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Transitions: A Nursing Concern

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Transitions: A Nursing Concern

Norma Chick and Afaf Ibrahim Meleis

Analysis is a methodological option in the development of knowledge in nursing. It is defined as a process of identifying parts and components, examining them against a number of identified criteria. Analysis includes both concept and theory analysis.

Concept analysis is a useful process in the cycle of theory development and testing and may occur at many points in the process. A number of structures have been provided in the literature as guidelines for concept analysis.¹⁻⁴ Strategies for analysis depend on levels of knowledge development within disciplines. As the boundaries of nursing domain develop and are sharpened, analysis takes on new dimensions. The use of multidimensional components of analyses that are more congruent with level of development in nursing would help in further developing nursing knowledge. The components used in analysis of transition are presented below. These may be used sequentially or nonsequentially.

1. Definition, identification, and description of the different dimensions and components of the concept. In defining different dimensions, a description of some of the antecedents to the concept and some of the consequences is essential, matching some of these descriptions with what occurs in nursing practice.
2. Examination and analysis of concept congruency with existing nursing theories and other domain concepts.

Note: The authors collaborated on this paper while Norma Chick was on sabbatical leave as a Visiting Lecturer in the Department of Mental Health and Community Nursing, University of California, San Francisco.

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3. Development, description, and analysis of exemplars of model cases. This step may include clinical or empirical results that are related to the concept.
4. Comparison with other concepts with similar properties and dimensions to establish its boundaries.
5. Development, description, and analysis of contrary cases to the normative cases. Situations in which the concept appears sometimes or under a new set of conditions are called borderline cases and are also useful in analyzing concepts.
6. Analysis of the research potential related to the concept by consideration of its properties as dependent and independent variable. This component is completed when measurement issues are considered.

Each of these processes has a methodology of its own and could be used as a test of the occurrence of a concept. These tests are both conceptual and clinical. When these processes are complemented by testing through empirically valid and reliable research instruments, the cycle of theory-research-theory is complete.

The purpose of this chapter is twofold: to articulate an argument for the centrality of transitions as a concept within the domain of nursing by using the guidelines of concept analysis identified earlier and to provide an analysis of transition as an exemplar for concept analysis.

DEFINITION, DIMENSIONS, AND COMPONENTS OF TRANSITION

Transition is a familiar concept in developmental theories and in stress and adaptation theories. It accommodates both the continuities and discontinuities in the life processes of human beings. Transitions are invariably related to change and development, both of which are highly pertinent themes for nursing. Superimposed on developmental transitions are other forms of transition that are linked more directly to situational and health-illness events. One example of the latter is hospitalization for acute illness or injury, which automatically precipitates the person into contact with nurses and nursing. In some instances, transition is initiated by events beyond the individual's control; in other cases, it may be sought deliberately through events such as marriage, migration, career change, or cosmetic surgery.

Transitions are those periods in between fairly stable states. Transitions fall within the domain of nursing when they pertain to health or illness or when responses to the transition are manifested in health-related behaviors. It is conceivable that in the first instance, the health-illness condition is the independent variable and the transition, the dependent variable. An acutely

ill patient who is hospitalized, a patient who is discharged from a health care institution, and a patient undergoing surgery are all examples of conditions or situations with an impending state of transition. In the second instance, exemplified by immigration, transition is the independent variable that may predispose human beings to health problems. The transition may also influence responses to health problems and types of action taken because of potential or actual health problems.

A number of writers have argued that there is now sufficient consensus about the discipline's central concerns—human beings, environment, and health—for these concepts to be accepted as summarizing nursing's domain.⁵ While each of these, singly or in various combinations, is the concern of scholars and researchers from many disciplines, nursing's concern lies in their interrelatedness as the irreducible minimum from which knowledge for nursing practice can evolve. Given that this triad forms the basic structure for nursing knowledge, it is conceivable that additional concepts will be required before we can identify all the intricate patterns that make up the whole of nursing. Transition is one such concept. It offers a key to interpreting person-environment interactions in terms of their actual and potential effects on health. In the wake of sound empirically based descriptions of transition, both as process and as outcome, more prescriptive theory can be generated to impact on practice. Nursing practice stands to gain from careful conceptualization of transition and its consequences in all the biopsychosociocultural variations.

Definition

The noun transition is derived from the Latin verb *transire*, meaning to go across. That sense is reflected in the first meaning given in *Webster's Third International Dictionary*⁶: "a passage or movement from one state, condition, or place to another." Because there are connotations of both time and movement, transition can be thought of as linking change with experienced time.

