

Relocation Stress Syndrome in Older Adults **By Tracy Greene Mintz, MA, MSW, ACSW** *Social Work Today* **Vol. 5 No. 6 P. 38**

Relocating is stressful for anyone but, faced with moving a lifetime of cherished memories, older adults have special needs.

Imagine you are sitting in your kitchen at a table handed down to you from your parents, sipping coffee from your favorite mug, when there's a knock at the door. It's a county employee who politely explains that she has been asked by your landlord to check on you. A bit perplexed, you assure her that you are fine. A week later, the worker returns with a few others to inform you that you are being moved to a place where you'll get nice new furnishings and three meals per day, that all your needs will be met, and that it is permanent. The favorite mug can go with you, but you will not be allowed to take the heirloom table—or most of your personal belongings. Does this scenario sound improbable? Not if you are one of the many older adults who are involuntarily relocated each year, either from their own homes to elder care facilities or from one facility to another.



This may seem an extreme example, but it is true that Adult Protective Services (APS) workers, social service agencies, and well-meaning family members can remove elders from their homes with little time to prepare. Discharge planners are in a similar predicament: If an older adult cannot be discharged to his or her home safely, then home has to become somewhere else. The scenario above is told from the older adult's point of view. What's missing is the part about the strong odor of urine throughout the apartment, the empty refrigerator, and newspapers stacked on the radiator. Naturally, someone does not swoop down and forcibly remove someone from a situation that is just fine, but that is exactly how it feels to an older person living in questionable or unsafe conditions. The reasons for relocation may be an unclean environment, history of falls, household hazards, medication errors, neglect by self or others, or physical changes that make self-care impossible.

Consider another scenario: A client comes to you with symptoms of caregiver burnout, even though she moved her mom from her home to an assisted living facility two months ago. Even though she and her mother had made the decision together and hired a mover, her mother is exhibiting some odd behaviors at the facility. Staff calls your client almost daily to inform her that if her mother continues to "get lost, miss meals, and overuse her call button," she may not be able to stay. Your client is overwhelmed at the prospect of moving mom—again.

Pack Up 40 Years in 30 Days

Moving at any age and under the best circumstances, such as a new job or to be near family, is stressful. The logistics of planning, packing, and paying for a move are one thing, but the emotional element of changing one's primary residence can lead to a condition called relocation stress syndrome (RSS) [Mallick & Whipple, 2000]. RSS, also known as transfer trauma, is the combination of physiological and/or psychological disturbances as a result of transfer from one environment to another (Jackson, Swanson, Hicks, Prokop, & Laughlin, 2000). It does not discriminate among those who have chosen to move, been involuntarily relocated, or been placed in a care facility for mental or medical needs.

Symptoms of RSS are the same in all age groups. They can include exhaustion, sleep disturbance, anxiety, financial strain, grief and loss, depression, and disorientation. In older people, these symptoms can quickly become exacerbated by dementia, mild cognitive impairment, poor physical health, frailty, lack of support system, and sensory impairment. Do clients understand why they were relocated? Did they participate in the decision? Can they see and hear sufficiently in their new accommodations to learn their way around a new building or neighborhood? Do they have anyone to help them pack or move? Will they remember that this is no longer their home? Can they keep their doctor? Friends? Pet?

Who Chooses to Live in a Nursing Home?

It is widely accepted that older adults want to stay in their own homes for as long as possible. Difficulty arises when there is disagreement about what possible means. Who determines that conditions are unlivable? In a recent survey

at one Los Angeles assisted living facility, an MSW intern interviewed residents about the relocation experience for her macro project. While reviewing the facility census to identify survey candidates, she discovered that 17% of residents had moved in reluctantly. One gentleman was losing his eyesight and could not see well enough to keep his apartment clean. His landlord called APS who, in turn, called a social service agency to move him. Another resident had a history of mental illness and was found by neighbors unkempt and undernourished. A woman had exceeded the charitable guidelines from the agency that was supplementing her rent and, hence, had to move from her apartment of more than 30 years. The agency paid a moving company to bring only what would fit in her new room. She never stopped grieving the loss of her books, which had been her best friends. The scope of the problem can be summed up in one national statistic: Between 800,000 and 1 million elders live in residential care facilities (Newcomer, & Maynard, 2002). That means many potential cases of RSS.

Moving someone into a nursing home is a relocation as well, even though in the professional vernacular we call it a placement, a transfer, or an admission. Those residents who are mentally able will tell you they believe the nursing home is where they go to die, but that's not necessarily true. Health and Human Services cites that in 1997, 73% of nursing home residents were discharged alive (Gabrel, 2000). They either went home, went to another facility, or most likely, were moved to an acute hospital after an injury or illness. Most aged and frail older adults, in their most compromised condition, are not immune from the stress of relocating.

A current trend is the development of age-in-place facilities that offer tiered levels of care. As the resident ages and care needs increase, he or she can stay at the facility. This is a positive trend; however, it has two significant drawbacks. First, as care needs increase, so may the monthly cost of residency, making asset conservation a serious concern. Second, even age-in-place facilities have licensing regulations that limit the level of acuity they can handle. Therefore, an acute illness or injury may force a move at an inopportune time. Like the nursing home patient, if the resident does not recover significantly from the acute episode, he or she will not be allowed to return to the facility and will have to move again.

