re-entry adjustment in the psychological, social and spiritual domains.

#### 8.4 A New Theoretical Framework for Re-entry: The Dual Process Model

##### Adapted for Re-entry (DPMR)

This thesis has demonstrated a new theoretical framework for re-entry: The Dual Process Model adapted for Re-entry (DPMR). This framework addresses the loss-orientation and restoration-orientation parameters of re-entry adjustment together with facilitators and barriers from this study which may identify those at risk of psychological distress.

For clinicians, this framework offers an evidence-based approach to the diagnosis and management of psychological distress in all domains which may flag those at risk of significant psychological morbidity. The DPMR may be used to assess the loss and restoration parameters for the re-entering missionary and identify those at

risk. It may be used to develop treatment programs for GPs and other clinicians to use, as part of Cognitive Behavioural Therapy (CBT), Narrative Therapy and in promoting the re-entering missionary's sense of coherence.

For the re-entering missionary's communities, the DPMR is a useful framework for explanation and action. It provides an opportunity for communities to understand the distress of the re-entering missionary, whilst emphasising the need to attend to some of the facilitators such as social support and barriers such as cognitive overload and disenfranchised grief. The DPMR may also be useful to develop psycho-educational tools which may be helpful in preparing the missionary and their communities for re-entry.

For the re-entering missionary, The DPMR offers an evidence based assessment and management tool which may be developed to lessen their psychological distress during re-entry and promote resilience as well as resources which will enhance their understanding of their distress and enable *liberation*.

## 8.5 Limitations of the Study

The limitations of this study are partly addressed in the articles. These include the limitation that the results are not generalizable due to the small number of participants who were all evangelical Protestant Australian adult missionaries returning to a western secular country, although Hansen (2006) noted that qualitative research results are rarely generalizable. The other limitations of qualitative research which are particularly applicable to this study are the lack of efficacy or the ability to study relationships between variables accurately to inform future management of re-entrants and the difficulty replicating the study with the same conditions (Sarantakos, 2005).

No questions were asked about the reasons why some participants chose not to review the transcripts. This means there was no opportunity to discover if possible reactivation of their loss and grief issues was a factor in their decision. Also, there was no follow-up to evaluate the reasons for non-responders so it was not possible to evaluate the impact of the reasons for this on the study. However, this impact may have been significant if they were particularly distressed and could not participate. There are other limitations of this study which have not been addressed in the articles. The questions in the interview schedule assume some distress, loss and grief as part of the re-entry experience; however, the research data should not be over-generalized to assume these are predominant factors for all re-entering missionaries. Lovell (1997) reported that 15% of participants in her study felt good or relieved about re-entry. The sample of 15 participants was self-selected after an invitation which discussed the exploration of re-entry loss and grief. Those who chose to volunteer may have been those who most readily identified with these concepts. There were four sets of couples within the sample so some overlap of themes and losses would have occurred. Although re-entry loss and grief issues were identified in this study, further exploration of their relationship to distress in other transitional life events such as relocation within the home country may be helpful in further defining the concepts. The categories of *fragile* and *resilient* were convenient labels for the participants and applied to a particular re-entry. The participants had not all had identical experiences in the same time frames which may have influenced their levels of distress and resilience. Some risk factors for distress associated with fragile participants' re-entry have been identified. These factors may need to be assessed on re-entry, although the sample surveyed is not large enough to answer the question of whether all re-entrants should be assessed. The study did not address in detail the participants' experience in

their host culture before re-entering and how much they wanted to return to Australia. These factors may have contributed to their distress, rather than the actual re-entry experience. Although the DPMR may be useful in treating loss and grief as a result of re-entry, a proportion of returned missionaries will need evidence-based treatment for mental health issues such as depression, anxiety, substance abuse, PTSD and other disorders. Further research is needed to define the place of the DPMR in the management of re-entry loss and grief.

## 8.6 Suggestions for Re-entrants' Communities from the Results of this Study

This study has enabled a number of suggestions to be made to improve missionary care during re-entry by the sending organisation, the faith community, and family and friends. The suggestions for clinicians have been discussed in section 7.3.

### *8.6.1 Suggestions for the sending organisation*

- Be informed about the incidence, risk factors and complications for psychological distress and the facilitators for resilience during re-entry
- Educate sending agency personnel and missionaries about re-entry distress in pre-field training, including disenfranchised grief and the importance of enfranchisement and the nature and complications of identity disparities. Particular attention needs to be paid to the recognition and management of identity gaps and the effects of depersonalisation of the missionary.
- Educate faith communities, family and friends about the nature of re-entry distress, including disenfranchised grief, and design pathways of care for those at risk or if there are concerns from other communities

- Give permission for re-entrants to express their distress in debriefings and then institute appropriate referrals
- Institute a multidisciplinary team approach which includes the missionary, faith community, and specialist services including spiritual advisors
- Understand the importance of social support for re-entrants, including support through technologies such as email, and provide support for the re-entrant for the first twelve months of re-entry adjustment and longer term as necessary

#### *8.6.2 Suggestions for the faith community*

- Be informed about the incidence, risk factors and complications for psychological distress and the facilitators for resilience during re-entry
- Institute member care training about re-entry distress for pastoral care personnel and those in church leadership, including training about disenfranchised grief and the importance of enfranchisement and the nature and complications of identity disparities
- Liaise with the sending organisation and other stakeholders such as the missionary, their friends and family: this may involve being an advocate for the missionary
- Provide social and spiritual support

#### *8.6.3 Suggestions for family and friends*

- Be informed about the incidence, risk factors and complications for psychological distress and the facilitators for resilience during re-entry

- Access pathways of care if concerned about the re-entering missionary
- Understand the importance of social support: this may include being an advocate for the missionary

## 8.7 Further Research

In many ways this thesis has asked more questions than it has answered. Further exploration of the frequency and types of loss and grief in larger, more diverse, samples of re-entrants is necessary with further data about their association with psychological distress including mental health indices and measures for PTSD. Investigation of distressed missionaries and aid workers to estimate the incidence of prolonged grief disorder and to explore the lived experience of those identified with this complication is vital to address the needs of those who are significantly impaired. Confirmation of the findings about resilience, including exploration of other identity gaps, in larger, more diverse, samples will be helpful in choosing and preparing missionaries and other overseas workers. Further development of the DPMR as a tool for assessment and management of psychological distress in returning missionaries and aid workers needs to be undertaken. Assessment of its potential for use with CBT and Narrative Therapy, validity, reliability and effectiveness in the clinical setting will be particularly useful. The research sample needs to be broadened from Western mission and aid workers to investigate psychological distress, particularly loss and grief, for those from non-western nations returning to their own culture. The application of the DPMR needs to be investigated in these settings.

## 8.8 Conclusion

It has been a privilege to share the journeys of this group of missionary aid workers who have re-entered Australia. Like the satellite picture of re-entry, from afar, it may appear to be a simple process of transition. In the closer focus of the lived experience of each of these participants, the complexities of their loss and grief, the characteristics of their resilience and the possibilities for enabling healing of their distress through the DPMR, the simple becomes multifaceted, affecting all domains of personhood and demanding a complex multidisciplinary approach which this thesis signposts.



## GLOSSARY: DEFINITIONS USED IN THIS THESIS

*Acculturation*

Refers to “cultural and psychological change brought about by contact with other peoples belonging to different cultures and exhibiting different behaviours” (Berry, Poortinga, Segall, & Dasen, 1992, p. 19).

*Aid worker*

A person who provides humanitarian assistance (Higney et al., 2004).

*Beneficence*

“The language of a *principle* or *rule* of beneficence refers to a normative statement of a moral obligation to act for the benefit of others, helping them to further their important and legitimate interests, often by preventing or removing possible harms.” (Beauchamp, 2008, January 2).

*Cross-cultural re-entrant or worker (may be shortened to re-entrant)*

A person “who leave their country of origin, move to a new host culture where they may be part of another subculture, and then return to their own culture again, sometimes multiple times.” (Selby et al., 2005, p. 864).

*Culture*

There are over 150 definitions for culture (Kroeber & Kluckhohn, 1963), however, I have chosen the definition by UNESCO (2002) as being most applicable to this thesis: “the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs”.

### *Deputation*

Refers to raising of prayer and financial support by missionaries by speaking at churches and other meetings before leaving for the field and during furloughs.

Adapted from (Liberty University, 2007).

### *Disenfranchised grief*

“The grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned or socially supported.” (Doka, 1989, p. 4).

There are two categories of disenfranchised grief: *societal* or *community* and *self* (Doka, 2002).

#### *Community or societal disenfranchised grief*

Doka (2002) defined the typology of community disenfranchised grief and described the five types:

- Lack of recognition of a relationship
- Lack of acknowledgement of the loss
- Exclusion of the griever
- The circumstances of the death
- The way individuals grieve.

#### *Self-disenfranchised grief*

This type of disenfranchised grief may be *self-initiated* or *self-absorbed*.

- Self-initiated disenfranchised grief

Kauffman (2002, p. 61) described this grief as “when one disallows the recognition of grief without any actual outside input”. He called this self-initiated disenfranchised grief and described self-disenfranchised grievers as those “who imagine that societal sanctions exist where they do not exist

in real social situations. Self-disenfranchisements are assumptions of disenfranchisement based on past experiences of disenfranchisement, relived as present disenfranchisement, or based on any psychological tendency to disallow and disavow one's own grief." (p. 62).

- Self-absorbed disenfranchised grief

This type of self-disenfranchised grief emerged from the data in this study and is described as the grief in which "the griever recognizes that they have been disenfranchised but then excuses the community of disenfranchisers, absorbing the grief themselves. The griever may blame themselves and take responsibility for the disenfranchisement." (Selby, Moulding et al., 2009, p. 30).

### *Ethnocentrism*

"The cross-cultural study of *differences* may lead to them being viewed as *deficiencies*: the evaluation of differences between groups (as in "us better – them worse") is known as *ethnocentrism*." (Berry et al., 1992, p. 8).

### *Ethnorelativism*

This is where the cross-cultural study of differences leads to the view that one's own culture is no longer a centre from which others should be judged. Other cultures are respected, compared, and contrasted within the framework of the cultures involved.

Adapted from Bennett (1993) and Berry (1992).

### *Expatriate*

Someone who does not live in their own country (Cambridge University Press, 2010).

*Expatriation*

The process of abandoning one's native land (Cambridge University Press, 2010).

*Field*

The location of the missionary's work.

*Furlough*

A period of rest and relaxation usually in the home country after a term of service as a missionary. Adapted from (Liberty University, 2007).

*General practice*

General practice is the provision of primary continuing comprehensive whole-patient medical care to individuals, families and their communities (RACGP, 2005).

*Grief*

Grief is the response affecting the physical, emotional, behavioural, cognitive, social and spiritual domains of the individual that occurs in response to:

- past, present and future losses;
- death related and non-death related losses;
- losses occurring directly to the individual;
- losses caused indirectly through experiencing grief in sympathy with the grief of others

Clark (2003) modified from Corr (1999)

*Grief phenomena*

Experiences characterising grief in the physical, emotional, social, behavioural, cognitive and spiritual domains Modified from Clark (2003) and Corr (1999).

*Home country*

The country of origin which the missionary leaves and returns to after working in the host country.

*Host country*

The country the missionary resides in to undertake their mission.

*Intercultural Sensitivity*

“An individual’s ability to develop a positive emotion towards understanding and appreciating of cultural differences that promotes an appropriate and effective behavior in intercultural communication” (Chen, 1997, p. 5).

*Loss*

“Loss is a perceived negative change by an individual due to the withdrawal of any valued person, object, commodity, state or opportunity from the life of the individual.” Clark (2003, p. 19) modified from Miller and Omarzu (1998).

The losses may be „physical“ or tangible and „psychosocial“ or intangible or primary or secondary in nature (Rando, 1993). Primary losses may be defined as the major loss perceived by the individual which may vary for each person on re-entry. These multiple primary losses may result in secondary losses on re-entry which may only become clear as time passes (Grieflink, 2010). Losses may be hidden, potential, and concurrent losses. Hidden losses are losses which are not socially acknowledged and may lead to disenfranchised grief (Grieflink, 2010). They may be deliberately hidden. Potential loss is loss which may or may not occur but is anticipated by the griever and some anticipatory mourning may take place even before it has occurred (Rando, 1993). Concurrent losses are those losses occurring on re-entry but which are not specific to re-entry and would have occurred anyway. Spiritual loss or

disconnection is defined as a break in the participant's relationship with God (personal spiritual disconnection); a break with their faith community in the host country or in Australia (faith community disconnection); or disconnection with the wider Australian community's concept of spirituality (Australian spiritual disconnection).

### *Missionary*

Somebody sent to another country by a church to spread its faith or to do social and medical work (Encarta® World English Dictionary [North American Edition] © & (P) 2009 Microsoft Corporation, 2009).

### *Prolonged Grief Disorder*

A significant loss event (bereavement) causes a disturbance which results in

- separation distress
- cognitive, emotional and behavioural symptoms. The bereaved person must have five (or more) of the following symptoms experienced daily or to a disabling degree:
  1. Confusion about one's role in life or diminished sense of self (i.e., feeling that a part of oneself has died)
  2. Difficulty accepting the loss
  3. Avoidance of reminders of the reality of the loss
  4. Inability to trust others since the loss
  5. Bitterness or anger related to the loss
  6. Difficulty moving on with life (e.g., making new friends, pursuing interests)
  7. Numbness (absence of emotion) since the loss

8. Feeling that life is unfulfilling, empty, or meaningless since the loss
9. Feeling stunned, dazed or shocked by the loss

Diagnosis should not be made until at least six months have elapsed since the death. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning (e.g., domestic responsibilities). The disturbance is not better accounted for by major depressive disorder, generalized anxiety disorder, or posttraumatic stress disorder (Prigerson et al., 2009).

### *Psychological distress*

The individual's response to a stressor posing a personal threat which results in:

- perceived loss of ability to cope
- change in emotional status involving loss
- loss of comfort or discomfort in other personal domains
- communication of discomfort
- resulting harm which may involve loss of physical or mental health

Modified from (Ridner, 2004).

### *Reacculturation*

Refers to "cultural and psychological change" (Berry et al., 1992, p. 19) for a person returning to live in their home culture after a time in a host culture (Abu Baker, 1999).

### *Re-entry adjustment*

The transition of returning to the home culture from another culture abroad (Adler, N. J., 1981) which may involve changes in person's physical, emotional, cognitive, behavioural, social and spiritual domains (Selby et al., 2005).

*Sojourn*

A significant period of time spent abroad working on a serious pursuit, not including tourism. Modified from Coschignano (2000, p. 5).

*Sojourner*

An individual who has spent a significant amount of time abroad working on a serious pursuit such as missionary work, fulfilling military duty, Peace Corp volunteer work, a paid work assignment, studying for a degree, working for the diplomatic corps, or accompanying their family. Modified from Coschignano (2000, p. 5).

*Third culture kid*

A Third Culture Kid (TCK) is a person who has spent a significant part of his or her developmental years outside the parents' culture. The TCK builds relationships to all of the cultures, while not having full ownership in any. Although elements from each culture are assimilated into the TCK's life experience, the sense of belonging is in relationship to others of similar background (Pollock and van Reken 2001, p. 19).



## APPENDIX 1: SEARCH STRATEGY FOR THE LITERATURE REVIEW IN CHAPTER 2

An initial search was carried out of national and international published literature from June 2004, with continuing searches during the course of the study and a final search reviewing data bases in September and October 2010. The literature search was done using key words including those in Medical Subject Headings (MeSH) categories. The search terms were acculturation; reacculturation; assimilation; reassimilation; reentry/re-entry; alienation; reentry/re-entry adjustment; repatriation adjustment ; reverse culture shock; reentry training; loss; losses; grief; grieve; grieving; loneliness; disenfranchised grief; cultural change; cross-cultural; cultural transmission; cultural change; cultural contact; cultural impact; intercultural sojourners; cross cultural worker; cross-cultural worker; aid worker; aid-worker; missionary; missionaries; missions; student; teacher; aid worker; military; armed forces; business; Peace Corps; family practices; family practice; primary practice; primary practices; general practice; general practices; primary care; family physician; family physicians; general practitioner; general practitioners; physicians family; treatment grief; grief measurement; resilience; identity; identity gap; psychological distress; depression; stress; anxiety; and post traumatic stress disorder. The searches were done using Pub Med, Sociofile, ISI Web of Science search, Academic Search Premier, Business Source Complete, CINAHL full text, Health Source: Nursing/Academic Edition, PsycARTICLES, Psychology and Behavioral Sciences Collection, PsycINFO and Religion and Philosophy Collection. The Adelaide College of Divinity library was also used for certain articles. A systematic review of the subject was not found in the Cochrane Collaboration. Alerts were sent from *ISI Web*

*of Science search and My NCBI what's new results* from April 2003 until September 2010. The reference lists of identified studies which were relevant after review of title, abstract and text were also searched. Searches were restricted to the English language due to financial constraints.

## APPENDIX 2: ETHICS APPROVAL FROM THE UNIVERSITY OF ADELAIDE



OFFICE OF THE DEPUTY VICE-CHANCELLOR (RESEARCH)

SABINE SCHREIBER  
SECRETARY  
HUMAN RESEARCH ETHICS COMMITTEETHE UNIVERSITY OF ADELAIDE  
SA 5005  
AUSTRALIATELEPHONE +61 8 8303 6028  
FACSIMILE +61 8 8303 3417  
email: sabine.schreiber@adelaide.edu.au  
CRICOS Provider Number 00123M

19 November 2003

Dr SE Clark  
General Practice

Dear Dr Clark

**PROJECT NO:** *The repatriation of adult cross-cultural workers to Australia: grief and loss issues*  
**H-58-2003**

I write to advise you that the Human Research Ethics Committee has approved the above project. Please refer to the enclosed endorsement sheet for further details and conditions that may be applicable to this approval.

**Approval is current for one year. The expiry date for this project is: 31 December 2004**

Where possible, subjects taking part in the study should be given a copy of the Information Sheet and the signed Consent Form to retain.

Please note that any changes to the project which might affect its continued ethical acceptability will invalidate the project's approval. In such cases an amended protocol must be submitted to the Committee for further approval. It is a condition of approval that you immediately report anything which might warrant review of ethical approval including (a) serious or unexpected adverse effects on participants (b) proposed changes in the protocol; and (c) unforeseen events that might affect continued ethical acceptability of the project. It is also a condition of approval that you inform the Committee, giving reasons, if the project is discontinued before the expected date of completion.

A reporting form is available from the Committee's website. This may be used to renew ethical approval or report on project status including completion.

Yours sincerely

CE MORTENSEN  
Convenor  
Human Research Ethics Committee



OFFICE OF THE DEPUTY VICE-CHANCELLOR (RESEARCH)

SABINE SCHREIBER  
SECRETARY  
HUMAN RESEARCH ETHICS COMMITTEE  
THE UNIVERSITY OF ADELAIDE  
SA 5005  
AUSTRALIA  
TELEPHONE +61 8 8303 6028  
FACSIMILE +61 8 8303 3417  
email: sabine.schreiber@adelaide.edu.au  
CRICOS Provider Number 00123M

Applicant: Dr SE Clark

Department: General Practice

Project Title: *The repatriation of adult cross-cultural workers to Australia: grief and loss issues*

---

THE UNIVERSITY OF ADELAIDE HUMAN RESEARCH ETHICS COMMITTEE

Project No: H-58-2003

RM No: 0000005754

APPROVED for the period until: 31 December 2004

Thank you for the modified information and consent documentation dated 10.11.03. It is noted that this study will be conducted by Dr Susan Selby, Masters candidate.

Refer also to the accompanying letter setting out requirements applying to approval.