As conceptualized in this chapter, transition, as passage from one life phase, condition, or status to another, is a multiple concept embracing the elements of process, time span, and perception. Process suggests phases and sequence; time span indicates an ongoing but bounded phenomenon; and perception has to do with the meaning of the transition to the person experiencing it. The process involves both the disruption that the transition occasions and the person's responses to this interference. The time span extends from the first anticipation of transition until stability in the new status has been achieved. Perception of the transition will reflect how the associated role ambiguity and threat to self-concept are experienced. In summary, transition refers to both the process and the outcome of complex

person-environment interactions. It may involve more than one person and is imbedded in the context and the situation. (J. Benoiel, personal communication, 1985).

One important characteristic of transition is that it is essentially positive. The completion of a transition implies that the person has reached a period of greater stability relative to what has gone before. Even if overall, by comparison with a pretransition state, the changes seem more decremental than incremental, this does not mean that the transition outcome cannot be positive. The completed transition would then signify that the potential for disruption and disorganization associated with the precipitating circumstances had been countered. As Hall noted, "A theory focused on transition could deal with decreases as well as increases."^{7(p3)}

Defining characteristics of transition include process, disconnectedness, perception, and patterns of response.

Process

Whether the event that causes the transition is anticipated or not, and whether the event is short or long term, transition is a process. Its beginning and end do not occur simultaneously; there is a sense of movement, a development, a flow associated with it. The distance between the beginning and the end may be short or long, and its end may or may not have the same characteristics as its beginning. Certain boundaries imply limits to the process. Although Bridges conceptualized the structure of life transitions a little differently, referring to "(1) an ending, followed by (2) a period of confusion and distress, leading to (3) a new beginning,"^{8(p9)} there is still the same sense of transition being an ongoing and bounded phenomenon.

Although certain aspects of an individual's life will be affected more than others by the transition that he or she is currently experiencing, the extent and intensity of this influence may vary over time. Further, the boundaries of transition-related behavior are not fixed, but may expand and recede in accordance with other happenings in the total context of the person's life. Events and circumstances that are likely to be precursors to the process of transition are listed in Table 18-1.

Disconnectedness

Perhaps the most pervasive characteristic of transition is disconnectedness associated with disruption of the linkages on which the person's feelings of security depend. It is interesting in this regard to note that the authors of an extensive review of factors related to health commented that all the findings they described have "as a common element the importance to health of being 'connected.' . . . These connections are not passive, but require that people actively relate to one another and with the environment."^{11(p354)} Other

Table 18-1 Events Leading to a Process of Transition

Illness	Loss	Pregnancy
Recovery	Immigration	Retirement
Birthing	Migration	Maturation
Death	Hospitalization	

characteristics allied to disconnectedness are loss of familiar reference points, incongruity between expectations based on the past and perceptions dictated by the present, and discrepancy between needs and the availability of, as well as access to, means for their satisfaction.

Perception

Meanings attributed to transition events vary between persons, communities, and societies, and thus influence the outcome. Hospitalization is considered necessary for healing by some and as a step toward dying by those from another culture.¹¹ A patient describing her hemiparesis after a stroke—"I feel like I have a dead body in bed with me" (N. Doolittler, personal communication, February 1985)—aptly illustrates the individuality of perception. This characteristic suggests that differences in perception of transition events may influence reactions and responses to such events, so making them less predictable.

Awareness

Transition is a personal phenomenon, not a structured one. Processes and outcomes of transitions are related to definitions and redefinitions of self and situation. Such defining and redefining may be done by the person experiencing the transition or by others in the environment. However, it is contended here that to be in transition, a person must have some awareness of the changes that are occurring. In the event that the changes have not yet reached the level of awareness, or are being denied either totally or in terms of their implications (irrespective of whether the denial is conscious or unconscious), then that person is not yet in transition. He or she is still in a pretransition phase. In such cases, it would be necessary to resolve barriers to awareness of transition before attempting to facilitate the transition itself.

Patterns of Response

Patterns of response arise out of the observable and nonobservable behaviors during the process of transition that, however disturbed or

dysfunctional they may appear, are not random occurrences. The behaviors embody patterns that reflect both intrapsychic structure and processes as well as those of the wider sociocultural context.¹¹ Pattern recognition would be an important part of developing a taxonomy of transitions. Table 18–2 shows the labels commonly applied to some of these patterns. Examples are disorientation, distress, and perhaps elation and happiness.