Tailor-Made for Interdisciplinary Teamwork

For social workers, RSS symptoms meet the diagnostic criteria for adjustment disorder (Diagnostic and Statistical Manual of Mental Disorders IV). Moving is an adjustment that some people make easier than others. Mood and mental changes that can occur include depression, anger, suicidal ideation, confusion, anxiety, and paranoia. Some may exhibit denial by overidealizing the move (Isn't this place wonderful? Everything is just perfect!). Behaviors we are likely to see in older people are somatic complaints, wandering, aggression, isolation, excessive demands for medical and nonmedical attention, and substance use, abuse, or misuse. Physical signs may include pain, agitation, aggression, incontinence, appetite or weight changes, sleep disturbance, and the most dreaded yet too common—falls. Adjustment disorder can take up to three months to manifest. Those can be three difficult and heart-breaking months for residents, family, and staff. In the Los Angeles facility survey previously mentioned, one third of new residents had an acute hospitalization within 30 days of moving into the residential care facility. At the affiliated nursing home, 11% of new residents passed away within 30 days. If the disorder does not resolve after six months, it is no longer about adjustment, and the relocation may have triggered another chronic illness.

So Many Ways to Help

Care plans should begin with a comprehensive psychiatric and medical assessment, including a medication review. A thorough history of the client should include how often the person has moved and past coping skills used for other relocations. These first steps provide a baseline from which staff can measure changes that may result from RSS. Next, a new resident must be given a proper orientation to both the physical layout of the facility and the rules of living there. Too often the staff have expectations of a new resident, such as what he or she should wear to breakfast, and the newcomer has other expectations, such as a habit of dining in his or her slippers, and these are never discussed but immediately cause problems. Sometimes these early problems lead to labeling new residents as troublemakers or even demented. Explain to new residents that while this is their new home, it is still an institution that has policies and regulations that transcend their individual needs and desires.

Establishing trust and a safe feeling for new residents cannot be understated. We are asking someone who may have moved unwillingly to trust a set of strangers to help them shower, give them their pills, handle their finances, take away their laundry. It is normal for a newcomer to have some trepidation, so staff need not get offended if help is refused or questioned initially. One helpful tool is to let newcomers get together and share their concerns,

frustrations, and successes with each other. Encourage connections with long-time residents through a buddy system. There are always friendly residents who are willing to show the “new guy/gal” the ropes. Supportive counseling from knowledgeable staff is also helpful. Allow the new resident to grieve the loss of their old residence, examine and accept the need to move, and explore the meaning of home.

A frequent barrier to intervention in older clients is mild cognitive impairment or dementia. Memory problems can be downright dangerous if clients cannot remember that they’ve moved and head back to their old place. Another common obstacle is the lack of a thorough assessment. Family members may underestimate the level of care needed or underreport the difficulties of the prior living situation. A rushed relocation can easily result in an unfit placement, making adjustment unattainable. Elders with little or no community support are also at a disadvantage, as friends and family can help by reinforcing newly acquired information about facility life. The greatest barrier for everyone is time. Adjustment takes time, during which the resident can become frustrated, staff can burn out, and finances can be drained.

Reframe Challenges As Opportunities

There are many positive aspects of elder relocation and, of course, these are always what we have in mind when we think about moving someone. Increased socialization, freedom from the demands of maintaining a home, and increased opportunities for both mental and physical activity can vastly improve quality of life. Moving a loved one into a facility can also do wonders to alleviate caregiver burden if the family has been working hard to keep an older person at home. The most important positive aspect of moving is that the older adult’s care needs are met on a daily basis.

These benefits are highlighted in the messages elders hear when it is time to move into a facility, voluntarily or involuntarily. However well-intentioned, the messages often conflict with the emotional reality of relocation. Phrases such as “You’re going to love it here” ring hollow when the new resident thinks, “I’ve come here to die.” Other messages such as “You’ll make new friends” or “We take care of all your needs” set up impossible expectations for the new resident who may have never been at ease with new people, does not think he or she has many needs, or thinks he or she cannot afford to pay for the needed services.

The risk of RSS and adjustment disorder can be minimized prior to moving day by doing for clients basically what we would do if it were our own move. Respect individuals by telling them it is an adjustment for them as well as for others and let them know it takes time. Allow as much time as possible before the move to prepare. Give a floor plan of the room and a list of items the person will need from home. Encourage the new resident to retain patterns from home, such as subscribing to the newspaper, having afternoon tea, or taking walks. Can they bring a pet or favorite plants? Counsel new residents on the ups and downs of communal living. Help educate the rest of the team on how to see the whole person coping with a new environment.

Healthy Adjustment Is Always the Goal

Chances are that senior residences are popping up all over your city with enticements to move yourself in, or choose this place for loved ones. We know most people prefer to age in their own homes and, statistically, most do. But when relocation is inevitable, remember that elders are adults and should participate in the decision to move however they can. Less move-related stress benefits the facility staff, other residents, family, friends, and seniors. Planning, teamwork, and adjusting expectations can create a positive outcome when you have to set up camp somewhere new. During a move at any age, these efforts are helpful—and essential.