Professor CE Mortensen  
Convenor

Date: 19 NOV 2003

### APPENDIX 3: THE PARTICIPANT INFORMATION SHEET

#### Participant Information Sheet for The Development of a Repatriation Program to Deal with Issues of Grief and Loss in Adult Australian Cross-Cultural Workers

Susan Selby is a Medical Practitioner with a special interest in Missionary Health Care. She is undertaking study towards her PhD, through the Department of General Practice, the University of Adelaide. This study is being performed as part of that process.

The purpose of this project is to understand the experiences of adult Australian missionaries returning from overseas service and to give them an opportunity to tell their stories. This may result in exploring and discovering new ground particularly in the areas of loss and grief so that the best care may be given and programmes developed to facilitate repatriation or re-entry.

You may not benefit personally from this study. However, your participation will be important in determining benefit to the missionary community.

You will be asked to complete three brief questionnaires about demographics; grief and loss; and current stresses including measures of depression and anxiety and take part in an interview lasting 30 to 60 minutes. You would be interviewed by Dr Susan Selby either personally or by telephone using a speaker if you are interstate and there is no possibility of personal interview.

With your permission the interview will be audio taped. Your name will not be used on the tape. The tapes will be transcribed and will be destroyed after the study is completed. Tapes may be transcribed by secretarial staff but your confidentiality will be protected.

Deidentified information from the tapes may be used in publications resulting from the project. The results will also be presented in a dissertation as part of the PhD. You will be offered a transcript of your interview to confirm that it is a true record of that interview, before the study is reported. You will also be offered a final copy of the dissertation.

Enrolment in the project is entirely voluntary and you may withdraw from it at any time.

Your anonymity will be maintained throughout the project and your personal details will not be revealed to anyone. There are no foreseeable risks in this study.

If there are any personal issues which arise as a result of participating, counselling will be offered if you wish. This project has been approved by the Human Research Ethics Committee of the University of Adelaide.

Please refer to the attached Contacts for Information on Project and Independent Complaints Procedure Form if you wish to make any enquiries. Should any difficulties arise regarding the study, you should contact Dr Susan Selby on the following phone number XXXX XXX XXX or confidential email addresses [susan.selby@adelaide.edu.au](mailto:susan.selby@adelaide.edu.au) cc. [XXXXXXXXXX@hotmail.com](mailto:XXXXXXXXXX@hotmail.com)

*Personnel involved in the project:*

Supervisors:

Dr Sheila Clark, MD, MBBS, BSc, DRCOG, FRACGP, FACPsychMed.

Senior Lecturer, Department of General Practice, The University of Adelaide.

Professor Justin Beilby, MD, MPH, MBBS, FRACGP, DRACOG, DA

Head of the Department of General Practice, The University of Adelaide.

*Student:*

Dr Susan Patricia Selby, MBBS, FRACGP, FACPsychMed.

Research Student, PhD, Department of General Practice, The University of Adelaide.

The University of Adelaide Human Research Ethics Committee  
Document for People who are Subjects in a Research Project

*Contacts for Information on Project and Independent Complaints Procedure*

The Human Research Ethics Committee is obliged to monitor approved research projects. In conjunction with other forms of monitoring it is necessary to provide an independent and confidential reporting mechanism to assure quality assurance of the institutional ethics committee system. This is done by providing research subjects with an additional avenue for raising concerns regarding the conduct of any research in which they are involved.

The following study has been reviewed and approved by the University of Adelaide Human Research Ethics Committee:

Project title: The Development of a Repatriation Program to Deal with Issues of Grief and Loss in Adult Australian Cross-cultural Workers

1. If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the project co-ordinator:

Name: Dr Susan Selby      telephone: XXXXXXXXXXXX.

2. If you wish to discuss with an independent person matters related to
- making a complaint, or
  - raising concerns on the conduct of the project, or
  - the University policy on research involving human subjects, or



- your rights as a participant

contact the Human Research Ethics Committee's Secretary on phone (08) 8303 6028.

## APPENDIX 4: CONSENT FORM

Standard Consent Form for People who are Subjects in the Research Project: The  
Development of a Repatriation Program to Deal with Issues of Grief and Loss in  
Adult Australian Cross-Cultural Workers

1. I ..... *(please print name)* consent to take part in the research project entitled: The Development of a Repatriation Program to Deal with Issues of Grief and Loss in Adult Australian Cross-cultural Workers.
2. I acknowledge that I have read the attached Information Sheet entitled: Participation Information Sheet for The Development of a Repatriation Program to Deal with Issues of Grief and Loss in Adult Australian Cross-cultural Workers.
3. I have had the project, so far as it affects me, fully explained to my satisfaction by the research worker. My consent is given freely.
4. Although I understand that the purpose of this research project is to improve the quality of medical care in the area of grief and loss, it has also been explained that my involvement may not be of any benefit to me.
5. I have been informed that, while information gained during the study may be published, I will not be identified and my personal results will not be divulged.
6. I understand that I am free to withdraw from the project at any time and that this will not affect medical advice in the management of my health or cross-cultural work, now or in the future.
7. I am aware that I should retain a copy of this Consent Form, when completed, and the attached Participant Information Sheet.

- 8. I agree to the interview being taped (please tick the box)  Yes  
 No
- 9. I would like a transcript of the tape (please tick the box)  Yes  
 No
- 10. I would like a copy of the dissertation  Yes  
 No

Signature..... Date.....

WITNESS

I have described to ..... (*name of subject*) the nature of the research to be carried out. In my opinion she/he understood the explanation.

Status in Project: .....

Name: .....

Signature..... Date.....

Susan Selby, Researcher in the above project.

## APPENDIX 5: THE SURVEY

The survey consisted of:

- A. The Re-entry Demographics Questionnaire originally known as *Demographics Questionnaire*
- B. The Re-entry Grief Diagnostic Instrument originally known as *The Loss and Grief Questionnaire for Re-entry to Australia*
- C. The DASS 21

Appendix 5A. The Re-entry Demographics Questionnaire originally known as the  
*Demographics Questionnaire*

*The Development of a Repatriation Program to Deal with Issues of Grief and Loss in  
Adult Australian Cross-cultural Workers*

*Demographics Questionnaire*

Sending Agency Number:        
Worker number:                  
Audiotape Code:                  
Date:                               

Thank you for your willingness to assist in the study of re-entry to Australia after overseas service.

*Please turn the page and complete the following questions*

Instructions: Please answer each question by marking the box with the most appropriate answer or by writing the answer in the space provided.

1. Your Gender (*please tick relevant box*)      M       F
2. Your Year of Birth? .....
3. What is your country of birth? .....
4. What is your nationality? .....
5. What is your cultural background? .....
6. What is the main language spoken at home? .....
7. What is your religious affiliation? .....
8. In your main job, whilst serving in your last term of service overseas, what was your occupation? .....
9. How long have you been back in Australia since your most recent return?  
(*Please write in numbers*)      ..... years ..... months
10. How long was your immediate last term of service in another country prior to this current return? (*Please write in numbers*)      ..... years ..... months
11. How many times have you returned to Australia after spending at least two years serving overseas? (*Please write in numbers*)      .....
12. Please list your terms in each country/region beginning with the most recent and giving the approximate dates of service overseas and the reason for return to Australia e.g. home assignment, health issues.

Country	Region or Continent	Dates of Service Overseas	Reason for Return
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

13. At the current time, what are your plans for the next 12 months? *(Please tick more than one box if necessary)*

- Home Assignment then return to the overseas mission field
- Take leave of absence
- Retire
- Resign
- Uncertain
- Other *(please specify)*

.....

14. What is your current marital status? *(Please tick relevant box)*
- Never married
  - Married
  - Widowed
  - Separated
  - Divorced
  - Other *(please specify)*
- .....

15. What was your marital status at the time of your last re-entry?
- Never married
  - Married
  - Widowed
  - Separated
  - Divorced
  - Other *(please specify)*
- .....

*If you do not have any children you have now completed the questionnaire.*

***Thank you for your assistance.***

*If you have children, please complete the next question.*



16. Please give the age for each of your children at the time of your present re-entry including adult children.

Child one ..... Child two ..... Child three .....

Child four ..... Child five ..... Child six .....

*Thank you for completing this questionnaire.*

Appendix 5B. The Re-entry Grief Diagnostic Instrument also known as *The Loss and Grief Questionnaire for Re-entry to Australia*

*The Loss and Grief Questionnaire for Re-entry to Australia*

Sending Agency Number:     

Worker number:               

Audiotape Code:               

Date:                               

This questionnaire is about grief. Grief is the distress we feel when we lose anything of value in our lives. It can follow the death of someone we love, the breakdown of a relationship, or the loss of something or some circumstance that is precious to us. We may also experience grief knowing that someone we love or care for is grieving themselves. We may feel grief from losses we are currently experiencing, as well as from past or future losses.

*Please Continue*

*Section A*

This section determines the losses you have experienced since your return to Australia this time and whether you are experiencing grief at the present time for these losses.

Some losses may have occurred since your return and some losses may be a direct result of re-entry.

Please list any losses you have had since your return to Australia and please circle the grade in numbers from 1 (mild distress) to 5 (severe distress) for each loss.

Losses you may be feeling since your re-entry to Australia this time		Grade 1–5					Please describe your loss			
1	Fear of your own death?	Yes	<input type="checkbox"/>	1	2	3	4	5	a	_____
		No	<input type="checkbox"/>						b	_____
2	Loss of someone through separation, divorce, child leaving home, disagreements with family members or friends etc, death	Yes	<input type="checkbox"/>	1	2	3	4	5	a	_____
		No	<input type="checkbox"/>						b	_____
3	Serious illness or death of a pet, or separation from a pet	Yes	<input type="checkbox"/>	1	2	3	4	5	a	_____
		No	<input type="checkbox"/>						b	_____
4	Loss of freedom eg being a carer, retirement of spouse, gaol, etc	Yes	<input type="checkbox"/>	1	2	3	4	5	a	_____
		No	<input type="checkbox"/>						b	_____

Losses you may be feeling since your re-entry to Australia this time			Grade 1–5					Please describe your loss		
5	Job loss eg retirement, redundancy, unemployment, illness, birth of a baby etc	Yes	<input type="checkbox"/>	1	2	3	4	5	a	_____
		No	<input type="checkbox"/>						b	_____
6	Loss of opportunity eg missed career choice, promotion, an unfulfilled dream or life choices being different from those you expected etc	Yes	<input type="checkbox"/>	1	2	3	4	5	a	_____
		No	<input type="checkbox"/>						b	_____
7	Financial or property loss eg disaster, collapse of financial company, burglary etc	Yes	<input type="checkbox"/>	1	2	3	4	5	a	_____
		No	<input type="checkbox"/>						b	_____
8	Loss of quality of life eg illness, disability, aging, injury etc	Yes	<input type="checkbox"/>	1	2	3	4	5	a	_____
		No	<input type="checkbox"/>						b	_____
9	Loss of personal integrity eg domestic violence, rape, incest, war etc	Yes	<input type="checkbox"/>	1	2	3	4	5	a	_____
		No	<input type="checkbox"/>						b	_____
10	Losses through adoption/ fostering eg giving up, being or caring for an adopted or fostered child	Yes	<input type="checkbox"/>	1	2	3	4	5	a	_____
		No	<input type="checkbox"/>						b	_____
11	Loss or lack of pregnancy eg infertility, miscarriage, abortion, sterilisation, stillbirth etc.	Yes	<input type="checkbox"/>	1	2	3	4	5	a	_____
		No	<input type="checkbox"/>						b	_____
12	Loss of control of assignment outcome eg project terminated	Yes	<input type="checkbox"/>	1	2	3	4	5	a	_____
		No	<input type="checkbox"/>						b	_____

Losses you may be feeling since your re-entry to Australia this time		Grade 1-5					Please describe your loss			
13	Loss of closure on field eg unable to farewell colleagues	Yes	<input type="checkbox"/>	1	2	3	4	5	a	_____
		No	<input type="checkbox"/>						b	_____
14	Loss of family cohesiveness on the field	Yes	<input type="checkbox"/>	1	2	3	4	5	a	_____
		No	<input type="checkbox"/>						b	_____
15	Loss of role on field	Yes	<input type="checkbox"/>	1	2	3	4	5	a	_____
		No	<input type="checkbox"/>						b	_____
16	Loss of home culture eg loss of familiar landmarks, terms of speech	Yes	<input type="checkbox"/>	1	2	3	4	5	a	_____
		No	<input type="checkbox"/>						b	_____
17	Loss of host culture eg foods, smells	Yes	<input type="checkbox"/>	1	2	3	4	5	a	_____
		No	<input type="checkbox"/>						b	_____
18	Loss of identity	Yes	<input type="checkbox"/>	1	2	3	4	5	a	_____
		No	<input type="checkbox"/>						b	_____
19	Loss of spiritual beliefs	Yes	<input type="checkbox"/>	1	2	3	4	5	a	_____
		No	<input type="checkbox"/>						b	_____
20	Any other losses since this re-entry to Australia? Please list:			1	2	3	4	5	a	_____
	_____								b	_____
	_____			1	2	3	4	5	a	_____
	_____								b	_____

**NOW!**  
Have you ticked any 'yes' boxes?

**If 'yes'**

Please continue to the next  
section below

**If 'no'**

**Thank you.**  
You have completed the  
questionnaire

*Section B*

Now consider ALL the losses you ticked

*In the past 2 weeks:*

1. Have thoughts of your loss made it difficult for you to concentrate, remember things or make decisions?

A lot of the time     Quite a bit of the time     A little bit of the time     Never

2. Have you experienced images of the events surrounding the loss?

Continuously     Quite a bit of the time     A little bit of the time     Never

3. Have you found yourself longing for what is or will be lost?

A lot of the time     Quite a bit of the time     A little bit of the time     Never

4. Have reminders of the loss such as people, photos, situations, music, places etc caused you to feel longing for what is or will be lost?

A lot of the time     Quite a bit of the time     A little bit of the time     Never

5. Have thoughts or reminders of the loss caused you to feel guilt?

A lot of the time     Quite a bit of the time     A little bit of the time     Never

6. Have thoughts or reminders of what is or will be lost caused you to feel sick or ill in any way (eg generally unwell, loss of energy, headaches, dizziness etc)?

A lot of the time     Quite a bit of the time     A little bit of the time     Never

*Please Continue*

7. Have thoughts of the loss come into your mind whether you wish it or not?

- Continuously       Quite a bit of the time       A little bit of the time       Never

8. Have you felt distress by the reality of the loss?

- A lot of the time       Quite a bit of the time       A little bit of the time       Never

9. Have thoughts or reminders of the loss caused you to feel dread of the future?

- A lot of the time       Quite a bit of the time       A little bit of the time       Never

10. Have thoughts of your loss caused you to be more irritable with others?

- A lot of the time       Quite a bit of the time       A little bit of the time       Never

11. Overall how much have thoughts and feelings about your loss or losses distressed you?

- A lot of the time       Quite a bit of the time       A little bit of the time       Never

12. Have people or familiar objects (photos, possessions, rooms etc) reminded you of the loss?

- A lot of the time       Quite a bit of the time       A little bit of the time       Never

13. Have thoughts or reminders of the loss caused your emotions to feel numb?

- A lot of the time       Quite a bit of the time       A little bit of the time       Never



*Please Continue*

14. Have you found yourself imagining that the loss has/will not occur?

- A lot of the time     Quite a bit of the time     A little bit of the time     Never

15. Have reminders of the loss such as people, photos, situations, music, places etc cause you to feel sadness?

- A lot of the time     Quite a bit of the time     A little bit of the time     Never

16. Have thoughts or reminders of the loss caused you to feel anger?

- A lot of the time     Quite a bit of the time     A little bit of the time     Never

*Thank you for completing this questionnaire*

***Please proceed to Part 2: DASS 21 Questionnaire***

Appendix 5C. The DASS 21 Questionnaire  
(Lovibond & Lovibond, 1995)

NOTE:  
This appendix is included on page 278  
of the print copy of the thesis held in  
the University of Adelaide Library.

## APPENDIX 6: LETTER TO MISSION ADMINISTRATOR (DE-IDENTIFIED)

[Name and address]

[Date]

Dear [Name],

Thank you for indicating that your organisation would be interested in participating in research concerning missionary repatriation or re-entry.

During the last six years I have been involved in the medical care of missionaries returning to Australia after overseas service. On return from their placement, they present with issues of repatriation adjustment and I have noted that there may be multiple issues of grief and loss to work through.

In order to clarify these issues, I am undertaking a PhD at The University of Adelaide through the Department of General Practice. The title of the project is *The Development of a Repatriation Program to Deal with Issues of Grief and Loss in Adult Australian Cross-cultural Workers*. The purpose of the project is to determine what are the issues of grief and loss for adult Australian missionaries returning from overseas service after more than two years and in some cases multiple re-entries (Stage I). The results will then be used to develop future programs to assist in the care of missionaries as they negotiate repatriation, particularly for use in General Practice (Stage II).

Their participation for Stage I would involve an interview with Dr Selby, and completing three brief questionnaires re demographics; to assess grief and loss issues; and current stresses.

I have enclosed a copy of the introductory letter, participant information form, the consent form and the questionnaires for your perusal. Every effort will be made to conduct the interviews personally, however, where this is impossible telephone with speaker access may be used.

The project has been given approval by The Ethics Committee of the University of Adelaide.

If the mission is happy to participate in this research, I will email the invitation to be sent by you to the missionary (see attachment). If they agree to participate, I anticipate they will contact me directly using the details given. I would then email or post them an introductory letter, the participant information forms, the consent form, the demographics questionnaire, the grief and loss questionnaire and the DASS questionnaire. Once these have been returned to me, I will arrange an appropriate interview time.

Thank you for your encouragement and help with this research project. Please contact me if there is any aspect of it that needs further clarification or discussion.

Yours sincerely,

Susan Selby MBBS, FRACGP

Research Student for PhD

Department of General Practice

The University of Adelaide

[susan.selby@adelaide.edu.au](mailto:susan.selby@adelaide.edu.au)

cc. [XXXXXXXXX@hotmail.com](mailto:XXXXXXXXX@hotmail.com)

Tel: XXXX XXX XXX

APPENDIX 7: EMAIL INVITATION TO BE SENT BY THE MISSIONARY  
ORGANISATION TO PARTICIPANTS

Dear [Name of Participant],

We have been contacted by Dr Susan Selby who works with missionaries in their medical care and is researching issues affecting Australian adult missionaries returning to Australia. The research project is called The Development of a Repatriation Program to Deal with Issues of Grief and Loss in Adult Australian Cross-Cultural Workers. It is being conducted through the Department of General Practice at the University of Adelaide. It has received approval from The Ethics Committee of the University of Adelaide.

The purpose of this project is to understand the experiences of adult Australian missionaries returning from overseas service and to give them an opportunity to tell their stories. This may result in exploring and discovering new ground particularly in the areas of loss and grief so that the best care may be given.

If you are interested in participating in this project please email Dr Selby at [susan.selby@adelaide.edu.au](mailto:susan.selby@adelaide.edu.au) or telephone: XXXX XXX XXX or contact her at:

Dr Susan Selby  
Department of General Practice  
Level 3, Eleanor HARRALD Building  
Royal Adelaide Hospital  
The University of Adelaide  
SA, 5005.

for further details. Your participation would involve an interview with Dr Selby, and completing three brief questionnaires to assess demographic information, grief and loss issues and measures of stress, anxiety and depression. Your confidentiality will be protected and the mission will not have access to your data. Your involvement is entirely voluntary and you may withdraw at any time. If you decide not to participate, this will not affect your role with the mission in any way.

Thank you for your help with this matter.