Dimensions

Transitions are not experienced uniformly by different people even when the circumstances, such as first-time parenting, are similar. However, there are some commonalities. First of all, there is a general structure consisting of at least three phases: entry, passage, and exit. It may be, too, that research will reveal some general dimensions that can be used to categorize transitions across different types of events: life cycle, situational, and health-illness.

The sequence is invariant, but the duration of each phase and associated degree of disruption are not. Impediments to the passage can occur at any point. Phases are more likely to merge into one another than to be discrete. Research would yield information on which to base a typology of transitions. This knowledge in turn would open up the possibility of prediction about general forms and specific phases most likely to generate stress. Such understanding would provide a useful background against which to interpret an individual's perception of a particular transition. Some of the possible dimensions by which transitions can be described are duration, scope, magnitude, reversibility, effect, and the extent to which the transition is anticipated and voluntary and has clear boundaries. Some of the dimensions along which it is proposed that transitions may vary are listed in Table 18–3 as a set of polar opposites.

Knowledge of general patterns would be useful for guiding nursing assessment, but planning and implementation, to be effective, must take account of how the transition and associated events are perceived by the

Table 18–2 Patterns of Response to Transition Events

Disorientation	Changes in self-concept
Distress	Changes in role performance
Irritability	Changes in self-esteem
Anxiety	(And others)
Depression	

Table 18-3 Dimensions of Transitions

Single transition v multiple transitions
Clear entry and exit v ambiguous entry and exit
Impeded passage v unimpeded passage
Minor disruption v major disruption
Particular disruption v pervasive disruption
Brief duration v extended duration
Temporary v permanent
Positive value v negative value
Pleasant v unpleasant
Desired v undesired
Planned/predicted v unplanned/unpredicted

person experiencing them. In recognition of the likely degree of individual variation, one aspect of theory development in this area would concern instrument construction. The dimensions described earlier could provide the starting point for an instrument that would allow the nurse to generate a profile of how the individual perceives the transition of which he or she is the center. Its further development would depend on feedback from research and conceptual analysis. Cues from such a profile would help the nurse to more accurately infer the meaning that the situation has for the patient, this latter being the only valid data base from which to plan intervention. The transition event, the meaning and the consequences, are depicted in Figure 18-1.

Congruence with Nursing Theories and Relationship to Domain Concepts

There are strong threads of congruence among the many current theories in nursing. Each theorist appears to be working with different parts of the whole rather than with entirely different entities. The concept of transition has the potential for both accommodating and being accommodated by these various theoretical schemes.

Nursing theories, almost by definition, must address change in one form or another. The rationale for that assertion is that nursing's focus—responses to health-illness events—usually entails change and instability for the person concerned, and the achievement of nursing's health-related goals generally

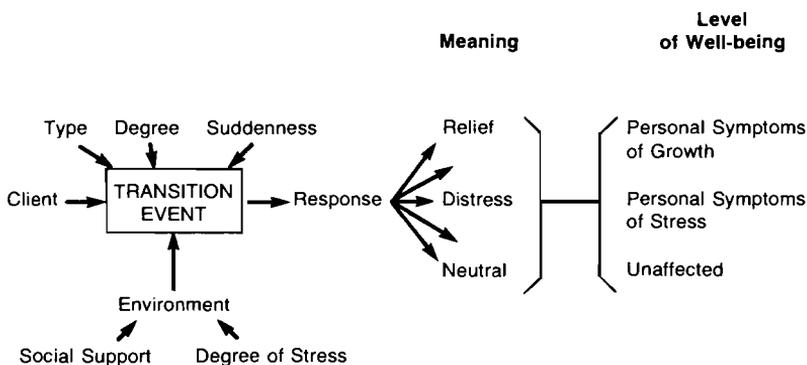


Figure 18-1. Factors Related to Response to a Transition Event

depends on initiation of changes in interaction between person and environment.

An early nursing theory such as that of Peplau,¹² with its emphasis on illness as an opportunity for personal growth and development, could be restated in terms of transition, as could the later work of Travelbee,¹³ which focuses on the evolution of a therapeutic relationship between nurse and patient and on the need for the patient to find meaning in the illness experience. Transition is also compatible with those theories that emphasize adaptation, such as the Roy Adaptation Model.^{14,15}

Transition involves patterns as well. Both Rogers^{16,17} and Newman^{18,19} see patterning as crucial to their theories. In Rogers's formulation, transitions would mark phases in the person's evolving unitary organization. In Orem's theory, self-care is the key concept,^{20,21} and transitions are inextricably linked to shifts in self-care capability.

