Relocation Stress Syndrome

in Older Adults Transitioning from Home to a Long-Term Care Facility

MYTH or REALITY?

ABSTRACT
Relocation stress syndrome is a nursing diagnosis characterized by symptoms such as anxiety, confusion, hopelessness, and loneliness. It usually occurs in older adults shortly after moving from a private residence to a nursing home or assisted-living facility. The primary purpose of this study was to validate the symptoms of relocation stress syndrome. Eight nursing home residents and 8 assisted-living facility residents were interviewed 2 to 10 weeks after admission, when symptoms of relocation stress syndrome are most likely to appear. Results of this study indicate that the incidence of relocation stress syndrome may be overestimated. More accurate diagnosis and treatment of depression in older adults is needed.

Relocation stress syndrome was accepted as a nursing diagnosis more than a decade ago (North American Nursing Diagnosis Association [NANDA], 1992). Although it lacks systematic validation (Mallick & Whipple, 2000), relocation stress syndrome has been used unequivocally as a basis for nursing intervention. This study attempted to validate the symptoms of relocation stress among older adults who had recently moved from their primary residence to a long-term care facility. Failure to identify psychosocial stress related to relocation can delay the diagnosis and treatment of physical and emotional illnesses among older adults.

CHARLES A. WALKER, PhD, RN, C; LINDA COX CURRY, PhD, RN; AND MILDRED O. HOGSTEL, PhD, RN, C
STATEMENT OF PROBLEM

Older adults may move from their homes for many reasons. Occasionally, the move is planned, such as downsizing after retirement, but sometimes, the move is an unplanned response to illness or disability. Whether the move is voluntary or not, the changes that accompany relocation to a long-term care facility are believed to be stressful (Chenitz, 1983; Morse, 2000). Even when older adults relocate voluntarily, the experience involves the loss of their primary residence, in which they may have lived for 40 or more years; often, they also lose cherished belongings and a rich social network of family and friends.

LITERATURE REVIEW

Relocation stress syndrome is defined as “physiological and/or psychosocial disturbances as a result of transfer from one environment to another” (Manion & Rantz, 1995, p. 108). Of those individuals affected by relocation stress syndrome, 50% to 79% exhibit dependency and withdrawal (NANDA, 1992). Although depressed mood, anxiety, and impaired social functioning prevail, other documented symptoms include gastrointestinal problems, loneliness, sad affect, sleep difficulties, social isolation, and weight loss (Kao, Travis, & Acton, 2004). Defining characteristics of relocation stress syndrome are listed in the Sidebar on this page.

Often, older adults move into a long-term care facility because of decreased ability to perform activities of daily living, death of a spouse or primary caregiver, chronic illness, or diminished cognition. Although they may have been living at home before an acute illness or injury requiring hospitalization, many nursing home residents (46%) are admitted directly from a hospital to a long-term care facility (Jones, 2002). The most severe psychological effects of relocation usually occur immediately after the move. Residents who did not want to be admitted to a long-term care facility have the most negative responses (Mikhail, 1992).

Phases of Relocation

Kao et al. (2004) identified three phases of relocation:
- Preinstitutionalization.
- Transition.
- Postinstitutionalization.

These phases of relocation closely parallel Chenitz’s (1983) classic, three-stage model of nursing home admission. Chenitz identified and studied problems related to relocation long before nurses and other health care professionals working in long-term care took relocation stress seriously.

Phase one (preinstitutionalization) includes selecting a long-term care facility, planning for legal and financial needs, and deciding what to do with the older adult’s house and belongings (Melrose, 2004). Tension builds and is released during phase one, which begins prior to admission and can last up to 2 weeks after admission. Rarely, residents die within days of being transferred (Smith, 2004), but these deaths are often unexplained. Some fatalities are related to cognitive impairment and accidents caused by unfamiliar surroundings.

Phase two is the transitional period, when symptoms of relocation stress syndrome appear. Ranging from minor transitional difficulties to emotional crisis, the symptoms experienced during phase two last for approximately 3 months (Chenitz, 1983).

Phase three (postinstitutionalization) involves long-term resolution and lasts at least 1 year (Mikhail, 1992), during which time either a healthy realignment or illness occurs.