Yours Sincerely,

[Name of Mission Administrator]

## APPENDIX 8: INVITATION TO PARTICIPANTS IN SURVEY PACK

Date

Dear [Name of Participant],

Thank you very much for your interest in participating in the Research Project: *The Development of a Repatriation Program to Deal with Issues of Grief and Loss in Adult Australian Cross-cultural Workers*. Over the last five years I have had the privilege of being involved with the medical care of a number of missionaries both in my role as a general practitioner and as the state medical registrar for one of the missionary organisations. As a result, I have noted that there are significant issues surrounding the repatriation of missionaries to Australia and the research outlined below is part of an effort to clarify these issues.

I have enclosed a Participant Information Sheet explaining the project and how you would be involved.

If you decide to participate could you please complete 2 copies of the enclosed Consent Form and complete the Demographics Questionnaire, The Loss and Grief Questionnaire for Re-entry to Australia and the DASS Questionnaire. Please return the three questionnaires and one copy of the Consent Form to me in the envelope provided. Please retain one copy of the Consent Form for your records. I will contact you regarding an interview time. My contact details are below and include my two confidential email addresses.

Your involvement is entirely voluntary and you may withdraw at any time. If you decide not to participate, this will not affect your role with the mission in any way.



Thank you again for considering being involved in this research. Your input will greatly add to our ability to explore and discover the rich tapestry of experiences in this area and to enable improvements in missionary care.

Yours Sincerely,

Susan Selby

Research Student for PhD

Department of General Practice

The University of Adelaide.

[susan.selby@adelaide.edu.au](mailto:susan.selby@adelaide.edu.au)

cc. [XXXXXXXXX@hotmail.com](mailto:XXXXXXXXX@hotmail.com)

Tel: XXXX XXX XXX

APPENDIX 9: RE-ENTRY DEMOGRAPHICS QUESTIONNAIRE:  
FIRST VERSION

*Draft Demographics Questionnaire for The Repatriation of Adult Australian Missionaries To Australia: Grief and Loss Issues Project*

Thank you for your willingness to assist in the study of re-entry or repatriation to Australia after overseas service.

Please complete the following questions.

*Instructions: Please answer each question by marking the box with the most appropriate answer or by writing the answer in the space provided.*

1. Your Gender (*please tick relevant box*)                      M                       F
  
2. Your Age (*please write your age in numbers*)                      .....
  
3. What is your country of birth?                      .....
  
4. What is your nationality?                      .....
  
5. How long have you been back in Australia since your most recent return?  

 years                       months
  
6. How long were you serving in another country prior to your last return?  

 years                       months

7. How many times have you re-entered Australia after spending at least two years serving overseas?

8. Please list each foreign country and/or region, the total length of time spent in that country, and the number of terms of service in each, beginning with the most recent.

Country	Region or Continent	Dates of Service Overseas	Reason for Return
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

9. At the current time, what are your plans for the future? (*please tick one box*)

- Home Assignment/Furlough then return to the overseas mission field
- Take leave of absence
- Retire
- Resign
- Other (please specify)
- Uncertain

10. What is your highest level of educational attainment?
- Still at school
- Left school at 15 years or less
- Left school after age 15 but no further study
- Left school after age 15 but still studying
- Trade qualification/apprenticeship
- Certificate/diploma
- Bachelor degree or higher
11. What is your current marital status? (please tick relevant box)
- Single
- Married/Partner
- Widowed
- Separated
- Divorced
12. What was your marital status at the time of your last repatriation?
- Single
- Married/Partner
- Widowed
- Separated
- Divorced

If you do not have any children you have now completed the questionnaire. Thank you for your assistance.

If you have children, please complete the next question.

13. Please give the age for each of your children at the time of your last repatriation.

Child one

Child two

Child three

Child four

Child five

Child six

*Thank you for completing this questionnaire.*

## APPENDIX 10: THE GRIEF DIAGNOSTIC INSTRUMENT

(Clark, 2003; Clark et al., 2005)

© Sheila Clark All Rights reserved

*The Grief Diagnostic Instrument*

Patient number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Practice number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

This questionnaire is about grief. Grief is the distress we feel when we lose anything of value in our lives. It can follow the death of someone we love, the breakdown of a relationship, or the loss of something or some circumstance that is precious to us. We may also experience grief knowing that someone we love or care for is grieving themselves. We may feel grief from losses we are currently experiencing, as well as from past or future losses.

*Section A Please complete all questions*1. Your age   eg  4  32. Post code of where you live    3. Your gender (*please tick relevant box*) M  F

4. In which country were you born?

Australia	<input type="checkbox"/>	If yes, are you of Aboriginal or Torres Strait Islander origin?	Yes	<input type="checkbox"/>
			No	<input type="checkbox"/>
New Zealand	<input type="checkbox"/>			
UK and Ireland	<input type="checkbox"/>			
Asian country	<input type="checkbox"/>			
European country	<input type="checkbox"/>			
African country	<input type="checkbox"/>			
North or South America	<input type="checkbox"/>			

5. What is your marital status?

Married/De facto	<input type="checkbox"/>
Never married	<input type="checkbox"/>
Separated/divorced	<input type="checkbox"/>
Widowed	<input type="checkbox"/>

*Please continue*

6. What is your highest level of educational attainment?

Still at school

Left school at 15 years or less

Left school after age 15 but no further study

Left school after aged 15 but still studying

Trade qualification/apprenticeship

Certificate/diploma

Bachelor degree or higher

7. What is your MAIN occupation?

Home duties

Retired

Student

Unemployed

Full or part-time employment

*Please continue*



*Section B*

This section determines whether you are experiencing grief at the moment. You may be feeling grief now from losses you are currently experiencing as well as from past losses or losses you know will happen in the future.

In the last TWO WEEKS have you been distressed about any of the following losses to you or someone close to you?

Use a separate line for each loss

				<b>Date when you first became aware of the loss</b>	
	Yes	No	Loss	Month	Year
1. Death or impending death of a loved one	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	3	.....	.....
2. Fear of your own death	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
3. Losses through migration or moving house	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....
4. Loss of someone through separation, divorce, child leaving home, disagreements with family members or friends etc	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	3	.....	.....
5. Serious illness or death of a pet, or separation from a pet	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....
6. Loss of freedom, eg being a carer, retirement of spouse, gaol etc	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....

Use a separate line for each loss

**Date when you first became aware of the loss**

	Yes	No	Loss	Month	Year
7. Job loss, eg retirement, redundancy, unemployment, illness, birth of a baby etc	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	3	.....	.....
8. Loss of opportunity eg missed career choice, promotion, an unfulfilled dream or life choices being different from those you expected etc	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....
9. Financial or property loss eg disaster, collapse of financial company, burglary etc	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....
10. Loss of quality of life, eg illness, disability, aging, injury etc	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	3	.....	.....
11. Loss or lack of pregnancy, eg infertility, miscarriage, abortion, sterilisation, stillbirth etc	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....
12. Loss of personal integrity, eg domestic violence, rape, incest, war etc	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....
13. Losses through adoption/fostering, eg giving up, being or caring for an adopted or fostered child	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....

Use a separate line for each loss

**Date when you first became aware of the loss**

	Yes	No	Loss	Month	Year
14. Any other loss ( <i>please specify</i> )					
.....	<input type="checkbox"/>		1	.....	.....
.....	<input type="checkbox"/>		2	.....	.....
.....	<input type="checkbox"/>		3	.....	.....

**NOW!**  
**Have you ticked any 'yes' boxes?**



**If 'yes'**

**If 'no'**

**Please continue to the next section below**

**Thank you.  
 You have completed the questionnaire**

*Section C*

Now consider ALL the losses you ticked

*In the past 2 weeks:*

1. Have thoughts of your loss made it difficult for you to concentrate, remember things or make decisions?

A lot of the time     Quite a bit of the time     A little bit of the time     Never

2. Have you experienced images of the events surrounding the loss?

Continuously     Quite a bit of the time     A little bit of the time     Never

3. Have you found yourself longing for what is or will be lost?

A lot of the time     Quite a bit of the time     A little bit of the time     Never

4. Have reminders of the loss such as people, photos, situations, music, places etc caused you to feel longing for what is or will be lost?

A lot of the time     Quite a bit of the time     A little bit of the time     Never

5. Have thoughts or reminders of the loss caused you to feel guilt?

A lot of the time     Quite a bit of the time     A little bit of the time     Never

6. Have thoughts or reminders of what is or will be lost caused you to feel sick or ill in any way (eg generally unwell, loss of energy, headaches, dizziness etc)?

A lot of the time     Quite a bit of the time     A little bit of the time     Never

*Please Continue*

7. Have thoughts of the loss come into your mind whether you wish it or not?

- Continuously       Quite a bit of the time       A little bit of the time       Never

8. Have you felt distress by the reality of the loss?

- A lot of the time       Quite a bit of the time       A little bit of the time       Never

9. Have thoughts or reminders of the loss caused you to feel dread of the future?

- A lot of the time       Quite a bit of the time       A little bit of the time       Never

10. Have thoughts of your loss caused you to be more irritable with others?

- A lot of the time       Quite a bit of the time       A little bit of the time       Never

11. Overall how much have thoughts and feelings about your loss or losses distressed you?

- A lot of the time       Quite a bit of the time       A little bit of the time       Never

12. Have people or familiar objects (photos, possessions, rooms etc) reminded you of the loss?

- A lot of the time       Quite a bit of the time       A little bit of the time       Never

13. Have thoughts or reminders of the loss caused your emotions to feel numb?

- A lot of the time       Quite a bit of the time       A little bit of the time       Never

*Please Continue*

14. Have you found yourself imagining that the loss has/will not occur?

- A lot of the time     Quite a bit of the time     A little bit of the time     Never

15. Have reminders of the loss such as people, photos, situations, music, places etc cause you to feel sadness?

- A lot of the time     Quite a bit of the time     A little bit of the time     Never

16. Have thoughts or reminders of the loss caused you to feel anger?

- A lot of the time     Quite a bit of the time     A little bit of the time     Never

*Thank you for completing this questionnaire*

Grief Diagnostic Instrument © Sheila Clark All Rights reserved

APPENDIX 11: PERMISSION TO USE THE GRIEF DIAGNOSTIC  
INSTRUMENT

Dr Sheila Clark,  
Department of General Practice,  
The University of Adelaide.



DEPARTMENT OF GENERAL PRACTICE  
FACULTY OF HEALTH SCIENCES

LEVEL 3 ELEANOR HARRALD BLD  
ROYAL ADELAIDE HOSPITAL  
THE UNIVERSITY OF ADELAIDE  
SA 5005  
AUSTRALIA  
TELEPHONE +61 8 8303 3460  
FACSIMILE +61 8 8303 3511

Dear Sheila,

**Re REQUEST FOR PERMISSION TO USE The Grief Diagnostic Instrument to measure grief in the research study entitled: Back home: Distress in re-entering cross-cultural missionary workers and the development of a theoretical framework for clinical management (also known as The Repatriation of Adult Cross-Cultural Workers to Australia: Grief and Loss Issues).**

I am writing as a PhD candidate in the Discipline of General Practice. I wish to use the following Material of which you are the author: **The Grief Diagnostic Instrument**

I propose to:

- (a) reproduce the material in hardcopy/digital form
- (b) publish the material in journal articles and in my thesis
- (c) modify the instrument for further use
- (d) I agree to acknowledge your work in publications and when reproduced

I seek your permission to use the above mentioned material in this way.

The purpose of the use would be to engage in research.

If you agree with the terms as described above, please sign the permission form below and send one copy in the self-addressed return envelope I have provided. A duplicate copy of this permission form is enclosed for your records.

Yours sincerely

Susan Selby  
PhD Candidate  
The Department of General Practice  
The University of Adelaide

**Permission granted for the use of the material as described above:**

Name: ...SHEILA...CLARK...  
Title: ...Dr...  
Organisation: ...University of Adelaide...  
Signature: ...  
Date: ...13.12.10...

---

APPENDIX 12: THE RE-ENTRY GRIEF DIAGNOSTIC INSTRUMENT: FIRST  
VERSION

*The Grief Diagnostic Instrument*

Patient number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Practice number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

---

This questionnaire is about grief. Grief is the distress we feel when we lose anything of value in our lives. It can follow the death of someone we love, the breakdown of a relationship, or the loss of something or some circumstance that is precious to us. We may also experience grief knowing that someone we love or care for is grieving themselves. We may feel grief from losses we are currently experiencing, as well as from past or future losses.

*Please Continue*



*Section A*

This section determines whether you are experiencing grief at the moment. We are interested in knowing if you are feeling grief now for losses you have experienced in relation to your return to Australia from the mission field.

Use a separate line for each loss

				<b>Date when you first became aware of the loss</b>	
	Yes	No	Loss	Month	Year
1. Death or impending death of a loved one	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	3	.....	.....
2. Fear of your own death	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....
3. Losses through migration or moving house	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....
4. Loss of someone through separation, divorce, child leaving home, disagreements with family members or friends etc	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	3	.....	.....
5. Serious illness or death of a pet, or separation from a pet	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....
6. Loss of freedom, eg being a carer, retirement of spouse, gaol etc	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....

Use a separate line for each loss

**Date when you first became aware of the loss**

	Yes	No	Loss	Month	Year
7. Job loss, eg retirement, redundancy, unemployment, illness, birth of a baby etc	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	3	.....	.....
8. Loss of opportunity eg missed career choice, promotion, an unfulfilled dream or life choices being different from those you expected etc	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....
9. Financial or property loss eg disaster, collapse of financial company, burglary etc	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....
10. Loss of quality of life, eg illness, disability, aging, injury etc	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	3	.....	.....
11. Loss or lack of pregnancy, eg infertility, miscarriage, abortion, sterilisation, stillbirth etc	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....
12. Loss of personal integrity, eg domestic violence, rape, incest, war etc	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....
13. Losses through adoption/fostering, eg giving up, being or caring for an adopted or fostered child	<input type="checkbox"/>	<input type="checkbox"/>	1	.....	.....
	<input type="checkbox"/>	<input type="checkbox"/>	2	.....	.....

Use a separate line for each loss

**Date when you first became aware of the loss**

	Yes	No	Loss	Month	Year
14. Any other loss ( <i>please specify</i> )					
.....	<input type="checkbox"/>		1	.....	.....
.....	<input type="checkbox"/>		2	.....	.....
.....	<input type="checkbox"/>		3	.....	.....

**NOW!**  
**Have you ticked any 'yes' boxes?**



**If 'yes'**

**If 'no'**

**Please continue to the next section below**

**Thank you.  
 You have completed the questionnaire**

*Section B*

Now consider ALL the losses you ticked in the past 2 weeks:

1. Have thoughts of your loss made it difficult for you to concentrate, remember things or make decisions?

- A lot of the time     Quite a bit of the time     A little bit of the time     Never

2. Have you experienced images of the events surrounding the loss?

- Continuously     Quite a bit of the time     A little bit of the time     Never

3. Have you found yourself longing for what is or will be lost?

- A lot of the time     Quite a bit of the time     A little bit of the time     Never

4. Have reminders of the loss such as people, photos, situations, music, places etc caused you to feel longing for what is or will be lost?

- A lot of the time     Quite a bit of the time     A little bit of the time     Never

5. Have thoughts or reminders of the loss caused you to feel guilt?

- A lot of the time     Quite a bit of the time     A little bit of the time     Never

6. Have thoughts or reminders of what is or will be lost caused you to feel sick or ill in any way (eg generally unwell, loss of energy, headaches, dizziness etc)?

- A lot of the time     Quite a bit of the time     A little bit of the time     Never

*Please Continue*

7. Have thoughts of the loss come into your mind whether you wish it or not?

- Continuously       Quite a bit of the time       A little bit of the time       Never

8. Have you felt distress by the reality of the loss?

- A lot of the time       Quite a bit of the time       A little bit of the time       Never

9. Have thoughts or reminders of the loss caused you to feel dread of the future?

- A lot of the time       Quite a bit of the time       A little bit of the time       Never

10. Have thoughts of your loss caused you to be more irritable with others?

- A lot of the time       Quite a bit of the time       A little bit of the time       Never

11. Overall how much have thoughts and feelings about your loss or losses distressed you?

- A lot of the time       Quite a bit of the time       A little bit of the time       Never

12. Have people or familiar objects (photos, possessions, rooms etc) reminded you of the loss?

- A lot of the time       Quite a bit of the time       A little bit of the time       Never

13. Have thoughts or reminders of the loss caused your emotions to feel numb?

- A lot of the time       Quite a bit of the time       A little bit of the time       Never

*Please Continue*

14. Have you found yourself imagining that the loss has/will not occur?

- A lot of the time     Quite a bit of the time     A little bit of the time     Never

15. Have reminders of the loss such as people, photos, situations, music, places etc cause you to feel sadness?

- A lot of the time     Quite a bit of the time     A little bit of the time     Never

16. Have thoughts or reminders of the loss caused you to feel anger?

- A lot of the time     Quite a bit of the time     A little bit of the time     Never

*Thank you for completing this questionnaire*

APPENDIX 13: THE SEMI-STRUCTURED INTERVIEW SCHEDULE:

FIRST DRAFT

Date

Sending Agency Number

Missionary's ID number

Audiotape Code

Introduction: Thank you for agreeing to be interviewed about areas of loss and grief during your re-entry to Australia. Please let me know if you want any questions clarified or if you wish to stop the interview at any stage. What you tell me will be completely confidential.

Can you explain the circumstances of your return?

Just to clarify your story, can you tell me where you fit in this table?

	Predictable Repatriation	Unpredictable Repatriation
Voluntary Repatriation		
Involuntary Repatriation		

Do you regard this as a loss? Does this loss situation cause you any distress at present?

Now that you have returned, what is your role in Australia? Do you regard this as a loss? Does this loss situation cause you any distress at present?

*Prompts: employment, church role , expatriate role, local role*

Now you have returned, are there any everyday aspects of life overseas that you regard as a loss? Does this loss situation cause you any distress at present?

*Prompts: housing, food, clothes, smells, language, shops, domestic help, daily routine, reinforcing events*

After your return, have you noted things in the Australian way of life that are different? Were there some things you expected about home which have not met your expectations? Do you regard this as a loss? Does this loss situation cause you any distress at present?

*Prompts: housing, food, clothes, smells, language, shops, domestic help, daily routine, reinforcing events*

Have you experienced any losses to do with your time management since your return? Does this loss situation cause you any distress at present?

*Prompts: wasted time, too little time, too much time*

Now that you have returned, do you think there are any changes in who you are as a person? Do you regard this as a loss? Does this loss situation cause you any distress at present?

*Prompts: personal attributes (traits , characteristics and dispositions), gender, ethnicity, social class, religion ,culture or person model*

How do you think others see you since your return? Do you regard this as a loss? Does this loss situation cause you any distress at present?

*Prompts: family in Australia, friends, acquaintances, personnel at sending agency, church contacts*



How has the family who have returned with you functioned since your return? Are there any losses here compared with your family life overseas? Does this loss situation cause you any distress at present?

*Prompt: family cohesiveness, loss of control of children, relationship with partner (more or less dependent), time issues*

Since your return to Australia are there significant personal relationships that have been loss situations? Does this loss situation cause you any distress at present?

*Prompts: other mission personnel, nationals, other expatriates, colleagues, friends, family*

Have you experienced any losses to do with the Mission organisation since your return? Does this loss situation cause you any distress at present?

*Prompts: personnel, attitudes, organisation, deputation work,*

Have you experienced any losses to do with your church community since your return? Does this loss situation cause you any distress at present?

*Prompts: personnel, attitudes, organisation, support*

Has there been a loss of your connection with God since your return to Australia?

Does this loss situation cause you any distress at present?

*Prompts: beliefs, feelings (do you feel you have let God down?), blocks*

When you left the mission field and returned to Australia were there any areas that were not properly closed off? Do you regard this as a loss? Does this loss situation cause you any distress at present?