Transition and Nursing Therapeutics

The most important *raison d'être* for nursing is the care of patients. This is based on knowledge related to care strategies, ie, the nursing therapeutics that would enable nurses to select the most fruitful kinds of action and optimal intervention points for achieving the desired health maintenance or health promotion goals. Nursing therapeutics could be conceptually considered in relationship to transitions, antecedents, and consequences. To develop knowledge related to nursing therapeutics, the dimensions of time, pattern,

type of transition, and timing of intervention should be considered. These dimensions will lead to the effective development of theoretical and researchable questions. Specifying other components of therapeutic or preventive clinical therapeutics may be useful to further the development of transition specific clinical therapeutics. For example, therapeutic intervention is conceptualized as occurring after the transition consequences have been experienced, and preventive intervention, as occurring before the transition or before the consequences.²²

Examples of existing studies that can be viewed from this perspective are numerous in the nursing literature. Lindeman's^{23,24} work on preoperative teaching exemplifies preventive clinical therapeutics. Other examples are work related to patient compliance-adherence with treatment regimens²⁵, that of Johnson,²⁶ which is geared toward strategies for reducing the stress associated with certain treatment procedures; and a study of role supplementation in the postnatal transition and in a cardiac rehabilitation program.^{27,28} These are all instances in which nurses have been concerned with facilitating, either preventively or therapeutically, the transition processes that clients experience. Some of the domain concepts and their relationship to the transition process are depicted in Figure 18-2.

Transition and Environment

Transition and environment are related in two main ways. On the one hand, changes in the environment may constitute, or be part of, the events that make the process of transition necessary. Adjustment to slowly occurring change may be so gradual as to be almost imperceptible. There is little, if any, sense of transition. More rapidly occurring environmental changes, whether they be natural, as in the case of an earthquake, or man-made, in the form of urban redevelopment, call for a larger response. Such events not only require adjustment to a new environment, but at the same time severely disrupt the usual sources of support that the individual draws from the environment. This leads to a second way in which transition and environment are linked. Irrespective of the source of the initiating conditions for the transition, its course may be mediated by what the environment offers in the way of support. The particular nature of the environment in which it occurs may either impede or facilitate a transition. In the transition from disabled person to able person, an example of a facilitating environment would be one that gives high priority to ensuring wheelchair access for the physically handicapped.

Another factor that may influence how smoothly a transition is experienced is the extent to which the environment in which the transition is occurring is itself stable or in flux. Concurrently occurring transitions compound one another. For instance, it has been commonly observed,

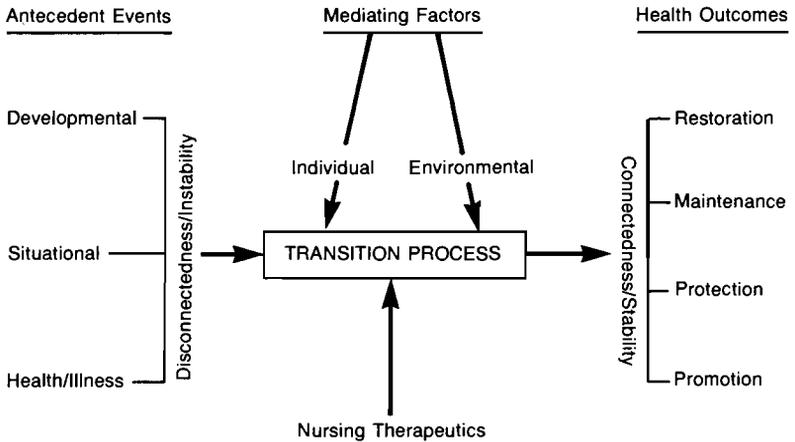


Figure 18-2. Relationships of Transitions to Other Domain Concepts

although perhaps not so well documented, that in clinical units in which staff are rotated and a large proportion change at one time, the ensuing unsettled period is reflected in patient states. Implications of this observation offer a source of pertinent questions for nursing research.

Transition and the Nursing Client

As with all person-environment interactions, neither processes nor outcomes are ever determined entirely by individual or environmental variables. Different sets of factors may be dominant at various points in time, but mostly what eventuates results from complex interplay between individual and environmental characteristics.