Reactions to Relocation

People exhibit various psychological reactions to relocation (Mikhail, 1992). Such reactions seem related to the importance of independence and autonomy to the individual at the time of the relocation. People who experience relocation stress syndrome comprise two distinct categories: resigned resisters and forceful resisters. Resigned resisters experience brief episodes of withdrawal, crying, and sadness to profound expressions of helplessness and hopelessness (Gass, Gaustad, Oberst, & Hughes, 1992). Resigned resisters are more often women, and they exhibit behavior typically associated with reactive depression or dysthymia. Forceful resisters exhibit anger and distrust (Kao et al., 2004). They may be uncooperative, aggressive, and physically or verbally abusive. Forceful resisters are more often men, and their behaviors mimic residual or agitated depression.

Effects of Relocation Stress

Confusion is a predictable result of abrupt changes in the environments of older adults. Because most nursing facilities are vastly
different from the residence occupied before a move, relocation to such a facility can cause confusion. Medications and deteriorating health may contribute to this confusion. Accurate assessment of mental status prior to relocation is necessary; otherwise, confusion cannot be assumed to be a transient condition. Other effects of relocation include increased mortality, decreased health status, and increased incidence of falls (Friedman et al., 1995).

**Nursing Interventions for Relocation Stress**

To avoid the worst effects of relocation stress, individuals must have control over their new environment and assistance to maintain familiarity. Preparation prior to the relocation is desirable (Morse, 2000). Nursing interventions recommended by Kao et al. (2004) and Melrose (2004) include:

- Involving residents in decision making.
- Adapting institutional routines to accommodate residents’ preferences and practices.
- Assessing residents’ adjustment and modifying the environment to enhance adjustment.
- Facilitating communication with residents’ family and friends.
- Promoting residents’ personal identity through productive activities and frank discussion about their relocation experience.

**METHOD**

**Study Aim**

The aim of this study was to verify the nature and kind of distress associated with relocation stress syndrome, to determine whether relocation stress syndrome manifests differently among residents of one kind of facility versus another.

The research questions were:

- How do older adults experience moving from their primary residence to a long-term care facility?
- Does the relocation experience differ for older adults transitioning to a nursing home versus an assisted-living facility?
- Is relocation to a long-term care facility uniformly perceived as stressful?

**Population and Sample**

The study population included residents of Medicare-eligible nursing homes and assisted-living facilities located in two rural counties in north central Texas. Residents younger than 65 or with more than mild cognitive impairment were excluded. Although Mini-Mental State Examination (Folstein, Folstein, & McHugh, 1975) scores were available for all residents, no routine assessment or protocol was in place to identify or mitigate relocation stress. During the 6-month study, facility administrators promptly notified investigators when a newly admitted resident met the study criteria. A convenience sample of 16 residents sufficed to achieve the study aims; the sample consisted of 8 nursing home residents and 8 assisted-living facility residents. Although place of residence distinguished the comparison groups, participants in the two groups were matched for age, ethnicity, gender, socioeconomic status, and severity of admitting diagnoses.

**Procedure**

Institutional review board approval was obtained, and all human participant protections were in place before data collection began. Because research participants were selected on the basis of their suspected vulnerability to relocation stress syndrome, special consideration was given to assessing psychological distress. Appropriate referrals to a facility-contracted psychologist were made as needed. Formal consent was obtained from facility administrators, participants, and their families. Participation was voluntary. Participants were not pressured to share information, and their privacy was maintained. All data were recorded and transcribed without personal identifiers.

**Data Collection**

Residents were interviewed during the transitional phase of their relocation. They were asked to describe disappointments, expressions of grief, and aspects of their lives (prior to relocation) they missed the most. In addition, residents were asked to evaluate their eating and sleeping habits, perceived health status, performance of activities of daily living, family participation, and coping strategies.
I’m an 82-year-old retired nurse. Eighteen months ago, I moved from [a large city] to live with my married daughter, son-in-law, and their children. At the time, I could still drive and function independently; however, in September, I had a small stroke, which left me too weak to move myself without help. Both my daughter and her husband work, and the kids are in school…so I chose to move here. [The resident asked if she could speak “off the record.” She was reassured that anything shared would be held in confidence so she cautiously continued.] My life partner died in 2003. We had lived together for nearly 40 years. We were active in the gay and lesbian community but kept a low profile at work and with our families. Her children were a lot more accepting than mine. Please don’t misunderstand…. I adore my family, but I regret moving to this small town with its small town attitudes…. I hide my identity in this place…. Straight people don’t get it! It’s not that I want to flaunt my lesbianism, but [the resident begins to cry.] I want to talk openly about my beloved, to display her picture, to express my grief. I can’t do that here.