*Prompts: work, relationships, church, health*

Are there any other areas of loss that you have experienced since re-entering Australia that you would like to discuss? Does this loss situation cause you any distress at present?

You have experienced some significant losses. Do you think that these have been recognised as legitimate by your family, friends, sending agency?

Does this distress you?

How do you feel about the various areas of loss now that you have been back and forth a number of times?

What sort of support would be useful in helping you at this time?

APPENDIX 14: THE ARTICLE: SELBY, S., JONES, A., BURGESS, T., CLARK, S., MOULDING, N., & BEILBY, J. (2007). DISENFRANCHISED GRIEVERS – THE GP’S ROLE IN MANAGEMENT. *AUSTRALIAN FAMILY PHYSICIAN*, 36, 768–770.

Selby, S., Jones, A., Burgess, T., Clark, S., Moulding, N., and Beilby, J. (2007)  
Disenfranchised grievors – the GP's role in management.  
*Australian Family Physician*, v. 36 (9), pp. 768-770, September 2007

NOTE: This publication is included in the print copy of the thesis  
held in the University of Adelaide Library.

## APPENDIX 15: DEMOGRAPHIC RESULTS FOR PILOT AND STUDY

## PARTICIPANTS

There were five participants who undertook the pilot studies for the Survey and the Interview.

Their pseudonyms and characteristics are listed in Table A15.1.

Table A15.1: *Demographic Information for the Pilot Study Participants*

Participants' Pseudonyms	Year of birth	Main role in last posting	Total years as missionary	Months since this re-entry at interview	Re-entry Long (L) or Short (S) Term	Marital Status	No. of children	Last Location
Judy	1950	Language specialist	30	5	L	S	0	Pacific
Phil	1961	Computer technical support worker	8	8	L	M	3	Asia
Belinda	1946	Pastoral carer	19	9	S	M	3	Asia
Marcus	1943	Administrator	18.5	9	S	M	3	Asia
Hilary	1961	Pastoral carer	10	16	S	S	0	Africa

There were 15 participants who undertook the main study for the Survey and the Interview.

Their pseudonyms and characteristics are listed in Table A15.2.

Table A15.2: *Demographic Information for the Study Participants*

<b>Participants' Pseudonyms</b>	<b>Year of birth</b>	<b>Main role in last posting</b>	<b>Total years as missionary</b>	<b>Months since this re-entry at interview</b>	<b>Re-entry Long (L) or Short (S) Term</b>	<b>Marital Status</b>	<b>No. of children</b>
Neil	1957	Doctor in medical administration	12	8	L	Married	3
Jenny	1966	Social worker	12	7	L	Married	3
Alan	1943	Houseparent	15	4	L	Married	3
Pam	1948	Houseparent	15	4	L	Married	3
Joan	1957	Administration	13	8	S	Widowed	3
Chas	1957	Administration	15	9	L	Married	3
Greta	1960	Administration	15	9	L	Married	3
Sam	1976	Administration	2	6	L	Married	0
Trudy	1976	Teacher	2	6	L	Married	0
Felicity	1946	Teacher	3	11	L	Married	2
Carrie	1967	Nurse	4	10	S	Single	0
Lily	1966	Language study/cultural training	2	7	L	Single	0
Grant	1973	Teacher	6	3	S	Married	1
Bernie	1956	Administration	15	7	L	Married	4
Helen	1968	Doctor	5	4	L	Married	4

## APPENDIX 16: ANALYSIS, RESULTS AND DISCUSSION OF THE QUANTITATIVE DATA FOR ALL PARTICIPANTS

### 16.1 Introduction

This appendix describes the results of the quantitative data in this study for all participants including data from the survey and the interviews. The survey, the less dominant method used in this study, consisted of three instruments of which two, the Re-entry Grief Diagnostic Instrument (RGDI) measuring loss and grief and the DASS 21 assessment measuring depression, anxiety and stress, have collected quantitative data. Quantitative data describing loss categories and disenfranchised grief were also collated from the interviews. This appendix will discuss the results of the loss assessments of the RGDI (section A) and the interviews; the grief measure of the grief measure (section B) of the RGDI and the disenfranchised grief measures from the interviews; and mental health indices measured by the DASS 21 assessment. A brief outline of these results is also discussed in Appendix 14 which contains an article (Selby et al., 2007). Further quantitative analysis and discussion including the limitations of the survey is described in Appendix 17. The development and analysis of the RGDI, the interview and the DASS 21 are described in Chapter 4.

### 16.2 Loss Assessment Results: Survey – RGDI (Section A) and Interview

Fifteen missionaries satisfied the inclusion criteria and completed surveys and interviews in line with the Sequential Transformative Strategy described in Chapter 3.

Results for the loss assessments will be presented consecutively for the RGDI (section A) and the interview for all participants.

### *16.2.1 The incidence of loss*

The loss assessments for both the RGDI and the interview have shown that all participants experienced multiple losses. For all 15 participants, the loss review (section A) of the RGDI identified 91 losses while the interview identified 114 losses (Table A16.1).

### *16.2.2 Multiples of loss categories*

All 15 participants indicated loss in three or more loss categories for the loss review (section A) of the RGDI and in four or more categories for the interview (Table A16.1).



Table A16.1. *Numbers of loss categories endorsed in the loss review (section A) of the RGDI and interview (N=15; adapted from [Clark, 2003])*

NOTE:

This table is included on page 319 of the print copy of the thesis held in the University of Adelaide Library.

### 16.2.3 Frequencies of loss categories

The frequencies of each loss category are shown in Table A16.2. The highest rates of endorsement for all participants for the loss review (section A) of the RGDI were for the re-entry loss category of *host culture* and the general loss categories of *job and opportunity*. The highest rates of endorsement for all participants for the interview was in the general loss categories of *separation/death* and *opportunity* and in the re-entry loss categories of *host culture* and *other losses*. Categories which were more highly endorsed by the interview than by the loss review (section A) of the RGDI were the general loss category of *separation/death* and the re-entry loss category of *other losses*.

Table A16.2. *Frequencies of Loss Categories for the Loss Review (Section A) of the RGDI and Interview (N=15)*

Loss category (type)		Frequencies (N=15)	
		RGDI (Section A)	Interview
General losses	Fear death	2	1
	Separation/ death	4	15
	Pet	6	3
	Freedom	2	2
	Job	9	9
	Opportunity	9	11
	Finance/ property	4	3
	Life quality	5	9
	Integrity	0	1
	Adopt/foster	0	0
	Pregnancy	3	3
Re-entry losses	Assignment outcome	4	3
	Field closure	3	2
	Family cohesion	4	3
	Role	7	7
	Home culture	4	7
	Host culture	13	12
	Identity	6	10
	Spiritual beliefs	2	2
Other losses	4	11	
Total number of losses		91	114

#### 16.2.4 Validity

The convergent validity (Armstrong et al., 1990) of the loss review (section A) of the RGDI has been checked to discover if there is a significant relationship between the loss review score and grief score. This is different between the loss review (section A) of the RGDI and the interview. What I have found is that there is a statistically significant relationship between the scores for the loss review (section A) of the RGDI and scores for the grief measure (section B) of the RGDI ( $p=0.003$ ). I also found higher loss scores in the interview compared to the RGDI (section 16.2.1), however loss scores increase at the same rate between the two groups (Graph A16.1). There is, however, a lot of variability as indicated by the low correlations (Correlation coefficient for the loss review (section A) of the RGDI v grief measure (section B) of the RGDI= 0.54; Correlation coefficient for loss review of the interview v grief measure (section B) of the RGDI = 0.49).

#### 16.3 Grief Assessment Results: Survey – RGDI (Section B) and Interview

Grief scores were measured in the grief measure (section B) of the RGDI and the number of participants suffering from disenfranchised grief in the interviews was counted. The difference between the loss assessment categories in the loss review (section A) of the RGDI and the interviews also indicated there was significant disenfranchised grief (Table A16.2; Clark, S. , 2003).

*16.3.1 Grief score analysis: survey – RGDI (section B)*

Grief scores were obtained from the grief measure (section B) of the RGDI of the survey. Descriptive statistics for the participants’ re-entry grief scores for the grief measure (section B) of the RGDI are presented in Table A16.3. The maximum possible grief score was 48 (section 4.3.1).

Table A16.3: *Descriptive Statistics for the Grief Measure (Section B) of the RGDI (N=15)*

Participants	RGDI Grief Score (section B)						
	N	Minimum	P25	Median	Mean	P75	Maximum
Total	15	6.00	8.00	12.00	15.13	20.00	32.00

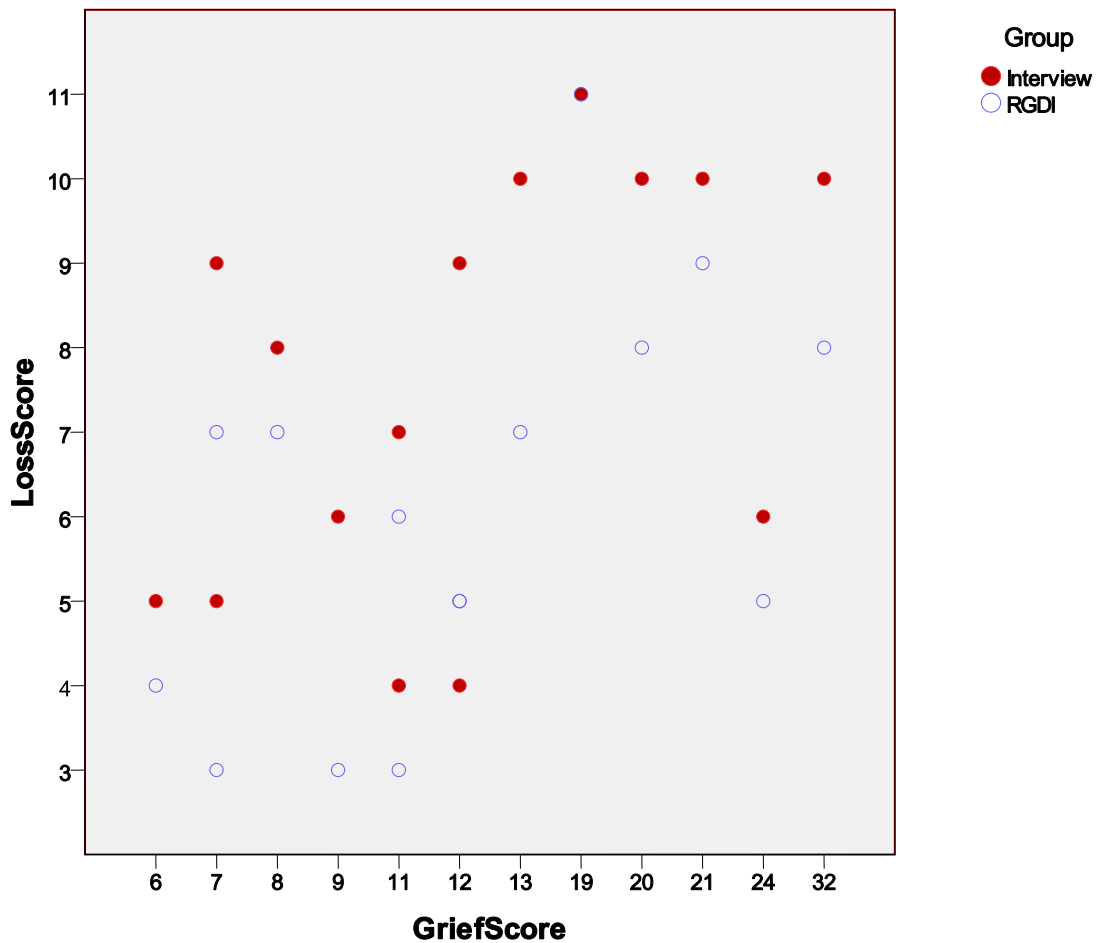
All participants had mild, moderate or severe grief (section 4.3.1). Ten had mild grief scores, three had moderate grief scores and two had severe grief scores (Table A16.4).

Table A16.4. *Frequencies of RGDI (Section B) Grief Scores (N=15)*

<b>Clinical score category</b>	<b>Score frequency N=15</b>
No grief	0
Mild (1–17)	10
Moderate (18–22)	3
Severe (>22)	2
Total	15

The re-entry grief scores showed adequate reliability in this sample (Cronbach's alpha = 0.92) indicating a high degree of consistency.

Figure A16.1. Loss Categories from the Loss Review (Section A) of the RGDI and Interview Compared with Grief Scores (N=15)



Comparison of loss categories from the loss review (section A) of the RGDI and the loss review of the interview with grief scores from grief measure (section B) of the RGDI demonstrated a relationship between the number of loss categories and the severity of the grief. Participants with moderate or severe grief scores experienced losses in more than seven loss categories for the loss review (section A) of the RGDI and more than nine categories for the interview, except for Trudy who experienced loss in five and six categories respectively. Participants with mild grief experienced losses in four to seven categories for the loss review (section A) of the RGDI and in four to nine categories for the interview.

### 16.3.2 Measurement of disenfranchised grief: interview

All participants met the criteria for disenfranchised grief (Appendix 14). All types of disenfranchised grief were represented (Appendix 14) with over three quarters of all participants experiencing disenfranchised grief in three of the six types: unacknowledged relationships, unacknowledged losses and self-disenfranchised grief (Doka, 2002). These were the highest rated types of disenfranchised grief for this sample.

## 16.4 Mental Health Indices: Survey – DASS 21 Questionnaire

The results for all the participants showed that three participants experienced mild stress, one participant experienced moderate anxiety, one participant experienced mild depression and two participants experienced moderate depression. The same participant experienced moderate anxiety and depression (Table A16.5).

Table A16.5. *Frequency of Clinical Scores for DASS 21.*

Clinical score	Score Frequency (N=15)		
	Stress	Anxiety	Depression
Normal	12	14	12
Mild	3	0	1
Moderate	0	1	2



The descriptive statistics for participants' DASS21 surveys have been described after further analysis in section 6.3 and there was adequate reliability for this sample (Selby, Braunack-Mayer et al., 2009, p. 709).

## 16.5 Discussion

### *16.5.1 Loss assessment results and grief scores*

The descriptive statistics for the quantitative results from the survey have shown that all participants experienced loss in three or more loss categories resulting in grief. In comparison, a study by Clark (2003) found that 57% of participants from a sample of 105 general practice patients, relatives and other companions experienced loss in one or more loss categories whereas 43% did not endorse any loss category and 30% had no grief. These results suggest that the occurrence of loss and grief in re-entering missionaries is significantly higher than in the general GP patient population.

As the interview loss categories are a more reliable measure of loss categories, including the disenfranchised losses, I will now specifically refer to them. The highest rates of endorsement for all participants for the interview were for the loss categories of *separation/death and opportunity*. Austin (1986) and Foyle (2001) also emphasise the importance of loss of opportunity; however, there is little discussion in the literature about the specific losses of relationships resulting from separation on reentry. These may not be seen as losses because of their disenfranchisement (Selby et al., 2007, p. 770) and the difference between the rankings for the loss review (section A) of the RGDI and the interview for *separation/death* lends weight to this explanation. However, there may be confusion about the term *separation* and its

meaning in the questionnaire with no specific question about loss of relationships. This may also have been a cause for the difference. There is further discussion in section 6.2.

The results from the rankings of the loss categories may also be discriminatory for those at risk of psychological distress during re-entry, although the sample is too small to conclude this. For example, except for one participant (Trudy), all those with moderate or severe grief described more than seven loss categories in the loss review (section A) of the RGDI and more than nine loss categories during the interview. The outlier, Trudy, suffered severe grief; however, this was probably related to the nature of one of her losses (pregnancy) which has been identified in the literature as a cause of complicated grief (Kersting, Kroker, Steinhard, Ludorff, Wesselmann, Ohrmann et al., 2007). This indicates the importance of the nature of the loss as well as the incidence.

The loss review (section A) of the RGDI and interview have been validated by the correlation of the results with the grief score of the grief measure (section B) of the RGDI to obtain convergent validity (Armstrong et al., 1990), however, further checks for construct validity and reliability need to be performed with a larger population as indicated by the correlation scores.

A clearer explanation of the meaning of *home culture*, the culture to which the participant was returning, and *host culture*, the culture in which the participant worked, in Q16 and 17 was necessary as two participants answered the questions as if the home culture was the host culture, although it was clear from their comments on the questionnaire that this had occurred. Two participants, Jenny (moderate grief) and Carrie (mild grief) did not complete one item in the grief measure (section B) of the

RGDI. However, completion of this item in any of the Likert scale choices would not have altered their categories of grief.

### 16.5.2 *Disenfranchised grief*

All participants also met the criteria for disenfranchised grief (Appendix 14). This is consistent with Clark's findings that *migration/moving* was the most disenfranchised category in her study (2003) as re-entry is a similar transition involving cultural adaptation.

The difference between the loss category scores for the loss review (section A) of the RGDI and the interview was significant with those for the interview being higher. This emphasises the value of the interview in detecting losses and is consistent with the results from the original GDI (Clark, 2003). These findings also support the incidence of disenfranchised grief as the participants themselves were unable to acknowledge their losses in the RGDI but after questioning they identified more loss categories. This conclusion was also reached by Clark (2003). The greatest category disparity between the separation/death category of the RGDI and the interview may indicate that the participants had not previously acknowledged the loss of relationships on re-entry due to self-disenfranchisement. This disparity may also be explained by the comprehensive nature of the interview which particularly explored the participants' lost relationships in the context of disenfranchised grief and gave permission for other losses to be discussed. The participants may have also been unable to reconcile non-death losses such as separation as a loss with one of the participants (Bernie) describing this during the interview (section 6.2). Limitations of the RGDI and interview data are discussed in Appendix 17 after further analysis.

### *16.5.3 Mental health indices*

This study is the first identifiable study which has measured loss categories, grief scores and depression, anxiety and stress scores for re-entrants who have returned after long term service overseas. Chamove and Soeterik (2006) measured scores for psychological well-being and grief in re-entering students, but not specific mental health indices and loss categories. Only three participants had abnormal stress scores (all mild) and this is consistent with previous research about stress in missionaries and is more comprehensively discussed in section 6.2 (Selby, Braunack-Mayer et al., 2009, p. 715-716).

Three of the fifteen participants had depression and the two participants with moderate depression also had severe grief scores. This is consistent with the literature about the importance of identifying those with moderate or severe grief as Sanders (2005) found that a significant proportion of caregivers for those with Alzheimer's disease experienced high levels of grief which was a significant predictor of increased depressive symptoms. Chamove and Soeterik (2006) also identified a relationship between grief scores and psychological well-being for short term re-entrants, with high grief scores associated with poorer psychological well-being. It is important to remember that those with severe depression were excluded from this study and in fact some who were moderately or severely psychologically distressed may have self-selected not to participate in this study (Almeida, Kashdan, Nunes, Coelho, Albino-Teixeira, & Soares-da-Silva, 2008). This may mean that this sample is biased towards the less psychologically distressed re-entrants. Further analysis of the mental health indices is presented in section 6.3 (Selby, Braunack-Mayer et al., 2009, p. 709).

## 16.6 Conclusion

This Appendix has described the results of the quantitative data gathered from the survey and the semi-structured interviews for all the participants. The results from this study have demonstrated that all participants experienced multiple losses, grief and disenfranchised grief. Furthermore, there was a disparity in the losses detected during the interview compared to the loss review (section A) of the RGDI due to initial disenfranchisement of these losses by the participants (self-disenfranchisement) which was recognised during the interview process. This suggests that the interview is a more reliable instrument in the detection of loss during re-entry. The results are consistent with the previous literature about stress in missionaries and the links between grief and depression, however, the incidence of mental health disability in this sample may not reflect the true incidence in re-entering missionaries as the sample self-selected and the number was small.