Unfortunately, the concept of transition is not immune to stereotyped thinking, so a note of caution has to be sounded. There is a danger that we will impose explanation rather than allow understanding of the concept to emerge from evidence of how transitions are actually experienced by those undergoing them. There may be a tendency to use one's own experience or feelings as a frame of reference rather than elicit meanings from the client. Thus, on the basis of personal experience and societal values, the transition to

motherhood may be assumed always to be experienced positively. Negative connotations are simply not perceived. To take a further example, for most of us, colostomy poses a threat to autonomy over a natural bodily function, and hence is viewed negatively. Such a conclusion ignores the possibility that, for a particular individual, the colostomy and associated transition may be experienced as a positive resolution to a prolonged distressing and anxiety-provoking condition.

Technological advances in medicine are now subjecting people to transitions not dreamed of a few decades ago. At the moment, it is the associated ethical dilemmas that are attracting attention. In the meantime, nurses, by their very "thereness" (compared with the intermittent contacts of other care givers), are ideally placed to be in the vanguard to help patients and their families with these unprecedented situations.

EXEMPLARS

The critical question for the proposed conceptualization linking transitions with health is what utility it would have for nursing practice. Most currently used assessment guides and other documentation associated with the nursing process model are intended to alert nurses to life context variables relevant to the person's current health-illness status. Therefore, it is germane to ask if the concept of transition adds anything. We suggest that it does. For instance, as a focus for nursing intervention, it helps us to incorporate the "at-risk" status that accompanies many forms of transition not directly related to health-illness events. However, even when it is too late for preventive measures, nursing assessment done with the aim of highlighting the kinds of personal and social transitions in which the client is involved has much to offer. It will help to ensure that interventions are maximally relevant, and therefore genuinely therapeutic rather than merely being palliative.

Viewing transition as both process and outcome means that focus can be readily shifted between end result and process. Either can be the subject of assessment. In the first instance, comparisons would be made between present characteristics and those exhibited (or reported to have been present) at a pretransition phase. Some may have been lost, others modified, and some entirely new ones may have emerged. The values (both social and personal) placed on these characteristics will influence the degree of stress associated with such losses and gains. So the notion of transition is likely to be useful in formulating goals for nursing practice. It can also be applied retrospectively to help the nurse understand how a person feels about the outcome of a transition and the process that has led to it.

The concept of transition is consistent with the philosophy of holistic health, which is central to nursing practice. It is unavoidable that at a given point in time, attention will be focused on some aspects of the person more

than on others. In practice, there is no way that we can attend to the whole person simultaneously, but we can recognize the coextensiveness of the many dimensions of the person. Thinking in terms of transition promotes continuity not only across time, but also across dimensions of the person.

With transition viewed as a process, the aim would be to anticipate points at which the person is most likely to reach peaks of vulnerability with respect to health. Efforts could then be directed toward establishing and reinforcing defenses as well as modifying hazards. As knowledge accumulates concerning the likely course or trajectory of different types of transition, it will become increasingly possible to plan interventions according to the optimum moment and manner.

Nursing practice based on a transition model would run counter to therapeutic interventions aimed only at cure. Return to a disease-free state may not be possible, and even the premorbid level of health may be unattainable. A goal for nursing is that the client emerge from any nursing encounter not only more comfortable and better able to deal with the present health problem, but also better equipped to protect and promote health for the future.

Sometimes in the drama of a life-threatening event such as might be associated with admission to an intensive care unit or a cardiac care unit, the important point is lost, which is that for the ill person and significant others, the episode is part (perhaps just the beginning) of transition. By definition, crisis care is present-oriented. Yet the questions going through the minds of patient and family are likely to be future-oriented. First of all, "Is there a future? Is this the end?" Then, "If I do recover, what will I be like?" Even the questions themselves indicate a transition, from a time when such doubts and anxieties were nonexistent or peripheral to the moment of their present compelling impact. In other instances, the tendency may be for the person to be fixed in the past as a defense against both present and future. Here the nurse has to work at starting the transition process. The earlier these doubts and uncertainties are recognized and worked through, the sooner the transition to recovery will be achieved. Once the person perceives himself or herself as an invalid (ie, as being invalidated as a normal person), it may be difficult to eradicate this perception, even in the presence of seemingly good physical recovery. The difficulty will increase the longer the perception persists.

For some time now, acute care hospitals have been examining their admission procedures in terms of how this transition to inpatient might be facilitated. Currently, too, discharge planning is receiving much attention. Generally, these processes have not been explicitly conceptualized as transition, but there could well be gain in doing so. Tornberg, McGrath, and Benoliel³¹ are quite specific in describing their transition services as "a model of nursing practice designed to offer personalized services and continuity of

care to patients and families living with changing demands of progressive, deteriorating illness."^{29(p131)}

We know of another facility that, without labeling itself as a transition service, functions as one for people who have undergone plastic surgery. Such patients, especially in the case of cosmetic surgery, are often elderly. After the immediate postoperative period, they do not require the complex services of an acute care hospital (in fact, such an atmosphere may not be conducive to their recovery). Nor are they always ready for the full independence of returning home, particularly if they live alone. A short stay in an intermediate facility helps to smooth the multiple facets of this kind of transition.