The experiences of lesbian, gay, bisexual, and transgendered (LGBT) individuals in all stages of life are not well understood, but particularly misunderstood are those of LGBT older adults transitioning from home to a long-term care facility, as demonstrated in the example above. Because of prejudice among staff and other residents, previously “out” gay and lesbian residents may “retreat into the closet” in a communal setting. Not surprisingly, LGBT individuals may experience discrimination or harassment when they relocate to a nursing home or assisted-living facility. Even assumptions about heterosexuality or references to a heterosexual lifestyle may be intimidating (Sisk, 2006).

It is unclear from incidental data uncovered in this study whether this retreat to the closet happens because of external threats or internal inhibitions. Do LGBT older adults hide their sexual identity in long-term care settings because they perceive a hostile environment where it is unsafe to be out or because of fears and reticence anchored to individual personality style? Whatever the answer, it is clear that LGBT older adults are an at-risk population. Further research is needed to explore and clarify their experiences and ultimately improve the quality of life for LGBT older adults in long-term care facilities.

Interviews were conducted between 2 and 10 weeks of admission. Each interview session lasted 45 to 90 minutes. Licensed, mental health professionals conducted the semi-structured interviews. The interview method used to collect narrative data facilitated reflective discussion and emotional expression among residents. Narrative data were audiotaped and transcribed by the interviewers to ensure trustworthiness and consistency.

Data Analysis
Because the purposes and questions guiding this study were mixed, two qualitative approaches were used in tandem to analyze the narrative products of the resident interviews. First, a manifest content analysis (Polit & Beck, 2005) served to validate symptoms of relocation stress syndrome. Defining criteria for relocation stress syndrome (see the Sidebar on page 40) were listed ahead of time in a codebook, which was used to sort the data and determine the frequency of occurrence. This quasi-statistical approach was not useful, however, when attempting to answer the research questions. Ethnographic sensitivity to experiences of relocation required a more fluid and adaptable analytic strategy.

Second, constant comparison (Glaser & Strauss, 1967) was used to reanalyze the resident interviews. Data were re-sorted using linguistic expressions (e.g., words or phrases), and the emerging template of categories and themes underwent constant revision as more data were collected. Data collection continued until themes became redundant. Although the constant comparison analysis was interpretive, it was a much more literal interpretation than the highly subjective interpretations usually associated with qualitative nursing research.

Lincoln and Guba (1985) suggested procedures to assess the quality of findings by establishing their credibility. In this study, credibility was enhanced through use of investigator and method triangulation (Denzin, 1989). Two investigators were intricately involved in analyzing the data to diminish bias. Two methods of data analysis provided a more in-depth understanding of residents’ relocation experiences. Peer debriefing with an impartial colleague (Lincoln & Guba, 1985) was used to review the study process and highlight problems.

FINDINGS
The findings are reported on the basis of the three research questions guiding this study. Findings are demonstrated and elaborated using the research participants’ own words. Five representative examples (Residents A through E) are included in this article.

How Do Older Adults Experience Moving from Their Primary Residence to a Long-Term Care Facility?
A few participants described their relocation experience as a medical necessity, but all participants claimed it was a decision they made independently or in collaboration with family members. Although the locus of decision making is ambiguous in the following verbatim account, Resident A (assisted living) revealed no reluctance or resistance to his relocation:
I have cancer. While I was in the hospital the last time, my sons got this place ready for me. My moving here was a mutual agreement between me and my sons. My wife died in 1988...so I was by myself for several years.... I had no problem coming here to live. The food is good. [I like] not having to cook for myself or worry about it. My sleeping's not right. Oh, I sleep fine at night, but during the day I cannot. At home, I could take a nap, but I just can't do that here. Otherwise, my health is fine, no problems whatsoever.

Chronic illness and living alone, Resident A affirmed that his needs had been adequately met and his health has been stable since relocating. He reported satisfaction with the facility's menu and relief that meal planning and preparation were handled by others.