## APPENDIX 17: RESULTS OF THE QUANTITATIVE ANALYSIS FOR RESILIENT AND FRAGILE PARTICIPANTS

### 17.1 Introduction

This appendix will describe the quantitative results for the seven fragile (Neil, Jenny, Greta, Trudy, Felicity, Lily, Grant) and eight resilient (Alan, Pam, Joan, Chas, Sam, Carrie, Bernie, Helen) participants including data from the survey and the interviews. Results have previously been reported for all participants (Appendix 16). This appendix will discuss the results of the loss assessments of the Survey: RGDI (section A) and the interviews; the grief measure of the Survey: RGDI (section B) and mental health indices measured by the DASS 21.

### 17.2 Loss Assessment Results: Survey – RGDI (Section A) and Interview

Results for the loss assessment will be presented consecutively for the RGDI (section A) and the interview for the seven fragile and eight resilient participants.

#### *17.2.1 The incidence of loss*

The loss assessment of the RGDI (section A) identified that fragile participants experienced 51 losses while the resilient participants experienced 40 losses. The interview identified the fragile participants had experienced 61 losses and the resilient participants had experienced 53 losses (Table A17.1).

### 17.2.2 Multiples of loss categories

Results for the loss assessment of the RGDI (section A) and interview indicated differences between the fragile and resilient participants. In the RGDI (section A) fragile participants indicated loss in three to eleven loss categories whereas resilient participants indicated loss in three to seven loss categories. In the interview, fragile participants indicated loss in six to eleven loss categories and resilient participants indicated loss in four to ten loss categories.

### 17.2.3 Frequencies of loss categories

The frequencies of each loss category for fragile and resilient participants are shown in Table A17.2. The highest rates of endorsement for the loss assessment for both fragile and resilient participants for the RGDI (section A) was for *host culture*. The highest rates of endorsement for loss categories for fragile participants for the interview was for *separation/death* and *identity* with the highest rates of endorsement for resilient participants for the interview being *separation/death*.

### 17.2.4 Validity

There was no significant interaction between participant (fragile or resilient) and method of data collection (RGDI or Interview)  $p=0.07$ . Therefore the two participant groups do not respond to section A of the RGDI differently. As there is no significant difference in mean scores ( $p=0.3$ ) between the fragile and resilient participants or a significant difference between the questionnaires ( $p=0.21$ ), it can be concluded that

the mean scores for both questionnaires and both participant groups are on average similar. Although not statistically significant ( $p=0.3$ ), the fragile participants did have, on average, a higher overall loss score (mean=8) compared to the resilient participants (mean=6.8).

Table A17.1. *Numbers of Loss Categories Endorsed by Fragile (F; n=7) and Resilient (R; n=8) Participants in RGDI (Section A) and the Interview*

Multiples of loss categories	RGDI (section A)				Interview			
	Participants		Losses per category		Participants		Losses per category	
	F	R	F	R	F	R	F	R
0	0	0	0	0	0	0	0	0
1	0	0	0	0	0	0	0	0
2	0	0	0	0	0	0	0	0
3	1	2	3	6	0	0	0	0
4	0	1	0	4	0	2	0	8
5	1	2	5	10	0	2	0	10
6	0	1	0	6	2	0	12	0
7	1	2	7	14	0	1	0	7
8	2	0	16	0	1	0	8	0
9	1	0	9	0	0	2	0	18
10	0	0	0	0	3	1	30	10
11	1	0	11	0	1	0	11	0
Mean	7.3	6.0			8.7	6.6		
Total number	7	8	51	40	7	8	61	53



Table A17.2. *Frequencies of Loss Categories for RGDI (Section A) and Interview for Fragile Participants (F; n=7) and Resilient Participants (R; n=8)*

Loss Categories		Frequency			
		RGDI (Section A)		Interview	
		F n=7	R n=8	F n=7	R n=8
General losses	Fear death	1	1	0	1
	Separation/ death	2	2	7	8
	Pet	2	4	1	2
	Freedom	1	1	1	1
	Job	5	4	5	4
	Opportunity	5	4	6	5
	Finance/ property	3	1	2	1
	Life quality	3	2	5	4
	Integrity	0	0	0	1
	Adopt/foster	0	0	0	0
	Pregnancy	2	1	2	1
Re-entry losses	Assignment outcome	3	1	2	1
	Field closure	2	1	1	1
	Family cohesion	3	1	2	1
	Role	3	4	4	3
	Home culture	3	1	3	4
	Host culture	6	7	5	7
	Identity	4	2	7	3
	Spiritual beliefs	2	0	2	0
	Other loss	1	3	6	5
	Total number of losses	51	40	61	53
	Mean number of losses	7.3	6.0	8.7	6.6

17.3 Grief Measure Results: Survey – (Section B) RGDI and Interview

Grief measure (section B) results of the RGDI are reported and calculation of the frequency of disenfranchised griever from the interviews is presented.

*17.3.1 Survey – grief measure (section B) of RGDI: descriptive statistics; incidence of grief; reliability and validity*

The results of the analysis of the grief scores for fragile and resilient participants are presented. *Descriptive statistics* for participants’ re-entry grief scores for the RGDI (section B) are presented in Table A17.3 for the fragile and resilient participants. Re-entry grief scores for the resilient group were significantly lower than those for the fragile group ( $p < 0.03$ ). No resilient participants responded to item 3 on the Likert scale which measures maximum distress for particular grief phenomena in the RGDI (section B) whereas fragile participants completed this response in seven of the 16 questions (Q 2, 3, 4, 7, 8, 10, 15; Table 4, section 4.3.1).

Table A17.3: *Descriptive Statistics for the RGDI Grief Score (Section B)*

Participants	RGDI Grief Score (section B)						
	n	Minimum	P25	Median	Mean	P75	Maximum
Fragile	7	8.00	9.00	20.00	19.00	24.00	32.00
Resilient	8	6.00	7.00	11.00	9.88	12.00	13.00

*The incidence of grief* for both groups is presented. For the fragile participants, two had mild grief scores, three had moderate grief scores and two had severe grief

scores. Of the two with mild grief scores both had had previous counselling for psychological distress. Of the eight resilient participants, all had mild grief scores and none had had counselling (Table A17.4). Nearly three quarters of the fragile participants had moderate or severe grief, while none of the resilient participants were in these categories of grief.

Table A17.4. *Frequencies of RGDI Grief Scores For Fragile (n=7) and Resilient (n=8) Participants*

Clinical score category	Frequency		% of all subjects		% of group	
	F	R	F	R	F	R
No grief	0	0				
Mild (1–17)	2	8	13%	53%	29%	100%
Moderate (18–22)	3	0	20%		43%	
Severe (>22)	2	0	13%		29%	
Total	7	8	46%	53%		

The re-entry grief scores showed adequate *reliability* in this sample (Cronbach’s alpha = 0.92) indicating a high degree of consistency.

### 17.3.2 *Measurement of numbers of participants with disenfranchised grief*

In the framework analysis of the semi-structured interviews, all fragile and resilient participants met the criteria for disenfranchised grief with participants in both groups experiencing disenfranchised grief in the most common types: unacknowledged relationships, unacknowledged losses and self-disenfranchised grief (Appendix 14).

All fragile and resilient participants were counted as experiencing disenfranchised grief. This is confirmed by the number of losses detected in the loss assessment of the RGDI (section A) compared to the loss assessment of the interview (Table A17.2). The participants were given permission during the interviews to describe other losses, especially lost relationships due to separation, but these losses had been disenfranchised during the completion of the loss assessment of the RGDI (section A).

#### 17.4 Mental Health Indices: Survey – DASS 21 Questionnaire

The results for the fragile participants showed that two participants experienced mild stress, one participant experienced moderate anxiety and two participants experienced moderate depression. The same participant experienced moderate anxiety and depression. The results for the resilient participants were all normal except for one participant who experienced mild depression and one participant who experienced mild stress (Table A17.5).

*Table A17.5. Frequency of Clinical Scores for DASS 21 for Fragile (n=7) and Resilient (n=8) Participants*

Clinical score	Score Frequency Fragile Participants (n=7)			Score Frequency Resilient Participants (n=8)		
	Stress	Anxiety	Depression	Stress	Anxiety	Depression
Normal	5	6	5	7	8	7
Mild	2	0	0	1	0	1
Moderate	0	1	2	0	0	0

*17.4.1 Descriptive statistics*

Descriptive statistics for participants' DASS 21 scores are presented in this Appendix (Selby, Braunack-Mayer et al., 2009, p. 709) for the fragile and resilient participants. DASS 21 scores for the resilient participants were significantly lower ( $p=0.03$ ) than those for the fragile participants.

*17.4.2 Comparison of loss categories from RGDI (section A) and interview with grief scores from RGDI (section B) and DASS 21 scores*

Mean scores have shown higher loss category scores, higher grief scores and poorer DASS 21 scores for the fragile participants compared with the resilient participants (Table A17.6).

Table A17.6. *Comparison of Mean Scores for Loss Categories, Grief, Depression, Anxiety and Stress for All, Fragile and Resilient Participants*

Participants	Mean Scores					
	Loss Categories (RGDI, section A)	Loss Categories (Interview)	Grief (RGDI, section B)	Depression (DASS 21)	Anxiety (DASS 21)	Stress (DASS 21)
Total N=15	6.1	7.6	14.1	4.9	1.9	6.5
Fragile n=7	7.3	8.6	19.0	7.1	3.4	9.3
Resilient n=8	6.0	6.6	9.9	3.0	0.5	3.0

## 17.5 Discussion

This study has identified a relationship between loss category scores, grief scores, depression, anxiety and stress scores for fragile and resilient re-entrants with fragile participants experiencing higher mean scores in all measures.

### 17.5.1 Loss assessment results and grief scores

The frequencies of the loss categories may also be discriminatory for those at risk of psychological distress during re-entry, although the sample is too small to conclude this. As the interview loss categories are a more reliable measure of loss categories, I will refer to them only during the rest of the discussion. For both fragile and resilient participants the most common loss category was *separation/death* with *identity* also being of equal frequency for the fragile group. These results add weight to the

previous re-entry literature which confirms identity as an important variable in psychological distress during re-entry for missionaries (Austin, 1986; Foyle, 1999; Lester, 2000) and to this study in particular which has demonstrated the importance of identity disparities in this chapter (Selby, Braunack-Mayer et al., 2009).

The results of the grief score of the RGDI (section B) may be discriminatory for those who are at risk of psychological distress during re-entry. Although the sample was small, it is possible that the participant's grief scores may detect those who are less resilient as nearly three quarters of the fragile re-entrants experienced moderate or severe grief. Interestingly, the other fragile participants who had mild grief had had counselling prior to the study which may have decreased their grief scores (Larson & Hoyt, 2009) and enabled their re-entry adjustment. Furthermore, no resilient participants responded to item 3 on the Likert scale measuring maximum distress for particular grief phenomena whereas fragile participants completed this response in seven of the 16 questions (Q2, 3, 4, 7, 8, 10, 15; Table 4, section 4.3.1). It is possible that these may be discriminatory questions for re-entry grief and further research needs to be undertaken to clarify this.

#### *17.5.2 Disenfranchised grief*

Both fragile and resilient participants experienced disenfranchised grief with participants from both groups experiencing disenfranchised grief in the three most highly ranked categories (Appendix 14, [Selby et al., 2007, p. 769-770]). It is interesting that there is no apparent difference between the two groups and further research is needed to clarify this.

### 17.5.3 *Mental health indices*

The descriptive statistics have also shown that fragile participants have higher grief scores and higher DASS 21 scores than the resilient participants. Chamove (2006) found that short term re-entrants who found re-entry *hard* had higher grief scores and poorer psychological well-being than those who found re-entry *easy*. This finding may also be consistent with the results of this study for long term re-entrants. Other studies such as Sanders (2005) have found that a significant proportion of caregivers for those with Alzheimer's disease experienced high levels of grief and she noted that this group was at greater risk of developing complications and further research was needed to correlate their mental health indices. My study also suggests a relationship between re-entry grief and depression with moderate or severe re-entry grief being a possible predictor for depression, however, the sample is very small. Further research is needed in this area.

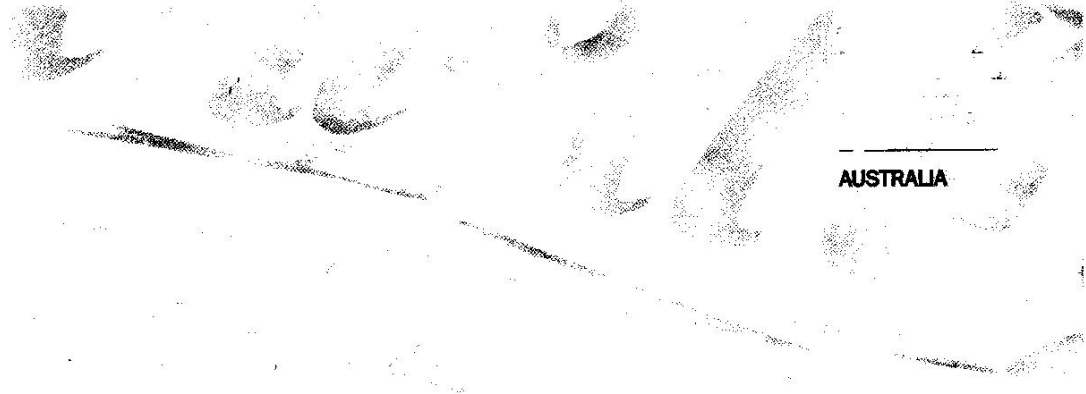
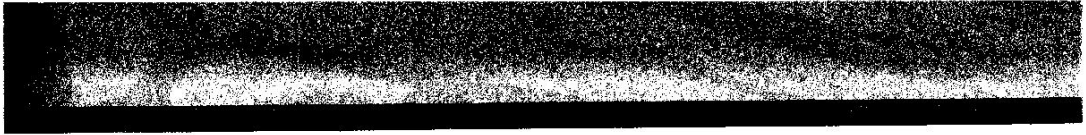
The quantitative results are consistent with the results from the qualitative analysis. The typology analysis identified two groups, the fragile and the resilient. The quantitative results have confirmed the participants' characteristics with the fragile participants having poorer mental health indices than the resilient group. The quantitative analysis has also confirmed the qualitative evidence for significant links between the participants' psychological distress and their loss and grief during re-entry, with the fragile participants having higher loss assessment scores and lower grief scores than the resilient participants. This is the first identifiable study which has linked grief scores with mental health indices, particularly for depression in long term re-entering missionary aid workers.



#### *17.5.4 Clinical uses of the survey*

Clinical uses of the RGDI in the re-entry context include exploring re-entrants' multiple losses, which is a risk factor for complicated grief (Rando, 1993), and their grief scores in order to identify individuals at risk of mental health complications and prolonged grief disorder. DASS 21 scores have also provided useful information which aids in the identification of those at risk of psychological distress. In line with the results of this study, scores from the RGDI and DASS 21 assessment appear to accurately predict those who are more likely to have less resilience during re-entry, needing careful clinical management. Serial assessment of re-entrants for their loss and grief and mental health indices during the 12 month re-entry period (Austin, 1986) may also discover those at risk of morbidity due to further concurrent losses which are not identified during their initial assessment. Re-entering missionaries with high scores in the loss categories for the RGDI may need to be interviewed to detect other loss categories and explore their disenfranchised grief.

APPENDIX 18: PERMISSION FROM MISSION AGENCIES TO CONDUCT  
RESEARCH (DE-IDENTIFIED)



To Whom it May Concern

I have reviewed past emails between the Administrator and Susan Selby and I am satisfied that permission was granted to interview workers. For reasons of confidentiality correspondence is restricted but this letter is available for inclusion in Susan Selby's thesis rather than the emails themselves.

Yours faithfully,

Chairman  
1 February 2007

INBOX Empty Trash Compose Folders Quizzes Search Problems Feedback Address Book Account Manager Log

Mail for Susan Selby <susan.selby@adelaide.edu.au>

Quota: 7730K / 50000K (15.46%)

INBOX: Research Project (248 of 248) Move | Copy This message to Delete | Reply | Reply to All | Forward | Blacklist | Message Source | Save as | Print | Report as Back to INBOX Spam

Date: Tue, 20 Jul 2004 15:26:57 +1000

From: [Redacted]

To: susan.selby@adelaide.edu.au

Cc: [Redacted]

Subject: Research Project

2 unnamed text/html 1.71 KB

Dear Susan,

I found your request, etc., waiting for me when I returned after my break away and am sending the appropriate email. I appreciate the courtesy of your approach to me before talking to any of our personnel.

We would be happy for you to interview others in a similar position if they are also are happy. In such a case we do not need anything other than what you have already sent me, do we? I suggest that we send an email to other returning missionaries as appropriate. If agreeable to the idea they would then contact you and take it from there. If we did this when would be the latest people could contact you given your deadlines?

Blessings on your research.

Australian Leadership Team

Delete | Reply | Reply to All | Forward | Blacklist | Message Source | Save as | Print | Report as Back to INBOX Spam

Move | Copy This message to

National Centre

ADVICE 009 25 953

Dr. Susan Selby

0065

28 March 2003

Dear Dr Selby

Thank you for your letter of 12 February 2003 requesting permission to submit questionnaires to certain of our members to be followed up by some interviews.

I have asked that Rick & Viv, as Directors of our Member Care Department, cooperate with you in this, as we consider the topic important and promising of results which will be of interest to all agencies involved in cross-cultural mission. Would you please relate to Rick & Viv in regard to the specific requirements of your research.

We trust this will be a rewarding project and look forward to receiving its conclusions.

Yours faithfully in Christ

Executive Director

**AUSTRALIA**

Dr Susan Selby,  
Discipline of General Practice,  
The University of Adelaide.

30/1/2008

Dear Susan,

It appears there has been a missing formal letter about the approval of  
for you to interview selected missionaries for your thesis.

This letter is to confirm that you had approval to proceed with interviews of  
missionaries for your thesis: *The Development of a Repatriation Program to Deal  
with Issues of Grief and Loss in Adult Australian Cross-Cultural Workers.*

The approval dated back to December 2003 with interviews to be conducted up  
to March 2005.

I understand that approval was given by the University of Adelaide's Ethics  
Committee on 19<sup>th</sup> November 2003.

Yours Sincerely,

APPENDIX 19: ARTICLE: SELBY, S., JONES, A., CLARK, S., BURGESS, T., &  
BEILBY, J. (2005). RE-ENTRY ADJUSTMENT OF CROSS CULTURAL  
WORKERS – THE ROLE OF THE GP. *AUSTRALIAN FAMILY PHYSICIAN*, 34,  
863–864, 878.

Selby, S., Jones, A., Clark, S., Burgess, T. and Beilby, J. (2005) Re-entry adjustment of cross cultural workers – the role of the GP.  
*Australian Family Physician*, v. 34 (10), pp. 863-865, October 2005

NOTE: This publication is included in the print copy of the thesis held in the University of Adelaide Library.