ANALYSIS OF TRANSITION IN RELATION TO OTHER CONCEPTS

Transition, Change, and Other Change-related Concepts

Part of the process of concept analysis is to compare the concept to others with comparable properties and dimensions in order to establish its boundaries.^{30,31} Although Hall⁷ saw certain risks in nursing's present emphasis on change concepts (principally, that we may come to equate understanding change with understanding people), it can still be argued that, for nursing, change is both a *raison d'être* and a means of goal achievement. Just as it is change in health status that brings about the need for health care, so the goal of intervention usually is to facilitate changes that will restore health to a premorbid level or better. Yet to say that nursing is about managing change is little more than a truism.

A broad concept such as change contains too much ambiguity for it to be effective in guiding either nursing conceptualizations or therapeutics. That is why Becker³² suggested that nursing might gain more from the exploration of microconcepts. Transition, although not quite micro in the sense intended by Becker, has similar advantages. It can be differentiated from the general concept of change sufficiently to make it useful in alerting nurses to relevant aspects of the life context of clients. In this instance, transition is seen as a special case of the general phenomenon of change.

When looking at the wider social science literature, one cannot but be struck by similarities between our thinking about transitions and other change-related phenomena being discussed by psychologists and sociologists. For instance, *Uprooting and Development* is a volume of essays described in the foreword as having to do with "one of the fundamental properties of human life—the need to change—and with the personal and social mechanisms for dealing with the need."^{33(pxi)} The author of the foreword goes on to emphasize dislocation as a distinguishing feature of uprooting events that range from self-imposed relocations and migrations to natural and man-made

disasters. Another contributor to the volume offers the following metaphorical description of what the experience of being uprooted is.

The closest human counterpart to the root structure by which a plant nourishes itself is, I suggest, the structure of meaning by which each of us sustains the relationships to people, work, and the physical and social circumstances on which our lives depend. Like roots, these structures of meaning are at once generic and sensitively adapted to the particular setting in which they are embedded; like roots, too, they transplant from this established setting only at the risk of wilting and stunting.^{34(p101)}

The concern with meaning is germane to our approach, which lends itself well to interpretive research methodologies. Preserving continuity of meaning, either by reestablishing disrupted connections or by substituting new ones, is an essential part of the transition process, and hence the ways of doing these things are of vital concern to nurses. Our sense of transition makes the latter concept complementary to notions such as uprooting. Transition is a response to the disrupting events. It takes up the developmental theme of the book title just cited.

As well as the focus on transition as a response, another difference from these other writings is provided by the health emphasis that emanates from our nurse-scientist perspective. Admittedly, the difference is largely one of emphasis. Writers in other disciplines are sensitive to the health hazards associated with change. Since the research of the 1960s and 1970s, we have been aware of the deleterious effects of accumulated stress from sequential and contiguous life changes.^{35,36} Some, such as Coelho and Stein,³⁷ refer specifically to health risks associated with rural to urban migrations. In all these instances, however, health risks are seen as consequents or dependent variables, that is, they are effects of the change phenomena. Perhaps subtler relationships emerge when, as from our health-centered focus, illness and injury are viewed as antecedent or independent variables that initiate the need for transition and, by their characteristics, help to determine the trajectory that the transition will follow. In this sense, the illness, injury, or "at-risk" status becomes analogous to the uprooting events described earlier.

RESEARCH POTENTIAL

Transition may enter the formulation of a research question as either an independent or a dependent variable, as indicated in Figures 18-3 and 18-4.

Transition as an Independent Variable

A transition resulting from such events as immigration, migration, relocation, pregnancy, birthing, and loss may lead to health-related consequences in the form of biophysical symptoms or psychosocial symptoms and may lead to ineffective health-seeking or help-seeking behavior. It may also lead to overutilization of health care services. Studies of transition as an independent variable may consider several relationships. These relationships are discussed and demonstrated in Figure 18-3.

Transitions and Health

Some transitions reflect movement along the health-illness continuum more directly than others. For instance, catastrophic illness, a diagnosis of chronic or degenerative disease, and discharge from hospital after a severe illness are all clearly related to health status. Certain developmental transitions, such as childbirth, aging, and dying also come within the orbit of health-illness services because of the way in which they have been institutionalized in Western societies.