Participants consistently conveyed resolution and acceptance. Despite a potentially catastrophic series of events, including transient ischemic attacks, hip fracture, and hospitalization, which were verified in the medical record, Resident B (nursing home) accepted his physical limitations and came to terms with the reality of relocation. He used humor to cope with his loss:

I'm 88 years old, and I've been here about 2 months. After my wife died in 1998, I lived by myself. Lately, I'd been having some spells...blood not getting to the brain. I fell down the back steps and broke my hip.... I went into the hospital to have it fixed. Then I decided to transfer to a nursing home. I don't think I will be able to go back home. My doctor says I'm doing good.... I sleep good, and I feel alright, but I can't walk by myself. I am like an old car. You get past 100,000 miles, and things don't work as well.

Despite many similarities, each resident's story of relocation was unique. Providing an incidental but important finding, one resident courageously revealed her experience as a lesbian in long-term care. Her story and a brief discussion of her situation are found in the Sidebar on page 42.

**Does the Relocation Experience Differ for Older Adults Transitioning to a Nursing Home Versus an Assisted-Living Facility?**

A few preadmission differences were identified between residents of nursing homes and residents of assisted-living facilities. Assisted-living facility residents made proactive choices, whereas nursing residents more often experienced a disabling condition prior to relocation. Resident C (assisted living) adopted an unusual and somewhat amusing adaptation strategy:

I'm 80 years old. Last year, I started blacking out at home. I would just wake up on the floor. I thought that while I had the capacity to make decisions, I'd better do something. I moved in here in February. They told me if I didn't like it after a month, they would refund my money.... My niece came and measured the room, and I had to decide what to bring from home.... I haven't sold my house.... I've been swapping things out as I need them. I still drive. I have two vehicles. I drive one a while and switch out and drive the other for a while....

I see my doctor routinely. I was diagnosed with cancer in 1998. But so far, so good. It's not going to kill me, or it would have by now. I seem to sleep just as well here as I did at home. I know that I eat better here.

Buoyantly optimistic, Resident C did not perceive her cancer as a grim diagnosis. She effectively practiced living in the present without dwelling dismally on an uncertain future or obsessively on a regretful past.

Regardless of the kind of facility, however, residents' responses to relocation were strikingly similar, particularly related to eating and sleeping patterns and their capacity to make informed and independent decisions. Contrary to common assumptions about perceived lack of control among institutionalized older adults, the residents in this study were guided by a strong sense of personal efficacy. For example, Resident D (nursing home) expressed sorrow and acknowledged significant physical and emotional losses, but he did not fatalistically surrender to the circumstances surrounding his relocation:

I am 85 years old. I have been here a little over a month. I had a hip replacement in December.... I think I was [in the hospital] about a week; then they brought me here. Now my wife, Francis, and I share this room. She had [a] stroke in August.... We have been married 63 years, and it's very hard to watch her like this.... [Francis tries to speak, but neither of us understands her. He continues.] I don't know if she will get any better. I go to physical therapy. Even though I can stand with a walker, I do not think we can manage at home.... I've been sleeping well, and I eat everything on my plate. I might even eat the plate someday.

**Is Relocation to a Long-Term Care Facility Uniformly Perceived as Stressful?**

While expressing sadness and acknowledging loss, most participants found their relocation a fairly easy transition, no more difficult than other life changes. They spoke of healthy adjustment to long-term care. Regularly scheduled mealtimes, diverse social activities, medication re-
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4. What appears to be relocation stress syndrome may be undiagnosed and untreated depression.

2. Relocation stress may be related more to residents’ perceptions of their new environment than to the actual move.

3. Relocation explains how or why older adults react negatively to the transition from home to a long-term care facility, but relocation stress syndrome may be a superfluous diagnosis.

4. What appears to be relocation stress syndrome may be undiagnosed and untreated depression.

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**KEY POINTS**

- Regardless of the kind of facility in which they live (e.g., assisted living or nursing home), residents were guided by a strong sense of personal efficacy.
- Relocation stress may be related more to residents’ perceptions of their new environment than to the actual move.
- Relocation explains how or why older adults react negatively to the transition from home to a long-term care facility, but relocation stress syndrome may be a superfluous diagnosis.
- What appears to be relocation stress syndrome may be undiagnosed and untreated depression.

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minders, paid utilities, and weekly transportation to medical and dental appointments were conveniences that offset the banality of institutional routine. Along with their families, participants in this study voiced appreciation for lives made easier, healthier, and safer by timely transition to a long-term care facility. Residents conveyed contentment and gratitude for an uneventful relocation:

I am 86 years old. Until 1994, my husband and I lived on a ranch. I was rushing him to the hospital every few weeks. We sold the ranch and moved into town, where I have lived by myself since he died in 1996. I was the one who told the kids that I’m going into assisted living…. I got tired of living alone and cooking just for me.