## APPENDIX 20: LIST OF GRIEF PHENOMENA

From the literature (Clark, 2001)

Unreality:

- Shock
- Disbelief
- Horror and Fantasies
- Fear

Survival:

- Why?
- Rejection
- A wasted life
- Anger
- Mood swings
- Guilt
- Unfinished business
- Shame
- Crisis of values
- Blame from others
- Isolation
- Loss of trust
- Legacy of the past
- Sense of loss
- Suicidal thoughts



- Daily tasks

Reorganisation:

- Quest for the positives
- Creating a new life
- New relationship with the deceased
- Finding meaning from the loss
- Rebuilding self
- Creating purpose

From the data:

- Mental fatigue
- Sadness
- Regret
- Relief
- Powerlessness
- Yearning

APPENDIX 21: CONFIRMATION OF UPCOMING PRINT PUBLICATION:  
SELBY, S., BRAUNACK-MAYER, A., JONES, A., CLARK, S., MOULDING, N.,  
& BEILBY, J. (2010). SPECIAL PEOPLE? AN EXPLORATORY STUDY INTO  
RE-ENTERING MISSIONARIES' IDENTITY AND RESILIENCE. *JOURNAL OF  
RELIGION AND HEALTH*, FEBRUARY 24, DOI: 10.1007/S10943-010-9337-8

Date: Tue, 21 Sep 2010 15:34:36 -0400  
From: "Ellis, Benjamin, Springer US" <Benjamin.Ellis@springer.com>  
To: susan.selby@adelaide.edu.au  
Cc: "Triner, Annette, Springer US" <Annette.Triner@springer.com>  
Subject: RE: Re: Article publication

Hi Susan,

Your article was posted online February 24th. You can view the article on  
Springerlink at the following URL:

<http://www.springerlink.com/content/deidentified/>

We do not yet have your article slated for a particular issue, but I would estimate  
that it will appear in print late 2011.

Please feel free to contact me if you have any further questions.

Best regards,

Ben

Benjamin Ellis

Production Editor

Springer Science & Business Media

233 Spring ST, Floor 5

New York, NY 10013

APPENDIX 22: CONFIRMATION OF ACCEPTANCE FOR PUBLICATION:  
SELBY, S., CLARK, S., BRAUNACK-MAYER, A., JONES, A., MOULDING, N.,  
& BEILBY, J. (IN PRESS, 2011). CROSS-CULTURAL RE-ENTRY FOR  
MISSIONARIES: A NEW APPLICATION FOR THE DUAL PROCESS MODEL.

*OMEGA*, 62, 329–351.

# OMEGA

## JOURNAL OF DEATH AND DYING

An Official Journal of the Association for Death Education and Counseling

**Kenneth J. Doka, Ph.D., Editor**  
Graduate School  
The College of New Rochelle  
New Rochelle, NY 10805-2308  
Tel: (914) 654-5418  
Fax: (914) 463-3132  
E-mail: KnDok@aol.com

August 7, 2010

Susan Selby  
The University of Adelaide  
Faculty of Health Sciences  
Level 3  
Eleanor Herrald Building  
Frome Road  
Adelaide, SA 5005  
Australia

Dear Ms. Selby:

I am pleased to inform you that your article "Cross-cultural re-entry for missionaries: A new application of the Dual Process Model" has been accepted for publication in *Omega: Journal of Death and Dying* pending revisions.

I have enclosed copies of the reviewer's comments. They may assist you as you prepare your final manuscript. As you can see these revisions simply clarify an excellent paper.

Please return a final manuscript in hard copy and disk as well as a signed copyright form. Please feel free to contact me for further assistance.

Warmly,

Kenneth J. Doka, Ph.D.  
Editor



Baywood Publishing Company, Inc.

## REFERENCES

- Abu Baker, K. (1999). Acculturation and reacculturation influence: Multilayer contexts in therapy. *Clinical Psychology Review, 19*(8), 951-967.
- Adler, N. J. (1981). Re-Entry: Managing cross-cultural transitions. *Group & Organization Studies, 6*, 341-356.
- Adler, P. S. (1972). Culture shock and the cross-cultural learning experience. In D. S. Hoopes (Ed.), *Readings in intercultural communication* (Vol. 2, pp. 6-21). Pittsburgh, PA: Regional Council for International Education.
- Adler, P. S. (1975). The transitional experience: An alternative view of culture shock. *Journal of Humanistic Psychology, 15*(4), 13-23.
- Almeida, L., Kashdan, T. B., Nunes, T., Coelho, R., Albino-Teixeira, A., & Soares-da-Silva, P. (2008). Who volunteers for phase I clinical trials? Influences of anxiety, social anxiety and depressive symptoms on self-selection and the reporting of adverse events. *European Journal of Clinical Pharmacology, 64*, 575-582.
- American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th., text rev. ed.). Washington, DC: Author
- Annandale, E. (1998). *The sociology of health and medicine: A critical introduction*. Cambridge, UK: Polity Press.
- Ano, G. G., & Vasconcelles, E. B. (2005). Religious coping and psychological adjustment to stress: A meta-analysis. *Journal of Clinical Psychology, 61*(4), 461-480.
- Antonovsky, A. (1996). The salutogenic model as a theory to guide health promotion. *Health Promotion International, 11*(1), 11-18.

- Armstrong, D., Calnan, M., & Grace, J. (1990). *Research methods for General Practitioners*. Oxford, UK: Oxford University Press.
- Armstrong, D., & Grace, J. (2000). *Research methods and audit for General Practice* (3rd ed.). Oxford, UK: Oxford University Press.
- Austin, C. (1986). Reentry stress: The pain of coming home. In C. Austin (Ed.), *Cross-Cultural reentry: A book of readings* (pp. 123-131). Abilene, TX: Abilene Christian University.
- Austin, C. (Ed.). (1986). *Cross-cultural reentry: A book of readings*. Abilene, TX: Abilene Christian University.
- Australian Bureau of Statistics. (2001). Census Dictionary. Retrieved June 11, 2004, from [www.abs.gov.au/Ausstats/abs@.nsf/66f306f503e529a5ca25697e0017661f/5d885de7659d4c8cca256a3800008ef3!OpenDocument](http://www.abs.gov.au/Ausstats/abs@.nsf/66f306f503e529a5ca25697e0017661f/5d885de7659d4c8cca256a3800008ef3!OpenDocument)
- Australian Council for International Development. (2007). ACFID Directory. Retrieved September 24, 2007, from <http://www.acfid.asn.au>
- Bagley, R. W. (2003). Trauma and traumatic stress among missionaries. *Journal of Psychology & Theology*, 31(2), 97-112.
- Barbour, R. S. (2001). Checklists for improving rigour in qualitative research: A case of the tail wagging the dog? *British Medical Journal*, 322(7294), 1115-1117.
- Barbulescu, R., & Ibarra, H. (2008). Identity as narrative: Overcoming identity gaps during work role transitions. *INSEAD Working Papers Collection*(27), 1-39.
- Barg, F. K., Huss-Ashmore, R., Wittink, M. N., Murray, G. F., Bogner, H. R., & Gallo, J. J. (2006). A mixed-methods approach to understanding loneliness and depression in older adults. *Journal of Gerontology: Social Sciences*, 61(6), S329-339.

- Barnett, K. L., Duvall, N. S., Edwards, K. J., & Hall, M. E. (2005). Psychological and spiritual predictors of domains of functioning and effectiveness of short-term missionaries. *Journal of Psychology & Theology*, 33(1), 27-40.
- Beauchamp, T. (2008, January 2). The principle of beneficence in applied ethics. In *Stanford Encyclopedia of Philosophy*. Retrieved December 2, 2010, from <http://plato.stanford.edu/entries/principle-beneficence/>
- Bennett, I., Switzer, J., Aguirre, A., Evans, K., & Barg, F. (2006). 'Breaking it down': Patient-clinician communication and prenatal care among African American women of low and higher literacy. *Annals of Family Medicine*, 4(4), 334-340.
- Bennett, M. J. (1986). Towards ethnorelativism: A developmental model of intercultural sensitivity. In R. M. Paige (Ed.), *Cross-cultural orientation: New conceptualizations and applications* (pp. 27-70). New York: University Press of America.
- Bennett, M. J. (1993). Towards ethnorelativism: A developmental model of intercultural sensitivity. In R. M. Paige (Ed.), *Education for the intercultural experience* (pp. 21-71). Yarmouth, ME: Intercultural Press.
- Berglund, C. (2001). Ethics as part of research. In C. Berglund (Ed.), *Health Research* (pp. 214-228). Melbourne, Australia: Oxford University Press.
- Berry, J. W. (1999). Intercultural relations in plural societies. *Canadian Psychology*, 40(1), 12-21.
- Berry, J. W., Kim, U., Minde, T., & Mok, D. (1987). Comparative studies of acculturative stress. *International Migration Review*, 21(3), 491-511.
- Berry, J. W., Poortinga, Y. H., Segall, M. H., & Dasen, P. R. (1992). *Cross-cultural psychology: Research and applications*. Cambridge, UK: Cambridge University Press.

- Billig, M. (2002). Henri Tajfel's 'cognitive aspects of prejudice' and the psychology of bigotry. *British Journal of Social Psychology*, *41*(2), 171-188.
- Black, J. S., & Gregersen, H. B. (1991). When Yankee comes home: Factors related to expatriate and spouse repatriation adjustment. *Journal of International Business Studies*, *22*(4), 671-694.
- Black, J. S., Gregersen, H. B., & Mendenhall, M. E. (1992). Toward a theoretical framework of repatriation adjustment. *Journal of International Business Studies*, *23*(4), 737-760.
- Bloecher, D. (2005). Good agency practices: Lessons from ReMAP II. *Evangelical Missions Quarterly* (April).
- Bochner, S., Lin, A., & McLeod, B. M. (1979). Cross-cultural contact and the development of an international perspective. *Journal of Social Psychology*, *107*(1), 29-41.
- Boelen, P. A., & Prigerson, H. G. (2007). The influence of symptoms of prolonged grief disorder, depression, and anxiety on quality of life among bereaved adults: A prospective study. *European Archives of Psychiatry and Clinical Neuroscience*, *257*(8), 444-452.
- Bonanno, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist*, *59*(1), 20-28.
- Bonanno, G. A., Wortman, C. B., Lehman, D. R., Tweed, R. G., Haring, M., Sonnega, J., et al. (2002). Resilience to loss and chronic grief: A prospective study from preloss to 18-months postloss. *Journal of Personality & Social Psychology*, *83*(5), 1150-1164.



- Bond. (2008). What is BOND? Retrieved February 29, 2008, from <http://www.bond.org.uk>
- Booth, B., Portelli, R., & Snowdon, T. A. (2005). *A quality framework for Australian general practice*. Melbourne: The Royal Australian College of General Practitioners.
- Booth, B., & Snowdon, T. (2007). A quality framework for Australian general practice. *Australian Family Physician*, 36(1-2), 8-11.
- Borkan, J. M. (2004). Mixed methods studies: A foundation for primary care research. *Annals of Family Medicine*, 2(1), 4-6.
- Borrell-Carrio, F., Suchman, A. L., & Epstein, R. M. (2004). The biopsychosocial model 25 years later: Principles, practice, and scientific inquiry. *Annals of Family Medicine*, 2(6), 576-582.
- Bowling, A. (2002). *Research methods in health* (2nd ed.). Buckingham, UK: Open University Press.
- Brabant, S., Eddie Palmer, C., & Gramling, R. (1990). Returning home: An empirical investigation of cross-cultural reentry. *International Journal of Intercultural Relations*, 14(4), 387-404.
- Braunack-Mayer, A. J. (2002). The ethics of participating in research. Simple statements of risks and benefits may not reveal the complexity of human responses to research participation. *Medical Journal of Australia*, 177(9), 471-472.
- Brislin, R. W., & Van Buren IV, H. (1986). Can they go home again? In C. A. Austin (Ed.), *Cross-Cultural Reentry: A Book of Readings* (pp. 219-230). Abilene, TX: Abilene Christian University.

- Bruce, E. J., & Schultz, C. L. (2001). *Nonfinite loss and grief: A psychoeducational approach*. Baltimore: Paul H. Brookes.
- Bryman, A. (2007). Barriers to integrating quantitative and qualitative research. *Journal of Mixed Methods Research, 1*(1), 8-22.
- Bueno, J. (2009). What is IPT? *Therapy Today, 20*(3), 19-21.
- Burkhart, L., & Solari-Twadell, A. (2001). Spirituality and religiousness: Differentiating the diagnoses through a review of the nursing literature. *Nursing Diagnosis, 12*(2), 45-55.
- Burnett, P., Middleton, W., Raphael, B., & Dunne, M. (1994). Concepts of normal bereavement. *Journal of Traumatic Stress, 7*(1), 123-128.
- Burnett, P., Middleton, W., Raphael, B., & Martinek, N. (1997). Measuring core bereavement phenomena. *Psychological Medicine: A Journal of Research in Psychiatry and the Allied Sciences, 27*(1), 49-57.
- Cambridge University Press. (2010). Cambridge Dictionaries Online. Retrieved September 22, 2010, from <http://dictionary.cambridge.org/>
- Caplan, G. (1990). Loss, stress, and mental health. *Community Mental Health Journal, 26*(1), 27-48.
- Capricornia Division of General Practice Ltd. (2007). Mental Health Screening Tools. Retrieved September 30, 2010, from [http://www.capdivgp.com/page/Programs/Mental\\_Health/Mental\\_Health\\_Screening\\_Tools](http://www.capdivgp.com/page/Programs/Mental_Health/Mental_Health_Screening_Tools)
- Caracelli, V. J., & Greene, J. C. (1993). Data analysis strategies for mixed-method evaluation designs. *Educational Evaluation & Policy Analysis, 15*(2), 195-207.

- Cartwright, A. (1988). Interviews or postal questionnaires? Comparisons of data about women's experiences with maternity services. *The Millbank Quarterly*, 66(1), 172-179.
- Catchlove, B. J. (2001). GP corporatisation: The why and the wherefore. *The Medical Journal of Australia*, 175(2), 68-70.
- Chamove, A. S., & Soeterik, S. M. (2006). Grief in returning sojourners. *Journal of Social Science*, 13(3), 215-220.
- Chen, G. M. (1997, January). *A review of the concept of intercultural sensitivity*. Paper presented at the 1997 Biennial Convention of the Pacific and Asian Communication Association, Honolulu, HI. Retrieved October 28, 2010, from <http://www.eric.edu.gov/PDFS/ED408634.pdf>
- Chew, M. (2005). What GPs want: Time and time again. *Medical Journal of Australia*, 183(2), 58-59.
- Chun Bun, L., & McBride-Chang, C. A. (2007). Resilience in young adulthood: The moderating influences of gender-related personality traits and coping flexibility. *Sex Roles*, 56(3/4), 159-172.
- Clara, I. P., Cox, B. J., & Enns, M. W. (2001). Confirmatory factor analysis of the Depression-Anxiety-Stress Scales in depressed and anxious patients. *Journal of Psychopathology and Behavioural Assessment*, 23(1), 61-67.
- Clark, S. (2001). Mapping grief: An active approach to grief resolution. *Death Studies*, 25(6), 531-548.
- Clark, S. (2003). *Loss and grief in general practice: The development and evaluation of two instruments to detect and measure grief in general practice patients*. Unpublished doctoral dissertation, The University of Adelaide--Adelaide.

- Clark, S., Marley, J., Hiller, J. E., Leahy, C., & Pratt, N. (2005). A grief diagnostic instrument for general practice. *Omega*, *52*(2), 169-195.
- Cohen, D. A. (1996). An empirical study of college students' grief responses: Death vs. non-death losses (Doctoral dissertation, Syracuse University, 1996). *Dissertation Abstracts International*, *58*, 94.
- Cohen, D. J., & Crabtree, B. F. (2008). Evaluative criteria for qualitative research in health care: Controversies and recommendations. *Annals of Family Medicine*, *6*(4), 331-339.
- Conway, S. (2007). The changing face of death: Implications for public health. *Critical Public Health*, *17*(3), 195-202.
- Corr, C. (1999). Enhancing the concept of disenfranchised grief. *Omega*, *38*(1), 1-20.
- Coschignano, D. (2000). Crossing borders: A descriptive analysis of the re-entry experiences of twenty adult United States citizens from Hawaii, Colorado, and California (Doctoral dissertation, Saybrook Graduate School, 2000). *Dissertation Abstracts International*, *62*, 5428.
- Council for International Organizations of Medical Sciences. (1999). International ethical guidelines for biomedical research involving human subjects. Retrieved October 2, 2010, from <http://www.codex.uu.se/texts/international.html>
- Cox, J. B. (2001). The impact of information and communication technology on cultural reentry adjustment (Doctoral dissertation, Texas A&M University, 2001). *Dissertation Abstracts International*, *62*, 1493.
- Cox, J. B. (2004). The role of communication, technology, and cultural identity in repatriation adjustment. *International Journal of Intercultural Relations*, *28*(3), 201-219.

- Crabtree, B. F., & Miller, W. L. (1992). *Doing qualitative research*. Newberry Park, CA: Sage.
- Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (2nd ed.). London: Sage.
- Crotty, M. (1998). Introduction: The research process. In *The foundations of social research: Meaning and perspective in the research process* (pp. 1-17). Crows Nest, Australia: Allen & Unwin.
- Cutcliffe, J. R., & McKenna, H. P. (2004). Expert qualitative researchers and the use of audit trails. *Journal of Advanced Nursing*, 45(2), 126-133.
- Daley, B. J. (2004). *Using concept maps in qualitative research*. Paper presented at the First International Conference on Concept Mapping, Pamplona, Spain.
- Denzin, N. K. (1978). *The research act: A theoretical introduction to sociological methods* (2nd ed.). New York: McGraw-Hill.
- Dogstar. (2008). InterHealth. Retrieved January 26, 2010, from <http://www.interhealth.org.uk>
- Doka, K. J. (1989). Disenfranchised grief. In K. J. Doka (Ed.), *Disenfranchised grief: Recognizing hidden sorrow* (1st ed., pp. 3-11). Lexington, MA: Lexington Books.
- Doka, K. J. (2002). *Disenfranchised grief: New directions, challenges and strategies for practice*. Champaign, IL: Research Press.
- Donovan, K. (1991). Beauty for ashes -- Redeeming premature field departure [Electronic Version]. *Evangelical Missions Quarterly*. Retrieved September 22, 2004 from <http://www.emisdirect.com/emq/issue-132/516>.
- Donovan, K. (2002). *Growing through stress*. Berrien Springs, MI: Institute of World Mission, Andrews University.

- Doyle, L., Brady, A., & Byrne, G. (2009). An overview of mixed methods research. *Journal of Research in Nursing, 14*(2), 175-185.
- Doyle, M. E., & Peterson, K. A. (2005). Re-entry and reintegration: Returning home after combat. *Psychiatric Quarterly, 76*(4), 361-370.
- Duke University Libraries. (2008). NGO Research Guide. Retrieved June 6, 2008, from [http://library.duke.edu/research/subject/guides/ngo\\_guide/ngo\\_links/development.html](http://library.duke.edu/research/subject/guides/ngo_guide/ngo_links/development.html)
- Durà-Vila, G., & Dein, S. (2009). The dark night of the soul: Spiritual distress and its psychiatric implications. *Mental Health, Religion & Culture, 12*(6), 543-559.
- Earvolino-Ramirez, M. (2007). Resilience: A concept analysis. *Nursing Forum, 42*(2), 73-82.
- Emery, O. B., & Breslau, L. D. (1989). Language deficits in depression: Comparisons with SDAT and normal aging. *Journal of Gerontology, 44*(3), M85-92.
- Encarta® World English Dictionary [North American Edition] ©, & (P) 2009 Microsoft Corporation. (2009). Dictionary. Retrieved August 14, 2010, from <http://encarta.msn.com/encnet/features/dictionary/DictionaryResults.aspx?lextype=3&search=missionary>
- Espineli-Chin, L. (2000). *Think home. A practical guide for Christian internationals preparing to return home*. Colorado Springs, CO: International Students.
- Faizullaev, A. (2006). Diplomacy and self. *Diplomacy & Statecraft, 17*(3), 497-522.
- Farley, Y. R. (2007). Making the connection: Spirituality, trauma and resiliency. *Journal of Religion & Spirituality in Social Work, 26*(1), 1-15.
- Fielding, N., & Thomas, H. (2001). Qualitative interviewing. In N. Gilbert (Ed.), *Researching Social Life* (2nd ed., pp. 123-144). Thousand Oaks, CA: Sage.