In other circumstances, the relationships are less clear-cut. Instead of figuring directly in the situation, the transition provides the ground against which the health-illness episode or period of increased vulnerability to risk occur. McKinlay³⁸ supports the view that ethnographic studies, historical epidemiology, and observations in societies where rapid increase of technology has occurred indicate that people who are in a state of physical and cultural transition have higher risk of illness. All too often the contribution of a concurrent transition is recognized only after a crisis, for example, acute depression, has occurred.

Although the foregoing discussion has emphasized the tendency for transition to increase vulnerability to health hazards, transitions can also be viewed as opportunities. Transition can mean gain or loss. The perturbations associated with the beginning of the transition process may create fertile

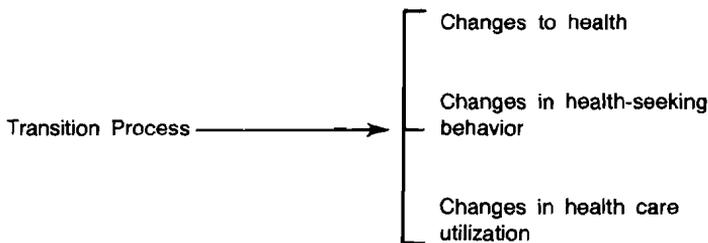


Figure 18-3. Transition as an Independent Variable

ground for new learning. In this sense, the concept of transition is consistent with eudaimonistic and self-actualizing views of health.³⁹

Transitions and Health-Seeking Behaviors

For someone in transition, health-seeking behavior may be inhibited simply because the appropriate course of action is no longer obvious. For instance, a new immigrant still operating within the norms of the culture of origin may not perceive the physician as a satisfactory substitute for the traditional healer and, in the absence of the latter, may delay taking any action until forced to do so by a crisis. Not knowing the available options, or even how to initiate entry into the health care system, is a further cause of inaction. Choosing a new physician in a strange city can be a daunting task for anyone. For a person unfamiliar with the customs and perhaps not fluent in the language, it may seem an insurmountable obstacle. One can only conjecture how often people in this situation are labeled by health care providers as irresponsible with respect to their children's health.

Retirement is another event that launches people into a period of transition. Particularly when involuntary, it is an outward sign of growing old. One effect of this transition on older persons is that, because of prevailing confusion between the effects of aging and symptoms of illness, they tend to accept distressing symptoms such as decreased sensory acuity and urinary incontinence as inevitable aspects of aging, and therefore are reluctant to seek advice or treatment. Thus to fully understand a person's response to being in transition, it is important to understand how they perceive the transition process and what expectations they have for the outcome.

Transitions and Health Care Utilization

Even if the transition does not prevent the person from seeking health care, it may result in changes in utilization of health services.³⁸ A familiar example is the new immigrant's utilization of the hospital emergency department when what is needed is a regular office visit. There are at least two possible reasons for this behavior. One is the visibility of the service and relative ease of access as compared with visiting a physician's office or other facility that operates on an appointment basis. Another is that the strangeness of the new environment and lack of familiar resources may result in a high level of uncertainty and anxiety, which leaves the person unable to make judgments about the severity and seriousness of symptoms. Consequently, there may be a tendency to overrely on professionals for reassurance.

Transition as a Dependent Variable

In this case, transition occurs as a result of illness and changes in health status as is presented in Figure 18-4. People who experience life-threatening illnesses pass through a transition. Although we have some insightful descriptive accounts,^{40,41} there is still much that is unknown about the meanings that are constructed out of these events and why—irrespective of the actual amount of pathology involved—they are more devastating for some people than for others. Rehabilitation and reablement programs assume a transition. The effectiveness of such programs depends on congruence between the goals of the client and those of the therapist. This in turn presumes knowledge about the transition process and the client's perception of it.

In approaching measurement issues associated with developing the concept of transition, it is likely that we will be able, in part, to build on existing work. The conclusion of a recent review paper was that "there are currently at least 27 published scales that measure various aspects of social functioning and that have been reasonably well developed and tested."^{42(p1257)} No doubt some of these overlap with the dimensions that we deem especially pertinent to the transition process. The growing literature on coping strategies is another likely source of material.