I’ve been here since January. I think the move has been as smooth as cream. My husband was one of those types who handled the bills and everything. So after he died, I had to learn to do it all. I’m glad to have made this decision. One of my daughters recently told me she was thankful I made this decision. It was so much easier for them….

I’m still in good health. I take no medication, except for a vitamin. This morning my pulse was 72, my blood pressure was 116/70, and my sugar was 81. The Lord has blessed me and taken care of me.

**DISCUSSION**

Characteristics of relocation stress (see the Sidebar on page 40) were conspicuously missing from the interview transcripts. A rigorous, but conservative, content analysis failed to reveal evidence that relocation is perceived as stressful among older adults transitioning from their primary residence to a long-term care facility. A search for deeper or hidden meanings would have required an extreme, revisionist interpretation of the residents’ words, which would have been inconsistent with the purposes of this study. The interview process gave residents an opportunity to share their thoughts and feelings about relocation, which is a recommended intervention for relocation stress syndrome.

**LIMITATIONS**

Narrative data for this study were obtained from residents who agreed to be interviewed. Some newly admitted residents declined to be interviewed, so results may have been skewed by participant self-selection and convenience sampling. In addition, residents of assisted-living facilities and nursing homes in rural Texas with no more than mild cognitive impairment might not comprise a representable sample. For example, results may have differed if residents with early-stage dementia had been interviewed. One-time interviews lasting less than 2 hours each would have yielded superficial and potentially inconclusive findings. Despite this limitation in the study design, however, the absence of data supporting relocation stress syndrome was unmistakable and surprising.

**CLINICAL IMPLICATIONS**

The negative public opinion regarding long-term care facilities, particularly nursing homes, probably influenced resident perceptions. Perhaps new residents were astonished to find that their new environment was not as bad as they had expected. If revised perception accounts for the absence of symptoms of relocation stress syndrome among study participants, then relocation stress syndrome may be more related to perception of the new environment than to the actual move.

**Diagnosing Relocation Stress Syndrome**

Diagnosing relocation stress syndrome is a problem, especially if stress is the only interpretive lens used and the relocation stress syndrome phenomenon is indistinguishable from other disorders. Indicators of depression were noted during several uncompleted interviews and were identifiable primarily through truncated responses or a hostile tone. Tone is difficult to convey in a written transcript, and unelaborated responses, punctuated by long silences, seem to add little to our understanding. Although the

Continued on page 45.
actual words of some near-silent residents are not reproduced here, their meaning was not lost. Rather than diagnosing residents with symptoms of depression as having relocation stress syndrome with an uncertain follow up, we referred them immediately to a geropsychologist for mental health evaluation.

Other Disorders and Diagnoses

Relocation stress syndrome is remarkably similar to other psychiatric diagnoses, including adjustment and depressive disorders. Adjustment to loss is a key component of relocation stress syndrome. Adjustment disorder is “the development of emotional or behavioral symptoms in response to an identifiable stressor” (American Psychiatric Association, 2000, p. 683). The defining criteria for relocation stress syndrome (see the Sidebar on p. 40) are diagnostic behaviors commonly seen in major depression, and the kinds of resistance to relocation (e.g., resigned or forceful) are linked with depressive symptoms. NANDA diagnoses useful in classifying the needs of relocated older adults are hopelessness, helplessness, and ineffective individual and family coping. In short, accurate assessment and diagnosis are crucial for appropriate intervention.

CONCLUSION

If the increased morbidity and mortality associated with relocation result from a stress reaction, then measures to mitigate relocation stress are warranted. Results of this study suggest that the incidence of relocation stress syndrome may be overestimated.

Relocation explains how or why an older adult reacts negatively to a transition from home to a long-term care facility, but relocation stress syndrome may be a superfluous diagnosis. A diagnosis too readily applied can delay appropriate diagnosis and treatment. What appears to be relocation stress syndrome may be a preexisting, undiagnosed, and untreated endogenous depression, exacerbated by relocation.

Diagnosing and treating depression in older adults is paramount. Many more suitable diagnoses than relocation stress syndrome exist, with codes to classify depressive disorders and refer residents to much needed mental health services.

REFERENCES