- Fowke, R. (1994). Psychological aspects of returning home after work overseas in caring for expatriates and workers abroad. In R. H. Behrens & W. Riley (Eds.), *Caring for expatriates and workers abroad* (pp. 16-18). London: British Postgraduate Medical Foundation.
- Foyle, M. F. (1999). *Expatriate mental health*. Unpublished doctoral dissertation, University of London--London.
- Foyle, M. F. (2001). *Honourably wounded. Stress among Christian workers*. London: Monarch Books.
- Fruity Solutions. (2010). PEOPLEINAID. Retrieved August 14, 2010, from <http://www.peopleinaid.org>
- Furler, J., Naccarella, L., James, C., MacDonald, J., & Hill, G. (2005). RACGP health inequalities project report 2005. Retrieved November 22, 2006, from <http://www.racgp.org.au/Content/NavigationMenu/Advocacy/IssuesinGeneralPractice/Healthinequalities/inequalities.htm>
- Gardner, L. M. (1987). A practical approach to transitions in missionary living. *Journal of Psychology & Theology*, *15*(4), 342-349.
- Gardner, L. M. (2002). Missionary care and counselling: A brief history and challenge. In J. R. Powell & J. M. Bowers (Eds.), *Enhancing missionary vitality* (pp. 41-47). Palmer Lake, CO: Mission Training International.
- Gaw, K. F. (2000). Reverse culture shock in students returning from overseas. *International Journal of Intercultural Relations*, *24*(1), 83-104.
- Geers, A. L., & Lassiter, G. D. (2003). Need for cognition and expectations as determinants of affective experience. *Basic & Applied Social Psychology*, *25*(4), 313.

- Gelenberg, A. J., & Hopkins, H. S. (2007). Assessing and treating depression in primary care medicine. *American Journal of Medicine, 120*(2), 105-108.
- Gibbard, I., & Hanley, T. (2008). A five-year evaluation of the effectiveness of person-centred counselling in routine clinical practice in primary care. *Counselling & Psychotherapy Research, 8*(4), 215-222.
- Global Connections. (2010). The UK network for world mission. Retrieved February 18, 2010, from <http://www.globalconnections.co.uk>
- Grbich, C. (1999). *Qualitative research in health*. Crows Nest, Australia: Allen & Unwin.
- Greene, J. C., Caracelli, V. J., & Graham, W. F. (1989). Toward a conceptual framework for mixed-method evaluation designs. *Educational Evaluation & Policy Analysis, 11*(3), 255-274.
- Gregersen, H. B., & Stroh, L. K. (1997). Coming home to the arctic cold: Antecedents to Finnish expatriate and spouse repatriation adjustment. *Personnel Psychology, 50*(3), 634-654.
- Grieflink. (2010). Grief reactions associated with indigenous grief. Retrieved January 11, 2006, from [http://grieflink.org.au/?page\\_id=499&cat1=199&cat2=28&cat3=29](http://grieflink.org.au/?page_id=499&cat1=199&cat2=28&cat3=29)
- Gu, Q., & Day, C. (2007). Teachers resilience: A necessary condition for effectiveness. *Teaching & Teacher Education, 23*(8), 1302-1316.
- Gullahorn, J. T., & Gullahorn, J. E. (1963). An extension of the U-curve hypothesis. *Journal of Social Issues, 19*(3), 33-47.
- Guthrie, T., & Stickley, T. (2008). Spiritual experience and mental distress: A clergy perspective. *Mental Health, Religion & Culture, 11*(4), 387-402.



- Hall, M. E. L., & Schram, J. L. (2002). Mental health professionals in missions: An overview. In J. R. Powell & J. M. Bowers (Eds.), *Enhancing missionary vitality: Mental health professions serving global mission* (pp. 15-22). Palmer Lake, CO: Mission Training International
- Hansen, E. C. (2006). *Successful qualitative health research*. Crows Nest, Australia: Allen & Unwin.
- Harrison, C. M., & Britt, H. (2004). The rates and management of psychological problems in Australian general practice. *Australian & New Zealand Journal of Psychiatry*, 38(10), 781-788.
- Harvey, J. H. (1998). *Perspectives on loss*. London: Brunner/Mazel.
- Haslam, N. (2006). Dehumanisation: An integrative review. *Personality and Social Psychology Review*, 10(3), 252-264.
- Hassed, C. (2005). The ESSENCE of health care. *Australian Family Physician*, 34(11), 957-960.
- Headington Institute. (2009). Headinton institute care for caregivers worldwide. Retrieved August 14, 2010, from <http://www.headington-institute.org>
- Henderson, S., Andrews, G., & Hall, W. (2000). Australia's mental health: An overview of the general population survey. *Australian & New Zealand Journal of Psychiatry*, 34(2), 197-205.
- Henry, J. D., & Crawford, J. R. (2005). The short-form version of the Depression Anxiety Stress Scales (DASS-21): Construct validity and normative data in a large non-clinical sample. *British Journal of Clinical Psychology*, 44(2), 227-239.

- Hickie, I. B., Andrews, G., & Davenport, T. A. (2002). Measuring outcomes in patients with depression or anxiety: An essential part of clinical practice. *Medical Journal of Australia* 177(4), 205-207.
- Higney, A., & Calvi-Parisetti, P. (2004). *Working in international development and emergency aid*. Retrieved September 24, 2007, from [www.gignos.ch/aidworkers/INT/](http://www.gignos.ch/aidworkers/INT/).
- Hill, C. B., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology*, 52(2), 196-205.
- Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist*, 25(4), 517-572.
- Hirshon, J. M., Eng, T. R., Brunkow, K. A., & Hartzell, N. (1997). Psychological and readjustment problems associated with emergency evacuation of Peace Corps volunteers. *Journal of Travel Medicine*, 4(3), 128-131.
- Hood, L. E., Olson, J. K., & Allen, M. (2007). Learning to care for spiritual needs: Connecting spiritually. *Qualitative Health Research*, 17(9), 1198-1206.
- Horrocks, S. L. (2006). A compendium of measurement instruments assessing grief, bereavement, and loss (Doctoral Dissertation, State University of New York at Buffalo, 2006). *Dissertation Abstracts International*, 67, 846.
- Howe, K. (1985). Two dogmas of educational research. *Educational Research*, 14(8), 10-18.
- Hroscikoski, M. C., Solberg, L. I., Sperl-Hillen, J. M., Harper, P. G., McGrail, M. P., & Crabtree, B. F. (2006). Challenges of change: A qualitative study of chronic care model implementation. *Annals of Family Medicine*, 4(4), 317-326.

- Huffman, J. A. (1989). Cross-cultural reentry and the family life cycle stage: A study of the impact of the family life cycle stage on cross-cultural reentry of adult missionaries (Doctoral dissertation, University of Georgia, 1989). *Dissertation Abstracts International*, 51, 415.
- Hunter, E. C. M., Sierra, M., & David, A. S. (2004). The epidemiology of depersonalisation and derealisation: A systematic review. *Social Psychiatry & Psychiatric Epidemiology*, 39(1), 9-18.
- Hunter, S. (2005). Coming home: Heartache, hope and helpful hints. *Evangelical Missions Quarterly*, 41(April), 150-154.
- Hurn, B. J. (1999). Repatriation - the toughest assignment of all. *Industrial & Commercial Training*, 31(6), 224.
- Isa, M. (2000). Phenomenological analysis of the reentry experiences of the wives of Japanese corporate sojourners. *Women & Language*, 23(2), 26-40.
- Isogai, T. Y., Hayashi, Y., & Uno, M. (1999). Identity issues and reentry training. *International Journal of Intercultural Relations*, 23(3), 493-525.
- Jacelon, C. S. (1997). The trait and process of resilience. *Journal of Advanced Nursing*, 25(1), 123-129.
- Janis, I. L. (1958). Summary of part I: Major psychodynamic hypotheses. In *Psychological stress: Psychoanalytic and behavioral studies of surgical patients*. (pp. 195-209). Hoboken, NJ: John Wiley.
- Jensma, J. L. (1995). A pilot study examining the predictive validity of the cross-cultural adaptability inventory among first-term missionaries (Doctoral dissertation, Biola University, 1995). *Dissertation Abstracts International*, 56, 5835.

- Johnstone, P., Mandryk, J., & Johnstone, R. (2006). *Operation world* (6th ed.). Milton Keynes, UK: Authentic Media.
- Jones, E. S., & Jones, M. E. (1994). Strangers and exiles -- caring for the missionary: Part 1 & 2. *Carer and Counsellor*, 4(1), 30-37.
- Jones, M. P., Bartrop, R. W., Forcier, L., & Penny, R. (2010). The long-term impact of bereavement upon spouse health: A 10-year follow-up. *Acta Neuropsychiatrica*, 22(5), 212-217.
- Jordan, P. (1992). *Re-entry*. Seattle, WA: YWAM.
- Joynt, K. E., & O'Connor, C. M. (2005). Lessons from SADHART, ENRICHED, and other trials. *Psychosomatic Medicine*, 67(Supplement 1), S63-66.
- Jung, E., & Hecht, M. L. (2004). Elaborating the communication theory of identity: Identity gaps and communication outcomes. *Communication Quarterly*, 52(3), 265-283.
- Jung, E., & Hecht, M. L. (2008). Identity gaps and level of depression among Korean immigrants. *Health Communication*, 23(4), 313-325.
- Jung, E., Hecht, M. L., & Wadsworth, B. C. (2007). The role of identity in international students' psychological well-being in the United States: A model of depression level, identity gaps, discrimination, and acculturation. *International Journal of Intercultural Relations*, 31(5), 605-624.
- Jureidini, J., & Tonkin, A. (2006). Overuse of antidepressant drugs for the treatment of depression. *CNS Drugs*, 20(8), 623-632.
- Katzman, M. A., Hermans, K. M., Van Hoeken, D., & Hoek, H. W. (2004). Not your typical island woman: Anorexia Nervosa is reported only in subcultures in Curacao. *Culture, Medicine & Psychiatry*, 28(4), 463-492.

- Kauffman, J. (2002). The psychology of disenfranchised grief: Liberation, shame and self-disenfranchisement. In K. J. Doka (Ed.), *Disenfranchised grief: New directions, challenges, and strategies for practice* (pp. 61-77). Champaign, IL: Research Press.
- Kellehear, A. (2007). The end of death in late modernity: An emerging public health challenge. *Critical Public Health*, 17(1), 71-79.
- Kellehear, A. (2009). On dying and human suffering. *Palliative Medicine*, 23(5), 388-397.
- Kersting, A., Kroker, K., Steinhard, J., Ludorff, K., Wesselmann, U., Ohrmann, P., et al. (2007). Complicated grief after traumatic loss: A 14-month follow up study. *European Archives of Psychiatry and Clinical Neuroscience*, 257(8), 437-443.
- Kidd, M. R., & Watts, I. (2006). Primary care is the answer: The role of general practice in Australia. *Asia Pacific Family Medicine*, 5, 51-56.
- Kitto, S. C., Chesters, J., & Grbich, C. (2008). Quality in qualitative research. *Medical Journal of Australia*, 188(4), 243-246.
- Klaff, L. G. (2002). The right way to bring expats home. *Workforce*, 81(7), 40-44.
- Knell, M. (2007). *Burn-up or splash down*. Atlanta, GA: Authentic.
- Koteskey, R., & Koteskey, B. (2003). Coming "home": The reentry transition. Retrieved December 27, 2008, from <http://www.missionarycare.com/ebook.htm>
- Koteskey, R., & Koteskey, B. (2004-2008). Reentry Resources. Retrieved February 18, 2010, from <http://www.missionarycare.com/reentry.htm>
- Krause, N., & Goldenhar, L. M. (1992). Acculturation and psychological distress in three groups of elderly Hispanics. *Journals of Gerontology*, 47(6), S279-S288.

- Kroeber, A. L., & Kluckhohn, F. (1963). *Culture: A critical review of concepts and definitions*. Cambridge, MA: Harvard University Press.
- Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. Thousand Oaks, CA: Sage.
- La Brack, B. (2003). What's up with culture? Retrieved February 18, 2010, from <http://www2.pacific.edu/sis/culture/>
- LaBrack, B. (1993). The missing linkage: The process of integrating orientation and reentry. In R. M. Paige (Ed.), *Education for the Intercultural Experience* (pp. 241-280). Yarmouth, ME: Intercultural Press.
- Larivaara, P., Kiuttu, J., & Taanila, A. (2001). The patient-centred interview: The key to biopsychosocial diagnosis and treatment. *Scandinavian Journal of Primary Health Care, 19*(1), 8-13.
- Larson, D. G., & Hoyt, W. T. (2009). Grief counselling efficacy: What have we learned? *Bereavement Care, 28*(3), 14-19.
- Lay, C., & Nguyen, T. (1998). The role of acculturation-related and acculturation non-specific daily hassles: Vietnamese-Canadian students and psychological distress. *Canadian Journal of Behavioural Science, 30*(3), 172-181.
- Leahey, M., & Svavarsdottir, E. K. (2009). Implementing family nursing: How do we translate knowledge into clinical practice? *Journal of Family Nursing, 15*(4), 445-460.
- Leech, N. L., & Onwuegbuzie, A. J. (2009). A typology of mixed methods research designs. *Quality & Quantity: International Journal of Methodology, 43*(2), 265-275.

- Lester, J. C. (2000). Strangers in their own land: Culture loss, disenfranchised grief, and reentry adjustment. (Doctoral dissertation, Antioch University, 2000). *Dissertation Abstracts International*, 61, 4992.
- Ley, D., & Kobayashi, A. (2005). Back to Hong Kong: Return migration or transnational sojourn? *Global Networks*, 5(2), 111-127.
- Liberty University. (2007). Glossary of Missionary Terms. Retrieved June 27, 2007, from <http://www.liberty.edu/academics/religion/globalministry/index.cfm?PID=3601>
- Lincoln, Y. S., & Guba, E. (1985). *Naturalistic enquiry*. Beverley Hills, CA: Sage.
- Littlewood, R. (1985). Jungle madness: Some observations on expatriate psychopathology. *International Journal of Social Psychiatry*, 31(3), 194-197.
- Lofland, J., & Lofland, L. H. (1995). *Analyzing social settings: A guide to qualitative observation and analysis* (3rd ed.). Belmont, CA: Wadsworth
- Lofland, J., Snow, D. A., Anderson, L., & Lofland, L. (2006). *Analyzing social settings: A guide to qualitative observation and analysis* (4th ed.). Toronto, Canada: Thomson Wadsworth.
- Lovell-Hawker, D. (2002). Guidelines for crisis and routine debriefing. In K. O'Donnell (Ed.), *Doing Member Care Well* (pp. 457-475). Pasadena, CA: William Carey.
- Lovell-Hawker, D., & Emmens, B. (2004). Effective debriefing. *People In Aid* Retrieved January 11, 2006, from <http://www.peopleinaid.org/pool/files/publications/effective-debriefing-inote.pdf>

- Lovell-Hawker, D. M. (2008). Cultural Adaptation. In J. S. Keystone, P. E. Kozarsky, D. O. Freedman, H. D. Nothdurft & B. A. Connor (Eds.), *Travel Medicine* (2nd ed., pp. 379-385). Edinburgh, UK: Mosby.
- Lovell, D. M. (1997). *Psychological adjustment among returned overseas aid workers*. Unpublished doctoral dissertation, University of Wales--Bangor.
- Lovibond, S. H., & Lovibond, P. F. (1995). *Manual for the Depression Anxiety Stress Scales*. Sydney, Australia: The Psychology Foundation.
- Luthar, S. S., & Brown, P. J. (2007). Maximizing resilience through diverse levels of inquiry: Prevailing paradigms, possibilities, and priorities for the future. *Development & Psychopathology, 19*(3), 931-955.
- Luthar, S. S., & Cicchetti, D. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development, 71*(3), 543-563.
- Lysgaard, S. (1955). Adjustment in a foreign society: Norwegian Fulbright grantees visiting the United States. *Acta Psychologica, 11*, 189-190.
- Mabitsela, L. (2003). *Exploratory study of psychological distress as understood by Pentecostal pastors*. Unpublished doctoral dissertation, University of Pretoria--Pretoria.
- Macdonald, J. (2004). Primary health care: A global overview. *Primary Health Care Research & Development 5*(4), 284-288.
- Maron, N., & Connell, J. (2008). Back to Nukunuku: Employment, identity and return migration in Tonga. *Asia Pacific Viewpoint, 49*(2), 168-184.
- Martin, A. J., & Marsh, H. W. (2006). Academic resilience and its psychological and educational correlates: A construct validity approach. *Psychology in the Schools, 43*(3), 267-281.



- Martin, J. N. (1984). The intercultural reentry: Conceptualizations and directions for future research. *International Journal of Intercultural Relations*, 8(2), 115-134.
- Martin, J. N., & Harrell, T. (1996). Re-entry training for intercultural sojourners. In D. Landis & R. S. Bhagat (Eds.), *Handbook of intercultural training* (2nd ed., pp. 307-326). Thousand Oaks, CA: Sage.
- Martin, J. N., & Harrell, T. (2004). Intercultural reentry of students and professionals: Theory and practice. In D. Landis, J. M. Bennett & M. J. Bennett (Eds.), *Handbook of intercultural training* (pp. 309-336). Thousand Oaks, CA: Sage.
- Marwit, S. J., & Meuser, T. M. (2005). Development of a short form inventory to assess grief in caregivers of dementia patients. *Death Studies*, 29(3), 191-205.
- Maybarduk, S. M. (2008). *An exploration of factors associated with reentry adjustment of U.S. Foreign Service spouses*. Unpublished doctoral dissertation, Smith College School for Social Work--Northampton, MA.
- McKay, L. (2007). On the road again: Coping with travel and re-entry stress. Retrieved February 18, 2010, from [http://www.headington-institute.org/Portals/32/resources/English\\_Translation\\_Travel\\_Stress.pdf](http://www.headington-institute.org/Portals/32/resources/English_Translation_Travel_Stress.pdf)
- McLaren, S., & Challis, C. (2009). Resilience among men farmers: The protective roles of social support and sense of belonging in the depression-suicidal ideation relation. *Death Studies*, 33(3), 262-276.
- Miller, E., & Omarzu, J. (1998). New directions in loss research. In J. H. Harvey (Ed.), *Perspectives on loss: A sourcebook*. Philadelphia: Brunner/ Mazel.
- Minton, M. E., & Barron, C. R. (2008). Spousal bereavement assessment: A review of bereavement-specific measures. *Journal of Gerontological Nursing*, 34(8), 34-48.

- Moore, L. A., Jones, B. V., & Austin, C. N. (1987). Predictors of reverse culture shock among North American Church of Christ missionaries. *Journal of Psychology & Theology, 15*(4), 336-341.
- Moyle, W. (2002). Unstructured interviews: Challenges when participants have a major depressive illness. *Journal of Advanced Nursing, 39*(3), 266-273.
- Nakashima, M., & Canda, E. R. (2005). Positive dying and resiliency in later life: A qualitative study. *Journal of Aging Studies, 19*(1), 109-125.
- National Health and Medical Research Council. (1999). National statement on ethical conduct in research involving humans. Retrieved February 27, 2006, from <http://www.nhmrc.gov.au/publications/synopses/e35syn.htm>
- Neuman, W. L. (1997). Ethical and political issues in social research. In W. L. Neuman (Ed.), *Social research methods: Qualitative and quantitative approaches* (3rd ed., pp. 442-475). London: Allyn & Bacon.
- Newton, S., Hutchings, K., & Kabanoff, B. (2007). Repatriation in Australian organisations: Effects of function and value of international assignment on program scope. *Asia Pacific Journal of Human Resources, 45*(3), 295-313.
- Ng, F., Trauer, T., Seetal, D., Callaly, T., Campbell, S., & Berk, M. (2007). The validity of the 21-item version of the Depression Anxiety Stress Scales as a routine clinical outcome measure. *Acta Neuropsychiatrica, 19*(5), 304-310.
- Novak, J. (1984). *Learning how to learn*. Cambridge, UK: Cambridge University Press.
- Oberg, K. (1960). The cultural shock and the problems of adjustment to new cultural environments. *Sociologia, 22*(1), 71-79.