SUMMARY AND CONCLUSIONS

This chapter illustrates one of the options for theory development—concept analysis and clarification. The broad concept of transition, a period of change between two relatively stable states that comes to be associated with some degree of self-redefinition, has been explored specifically within a nursing context, a context in which the central domains are person-client, health, and environment. Ramifications of the definition were traced. It was argued that a theory with transition as its central concept would provide continuity with directions evident from historical analysis of the work of other nurse theorists, meet nursing's present needs, and at the same time be

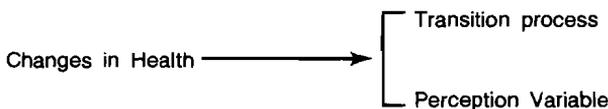


Figure 18-4. Transition as a Dependent Variable

congruent with trends in knowledge development in related fields. We see such a framework as conducive to more integrated and effective theoretical and research programs for nursing.

It is contended that the kind of theoretical development proposed would have at least the following three advantages that will have implications for further knowledge development.

1. Nurses sometimes tend to view clients historically, and therefore, they fail to recognize or meet the client's needs at the point where the client presently is in his or her perception of the situation. Conceptualizations that encompass flexible time orientation incorporating past, present, and future, as does transition, promote greater synchrony between the time orientations of nurse and client, and therefore provide a basis from which to more accurately define client needs.

2. Although the trend toward adopting "models of nursing practice" may be useful in alerting nurses to sets of problems associated with particular diagnostic categories, there is much that we still need to learn about how to set priorities in individual cases. There is a commonly held view that inadequacies in nursing care are due less to paucity of data than they are to failure by nurses to appreciate the relevance of data that are available. A transition framework would have the heuristic value of prompting researchers to pose questions pertinent to cue recognition and utilization.

3. An integrating and organizing conceptual framework makes it easier for a nurse to capitalize on what he or she knows already and to use existing knowledge more insightfully. This is not to deny the need for nurses to continually update their knowledge, which is a basic requirement in any practice discipline. But most nurses—through both education and experience—have already acquired a good deal of knowledge about human development and person-environment interactions. Unfortunately, such knowledge is not always well articulated and so made maximally available to benefit practice. Transition theory could be the key to changing this situation. This, broadly, has been the intent of this chapter: to analyze the concept of transition for the purpose of knowledge development in nursing.

We are aware that, in suggesting transition as a focus for theory development and research in nursing, the concept is not an entirely new one. Other disciplines are already working with it. However, analysis from a nursing perspective with the further development of theoretical and empirical linkages with nursing's other central domain concepts does signify an original approach with significant implications for knowledge development.

A theory linking transitions and health would meet Johnson's⁴³ three criteria for evaluating nursing theory: social congruence, social significance, and social utility. The ubiquity of the term transition in the recent nursing literature is evidence of its congruence with current orientations to change held by health care users and providers. That transition is a concept relevant

to many of nursing's immediate concerns is evident from the frequency with which the term has appeared in recent nursing literature in the context of transition and nursing practice,^{29,44,45} transition, education, and service,⁴⁶ research in transition,⁴⁷ and theory development.⁴⁸

Significance must be judged, finally, on empirical evidence. That the concept of transition already pervades much of the current thinking about nurses and nursing suggests that it is not a trivial notion or passing fad. In the body of this chapter, we have endeavored to show how the concept has potential application in a wide spectrum of nursing practice settings. It follows that the utility value of the concept is expected to be high. We see applications transculturally, for all age groups, and independent of clinical speciality. Yet, having micro aspects, it avoids the limitations of grand theory. Some general concepts that appear insightful in the broad scene have little to say in the individual case. So utility may in fact be this concept's major strength. Certainly nursing needs new knowledge, but it also needs tools and strategies that assist nurses to make best use of existing knowledge and to use it in a uniquely nursing way. Part of the work of theories is to generate new knowledge. They also serve to organize extant knowledge and make it more accessible. It may be that the concept of transitions will be a catalyst in the task of uncovering the knowledge embedded in clinical practice.^{49,50}

Finally, in order to meet the challenge of the American Nurses' Association policy statement that defines nursing as the "diagnosis and treatment of human responses to actual and potential health problems,"^{51(p9)} a plurality of theories is needed. A theory linking health, illness, and nursing with transition would not supercede the variety of theoretical formulations that now inform nursing research and practice. Certainly there would be some overlap (this speaks to the issue of validity), but transition theory offers a framework and a perspective for organization of knowledge related to events and responses to transitions. The realization of such a theory would depend on a program of inquiry aimed at clarifying theoretical and operational linkages between transition and a broad spectrum of health-illness states. The next stage would be the empirical testing of several kinds of propositions, such as those linking the transition process with health-illness states and those linking it with nursing therapeutics.

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