- Onwumechili, C., Nwosu, P. O., Jackson II, R. L., & James-Hughes, J. (2003). In the deep valley with mountains to climb: Exploring identity and multiple reacculturation. *International Journal of Intercultural Relations*, 27(1), 41-62.
- Palmer, A. (1999). Issues facing returning missionaries and how spiritual direction can help [Electronic Version], 2006, Research Project from [http://www.sgm.org.nz/research\\_papers.htm](http://www.sgm.org.nz/research_papers.htm).
- Pandora Web Box. (2009). Families in Global Transition. Retrieved August 14, 2010, from <http://www.figt.org>
- Parkes, C. M. (1988). Bereavement as a psychosocial transition: Processes of adaptation to change. *Journal of Social Issues*, 44(3), 53-65
- Parkes, C. M. (1998). Facing loss. *British Medical Journal*, 316(7143), 1521-1524.
- Pascoe, R. (2006). ExpatExpert. Retrieved February 18, 2010, from [http://www.expertexpert.com/rr\\_coming\\_home.re-entry\\_shock](http://www.expertexpert.com/rr_coming_home.re-entry_shock)
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). London: Sage.
- Peppiatt, R., & Byass, P. (1991). A survey of the health of British missionaries. *British Journal of General Practice*, 41(345), 159-162.
- Pirollo, N. (2000). *The Reentry Team*. San Diego, CA: Emmaus Road International.
- Pollock, D. C., & Van Reken, R. E. (2001). *Third Culture Kids: The experience of growing up among worlds*. Boston, MA: Nicholas Brealey North America.
- Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, 52(2), 126-136.
- Pope, C., Ziebland, S., & Mays, N. (2000). Qualitative research in health care. Analysing qualitative data. *British Medical Journal*, 320(7227), 114-116.

- Price, G. B. (1913). The causes of invaliding from the tropics. *British Medical Journal* 2, 1290-1293.
- Prigerson, H. G. (2008). A case for inclusion of Prolonged Grief Disorder in DSM-IV. *GriefMatters. The Australian Journal of Grief and Bereavement*, 11(1), 23-32.
- Prigerson, H. G., Horowitz, M. J., Jacobs, S. C., Parkes, C. M., Aslan, M., Goodkin, K., et al. (2009). Prolonged Grief Disorder: Psychometric validation of criteria proposed for DSM-V and ICD-11. *PLoS Medicine*, 6(8), 1-12.
- Prigerson, H. G., Maciejewski, P. K., Reynolds, C. F., III, Bierhals, A. J., Newsom, J. T., Fasiczka, A., et al. (1995). Inventory of complicated grief: A scale to measure maladaptive symptoms of loss *Psychiatry Research*, 59(1-2), 65-79.
- Psychology Foundation of Australia. (2003). Depression Anxiety Stress Scales. Retrieved January 13, 2007, from [www.psy.unsw.edu.au/dass/](http://www.psy.unsw.edu.au/dass/)
- Punnett, B. J. (1997). Towards effective management of expatriate spouses. *Journal of World Business*, 32(3), 243-257.
- QSR International Pty Ltd. (2002). NVivo, version 2. Doncaster, Victoria, Australia: QSR International Pty Ltd.
- Rabago, D., Barrett, B., Marchand, L., Maberry, R., & Mundt, M. (2006). Qualitative aspects of nasal irrigation use by patients with chronic sinus disease in a multimethod study. *Annals of Family Medicine*, 4(4), 295-301.
- RACGP. (2005). What is general practice? Retrieved October 5, 2007, from <http://www.racgp.org.au/whatisgeneralpractice>
- Rando, T. A. (1993). *Treatment of complicated mourning* (1st ed.). Champaign, IL: Research Press.

- Ray, R. A., & Street, A. F. (2007). Non-finite loss and emotional labour: Family caregivers' experiences of living with motor neurone disease. *Journal of Clinical Nursing, 16*(3A), 35-43.
- Regel, S. (2010). Psychological debriefing -- does it work? *Healthcare Counselling & Psychotherapy Journal, 10*(2), 14-18.
- Rice, P. L., & Ezzy, D. (1999). *Qualitative research methods: A health focus*. Melbourne, Australia: Oxford University Press.
- Rice, P. L., & Ezzy, D. (2005). *Qualitative research methods - a health focus* (2nd ed.). Oxford, UK: Oxford University Press.
- Ridner, S. H. (2004). Nursing theory and concept development or analysis. Psychological distress: Concept analysis. *Journal of Advanced Nursing, 45*(5), 536-545.
- Ritchie, J., & Spencer, L. (1993). Qualitative data analysis for applied policy research. In A. Bryman & R. Burgess (Eds.), *Analysing qualitative data* (pp. 173-194). London: Routledge.
- Robinaugh, D. J., & McNally, R. J. (2010). Autobiographical memory for shame or guilt provoking events: Association with psychological symptoms. *Behaviour Research and Therapy, 48*(7), 646-652.
- Rogers, J., & Ward, C. (1993). Expectation-experience discrepancies and psychological adjustment during cross-cultural reentry. *International Journal of Intercultural Relations, 17*(2), 185-196.
- Rohrlich, B. F., & Martin, J. N. (1991). Host country and reentry adjustment of student sojourners. *International Journal of Intercultural Relations, 15*(2), 163-182.

- Rudmin, F. (2009). Constructs, measurements and models of acculturation and acculturative stress. *International Journal of Intercultural Relations*, 33(2), 106-123.
- Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, 55(1), 68.
- Sackett, D. L., & Rosenberg, W. M. C. (1996). Evidence based medicine: What it is and what it isn't. *British Medical Journal*, 312(7023), 71-72.
- Sánchez Vidal, M. E., Sanz Valle, R., Barba Aragón, M. I., & Brewster, C. (2007). Repatriation adjustment process of business employees: Evidence from Spanish workers. *International Journal of Intercultural Relations*, 31(3), 317-337.
- Sandelowski, M. (1995). Focus on qualitative methods: Sample size in qualitative research. *Research in Nursing and Health*, 18(2), 179-183.
- Sandelowski, M. (2000). Combining qualitative and quantitative sampling, data collection, and analysis techniques in mixed-method studies. *Research in Nursing & Health*, 23(3), 246-255.
- Sanders, C. M., Mauger, P. A., & Strong, P. N. (1985). *A manual for the Grief Experience Inventory*. Palo Alto, CA: Consulting Psychologists Press.
- Sanders, S., & Adams, K. B. (2005). Grief reactions and depression in caregivers of individuals with Alzheimer's disease: Results from a pilot study in an urban setting. *Health and Social Work*, 30(4), 287-295.
- Sarantakos, S. (2005). *Social research* (3rd ed.). New York: Palgrave Macmillan.

- Schulz, D. M. (2002). Re-entry: An Introduction. In J. R. Powell & J. M. Bowers (Eds.), *Enhancing Missionary Vitality* (pp. 159-164). Palmer Lake, CO: Mission Training International.
- Scott, D. A., Valery, P. C., Boyle, F. M., & Bain, C. J. (2002). Does research into sensitive areas do harm? Experiences of research participation after a child's diagnosis with Ewing's sarcoma. *Medical Journal of Australia*, *177*(9), 507-510.
- Seiter, J. S., & Waddell, D. (1989, February 17-21). *The intercultural reentry process: Reentry shock, locus of control, satisfaction, and interpersonal uses of communication*. Paper presented at the Annual Meeting of the Western Speech Communication Association, Spokane, WA.
- Selby, S., Braunack-Mayer, A., Jones, A., Clark, S., Moulding, N., & Beilby, J. (2010). Special people? An exploratory study into re-entering missionaries' identity and resilience [Electronic Version]. *Journal of Religion and Health*. Retrieved February 24, 2010 from <http://www.springerlink.com.proxy.library.adelaide.edu.au/content/ut7553hl70t759q6/fulltext.pdf>.
- Selby, S., Braunack-Mayer, A., Moulding, N., Jones, A., Clark, S., & Beilby, J. (2009). Resilience in re-entering missionaries: Why do some do well? *Mental Health, Religion and Culture*, *12*(7), 701-720.
- Selby, S., Jones, A., Burgess, T., Clark, S., Moulding, N., & Beilby, J. (2007). Disenfranchised grievors -- the GP's role in management. *Australian Family Physician*, *36*(9), 768-770.

- Selby, S., Jones, A., Clark, S., Burgess, T., & Beilby, J. (2005). Re-entry adjustment of cross cultural workers. The role of the GP. *Australian Family Physician*, 34(10), 863-864, 878.
- Selby, S., Moulding, N., Clark, S., Jones, A., Braunack-Mayer, A., & Beilby, J. (2009). Back home: A qualitative study exploring re-entering cross-cultural missionary aid workers' loss and grief. *Omega*, 59(1), 19-38.
- Selby, S., Clark, S., Braunack-Mayer, A., Jones, A., Moulding, N., & Beilby, J. (in press). Cross-cultural re-entry for missionaries: A new application for the Dual Process Model. *Omega*.
- Sharpe, E., & Lankester, T. (2008). Re-entry after long-term travel or living abroad. In J. S. Keystone, P. E. Kozarsky, D. O. Freedman, H. D. Nothdurft & B. A. Connor (Eds.), *Travel Medicine* (2nd ed., pp. 387-391). Edinburgh, UK: Mosby.
- Shear, M. K., & Clayton, P. J. (2008). Bereavement-related depression. *Psychiatric Annals*, 38(10), 643-646.
- Silverman, D. (2001). *Interpreting qualitative data: Methods for analysing text, talk and interaction* (2nd ed.). London: Sage.
- Silverman, D. (2005). *Doing qualitative research*. (2nd ed.). Thousand Oaks, CA: Sage.
- Smith, T. W. (2006). Personality as risk and resilience in physical health. *Current Directions in Psychological Science*, 15(5), 227-231.
- Sobie, J. H. (1986). The Culture Shock of coming home again. In C. N. Austin (Ed.), *Cross-Cultural Reentry* (pp. 95-101). Abilene, TX: Abilene Christian University.



- Solberg, L. I., Crain, A. L., Sperl-Hillen, J. M., Hroschikoski, M. C., Engebretson, K. I., & O'Connor, P. J. (2006). Care quality and implementation of the chronic care model: A quantitative study. *Annals of Family Medicine, 4*(4), 310-316.
- Stain, H. J., Kisely, S., Miller, K., Tait, A., & Bostwick, R. (2003). Pathways to care for psychological problems in primary care. *Australian Family Physician, 32*(11), 955-956, 960.
- Stange, K. C., & Gotler, R. S. (2006). Mixed methods and diverse perspectives. *Annals of Family Medicine, 4*(4), 290-291.
- Stevenson, A. C. (2002). Compassion and patient centred care. *Australian Family Physician, 31*(12), 1103-1106.
- Storti, C. (2001). *The art of coming home*. Yarmouth, ME: Intercultural Press.
- Strada, E. A. (2009). Grief, demoralization, and depression: Diagnostic challenges and treatment modalities. *Primary Psychiatry, 16*(5), 49-55.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.
- Stringham, E. M. (1993). The reacculturation of missionary families: A dynamic theory. *Journal of Psychology & Theology, 21*(1), 66-73.
- Stroebe, M., & Schut, H. (1999). The dual process model of coping with bereavement: Rationale and description. *Death Studies, 23*(3), 197-224.
- Stroebe, W., & Stroebe, M. (1987). *Bereavement and health. The psychological and physical consequences of partner loss* (1st ed.). Cambridge, UK: Cambridge University Press.

- Sturmberg, J. P., & Martin, C. M. (2006). Rethinking general practice -- Part 1: Far from equilibrium disease-centred and econometric-oriented health care and general practice/family medicine. *Asia Pacific Family Medicine*, 5, 40-50.
- Suinn, J. F. (2009). Acculturation: Measurements and review of findings. In N. H. Trinh, Y. C. Rho, F. G. Lu & K. M. Sanders (Eds.), *Handbook of mental health and acculturation in Asian American families*. (pp. 3-23). Totowa, NJ: Humana Press.
- Sussman, A. L., Williams, R. L., Leverence, R., Gloyd, P. W., Jr., & Crabtree, B. F. (2006). The art and complexity of primary care clinicians' preventive counseling decisions: Obesity as a case study. *Annals of Family Medicine*, 4(4), 327-333.
- Sussman, N. M. (1986). Re-entry research and training: Methods and implications. *International Journal of Intercultural Relations*, 10(2), 235-254.
- Sussman, N. M. (2000). The dynamic nature of cultural identity throughout cultural transitions: Why home is not so sweet. *Personality & Social Psychology Review* 4(4), 355-373.
- Sussman, N. M. (2001). Repatriation transitions: Psychological preparedness, cultural identity, and attributions among American managers. *International Journal of Intercultural Relations*, 25(2), 109-123.
- Sussman, N. M. (2002). Testing the cultural identity model of the cultural transition cycle: Sojourners return home. *International Journal of Intercultural Relations*, 26(4), 391-408.
- Szanto, K., Prigerson, H., Houck, P., Ehrenpreis, L., & Reynolds, C. F., III. (1997). Suicidal ideation in elderly bereaved: The role of complicated grief. *Suicide and Life-Threatening Behavior*, 27(2), 194-207.

- Szkudlarek, B. (2008). *Spinning the Web of Reentry. (Re)connecting reentry training theory and practice*. Unpublished doctoral dissertation, Erasmus University--Rotterdam.
- Szkudlarek, B. (2009). Reentry - a review of the literature. *International Journal of Intercultural Relations*, 34(1), 1-21.
- Tafraite, R. C., Kassinove, H., & Dundin, L. (2002). Anger episodes in high and low trait anger community adults. *Journal of Clinical Psychology*, 58(12), 1573-1590.
- Tajfel, H. (1981). *Human groups and social categories*. Cambridge, UK: Cambridge University Press.
- Tashakkori, A., & Creswell, J. W. (2007). Editorial: The new era of mixed methods. *Journal of Mixed Methods Research*, 1(1), 3-7.
- Tashakkori, A., & Teddlie, C. (1998). *Mixed methodology: Combining qualitative and quantitative approaches*. Thousand Oaks, CA: Sage.
- Tashakkori, A., & Teddlie, C. (Eds.). (2003). *Handbook of mixed methods in the social and behavioral sciences*. Thousand Oaks, CA: Sage.
- Terluin, B., van Marwijk, H. W., Ader, H. J., de Vet, H. C., Penninx, B. W., Hermens, M. L., et al. (2006). The Four-Dimensional Symptom Questionnaire (4DSQ): A validation study of a multidimensional self-report questionnaire to assess distress, depression, anxiety and somatization [Electronic Version]. *BMC Psychiatry*, 6. Retrieved September 22, 2006 from <http://www.biomedcentral.com/1471-244X/6/34>.
- Thornton, G., & Zanich, M. L. (2002). Empirical assessment of disenfranchised grief: 1989-2000. In K. J. Doka (Ed.), *Disenfranchised grief: new directions*,

- challenges and strategies for practice* (1st ed.). Champaign, IL: Research Press.
- Tierney, L. M., & Henderson, M. C. (2005). *The patient history: Evidence-based approach*. New York: Lang Medical Books/McGraw-Hill.
- Tolkien, J. R. R. (1999). *The Hobbit or There and back again*. London: HarperCollins.
- Trinh, N.-H., Rho, Y. C., Lu, F. G., & Sanders, K. M. (Eds.). (2009). *Handbook of mental health and acculturation in Asian American families*. Totowa, NJ: Humana Press.
- Trochim, W. M. K. (2006). Descriptive Statistics. Retrieved June 9, 2010, from <http://www.socialresearchmethods.net/kb/statdesc.php>
- Trochim, W. M. K. (2007). Research Methods Knowledge Base. Retrieved October 2, 2010, from <http://www.socialresearchmethods.net/kb/index.php>
- Uehara, A. (1986). The nature of American student re-entry adjustment and perceptions of the sojourn experience. *International Journal of Intercultural Relations*, 10(4), 415-438.
- UNESCO. (2002). UNESCO universal declaration on cultural diversity. Retrieved September 22, 2010, from [http://www.unesco.org/education/imld\\_2002/universal\\_decla.shtml#2](http://www.unesco.org/education/imld_2002/universal_decla.shtml#2).
- Verhaak, P. F. M., Van Den Brink-Muinen, A., Bensing, J. M., & Gask, L. (2004). Demand and supply for psychological help in general practice in different European countries. *European Journal of Public Health*, 14(2), 134-140.
- Villagomez, L. R. (2005). Spiritual distress in adult cancer patients: Toward conceptual clarity. *Holistic Nursing Practice*, 19(6), 285-294.

- Vinokurov, A., Trickett, E. J., & Birman, D. (2002). Acculturative hassles and immigrant adolescents: A life-domain assessment for Soviet Jewish refugees. *The Journal of Social Psychology, 142*(4), 425-445.
- Wade, D. T., & Halligan, P. W. (2004). Do biomedical models of illness make for good healthcare systems? *British Medical Journal, 329*(7479), 1398-1401.
- Walling, S. M., Eriksson, C. B., Meese, K. J., Ciofica, A., Gorton, D., & Foy, D. W. (2006). Cultural identity and reentry in short-term student missionaries. *Journal of Psychology & Theology, 34*(2), 153-164.
- Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 629-640.
- Ward, C., Bochner, S., & Furnham, A. (2001). *The psychology of culture shock*. East Sussex, UK: Routledge.
- Ward, C., & Rana-Deuba, A. (2000). Home and host culture influences on sojourner adjustment. *International Journal of Intercultural Relations, 24*(3), 291-306.
- Ward, C., & Styles, I. (2003). Lost and found: Reinvention of the self following migration. *Journal of Applied Psychoanalytic Studies, 5*(3), 349-367.
- Weinrach, S. G. (1988). Cognitive Therapist: A dialogue with Aaron Beck. *Journal of Counseling & Development, 67*(3), 159.
- Werkman, S. (1986). Coming home: Adjustment of Americans to the United States after living abroad. In C. N. Austin (Ed.), *Cross-Cultural Reentry* (pp. 5-18). Abilene, TX: Abilene Christian University.
- Wilkes, G. (2002). Abused child to nonabusive parent: Resilience and conceptual change. *Journal of Clinical Psychology, 58*(3), 261-276.

- Wilson, K. G., Curran, D., & McPherson, C. J. (2005). A Burden to others: A common source of distress for the terminally ill. *Cognitive Behaviour Therapy, 34*(2), 115-123.
- Wilson, M. (2004). I desperately want to work overseas as a relief, health, or aid worker. I have a large student debt. Is it possible to find humanitarian work and expect a salary? Retrieved December 28, 2006, from <http://careers.bmj.com/careers/advice/view-article.html?id=518>
- Windus, A. K. (1999). The roles and identity of missionary women: A pilot study (Doctoral dissertation, The Southern Baptist Theological Seminary, 1999). *Dissertation Abstracts International, 60*, 1616.
- Wise, J. M. (2000). Home: Territory and identity. *Cultural Studies, 14*(2), 295-310.
- Yanchar, S. C., & Williams, D. D. (2006). Reconsidering the compatibility thesis and eclecticism: Five proposed guidelines for method use. *Educational Researcher, 35*(9), 3-12.
- Zlotnik, H. (1987). Measuring international migration: Theory and practice. *The International Migration Review, 21*(4), v-925-155.