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Experiencing Transitions: An Emerging Middle-Range Theory

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Abstract

Changes in health and illness of individuals create a process of transition, and clients in transition tend to be more vulnerable to risks that may in turn affect their health. Uncovering these risks may be enhanced by understanding the transition process. As a central concept of nursing, transition has been analyzed, its components identified, and a framework to articulate and to reflect the relationship between these components has been defined. In this article, the previous conceptual analysis of transitions is extended and refined by drawing on the results of five different research studies that have examined transitions using an integrative approach to theory development. The emerging middle-range theory of transitions consists of types and patterns of transitions, properties of transition experiences, facilitating and inhibiting conditions, process indicators, outcome indicators, and nursing therapeutics. The diversity, complexity, and multiple dimensionality of transition experiences need to be further explored and incorporated in future research and nursing practice related to transitions.

Changes in health status may provide opportunities for enhanced well-being and expose individuals to increased illness risks, as well as trigger a process of transition. Vulnerability may be conceptualized as a quality of daily lives uncovered through an understanding of clients' experiences and responses during times of transition. In this sense, vulnerability is related to transition experiences, interactions, and environmental conditions that expose individuals to potential damage, problematic or extended recovery, or delayed or unhealthy coping. Clients' daily lives, environments, and interactions are shaped by the nature, conditions, meanings, and processes of transition experiences. Transitions are both a result of and result in change in lives, health, relationships, and environments.

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Nurses often are the primary caregivers of clients and their families who are undergoing transition. They attend to the changes and demands that transitions bring into the daily lives of clients and their families. Furthermore, nurses tend to be the caregivers who prepare clients for impending transitions and who facilitate the process of learning new skills related to clients' health and illness experiences. Examples of transitions that may make clients vulnerable are *illness experiences* such as diagnosis, surgical procedures, rehabilitation and recovery; *developmental and lifespan transitions* such as pregnancy, childbirth, parenthood, adolescence, menopause, aging, and death; and *social and cultural transitions* such as migration, retirement, and family caregiving. 1,2

As a central concept in nursing, transition has been analyzed and a framework has been defined to articulate and reflect the relationships among the components of a transition. 1,3 Transition has been used both as a perspective and as a framework. The purpose of this article is: (a) to continue the conceptual analysis of transition from a nursing perspective, extending and refining the existing framework by drawing on the results of five nursing studies that were based on a transition framework, 4-8 and (b) to identify future directions for nursing research and theory building regarding transitions and a transition framework. In the process, the findings across studies were compared and contrasted, emerging properties were identified, the literature from 1993 to 1997 was reviewed, and respective clinical and research experiences and perspectives were integrated into the analyses. Using an integrative concept analysis strategy, 9 a middle-range theory was developed. In presenting the analysis, each study will be introduced briefly and then the emerging theoretical framework and the conceptual modifications that were developed from the analysis of this collective research will be outlined.

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STUDIES USING TRANSITIONS AS A FRAMEWORK

The frameworks articulated by Chick and Meleis 3 and Schumacher and Meleis 1 were used to guide the development of each of the following studies and the analysis of data. The intent of each study was to uncover emerging themes that may not have been originally a part of the framework. The process of using inductive and deductive reasoning not only enabled evaluation of the utility of the different components of the framework, but also identified additional emerging components.

The studies reflect cultural diversity in vulnerable populations including African Americans, Brazilian immigrants, and Korean immigrants. They also reflect a variety of transitions that may lead to heightened vulnerability, including pregnancy, motherhood, menopause, work, migration, caregiving, and diagnostic processes. Although different approaches were used for data analysis, each study used a qualitative research design with the goal of theory development. In addition, each study reflected a feminist perspective in the design and in the interpretation of data, allowing an examination of the data within the context of race, class, culture, and gender.

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Becoming an African-American mother

Using grounded theory methodology, 17 first-time African-American mothers were interviewed to elicit their experiences of pregnancy and motherhood. 4,10 This transition spanned the time period between the woman's decision to get pregnant or to continue a pregnancy and the time when mothering was incorporated into her identity. Women were interviewed both individually and in focus groups from one to three times during the postpartum period. *Engaged mothering* was identified as the core category, denoting the active, involved, and mutual process in which African-American mothers get ready to be a mother, deal with the reality involved, settle in with their babies, and dream and plan for a good life for themselves and their children and families. The outcome of engaged

mothering is incorporation of mothering into the woman's identity and a healthy, happy, strong, safe, and secure child. In this study, all women demonstrated engaged mothering. However, the environment for this group of women increased their stress during pregnancy. Women frequently anticipated and dealt with incidents of racism, stereotyping, and negativity in their daily lives. The environment mediated the transition both by providing support and by increasing stress. Two conditions affected transition experiences and responses: First, the level of planning for motherhood was influenced by the degree to which the pregnancy was intentional, with women who were actively trying to get pregnant proceeding through the transition more easily. Second, prior miscarriage or history of health problems of the mother diminished the woman's sense of emotional and physical well-being and inhibited the transition. 10

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Neglecting and ignoring the menopausal transition

The purpose of this study was to describe the perceived meanings that low-income Korean immigrant women had about their menopausal transition, to describe their perceived symptoms during this transition, and to analyze their responses within a context of immigration and their work situations. 5 The study was cross-sectional, utilizing methodological triangulation. 11 For the qualitative portion of the study, semi-structured in-depth interviews were conducted with 21 perimenopausal or postmenopausal women. Data were analyzed using thematic analysis. A major conceptual category that emerged was *neglecting and ignoring the menopausal transition* because of other imminent demands in the women's lives because of immigration, new work experiences, and the patriarchal cultural heritage that makes women's experiences invisible and inaudible. The number, seriousness, and priority of transitions that these women were experiencing contributed to neglect of their menopausal transition. 12 In addition, the participants relayed stories of neglect and of their experiences within the context of gender, low-income status, and attitudes toward health and illness. Participants related these conditions to their menopausal transitions.

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Parents and diagnostic transitions

Messias et al 6 examined the experiences of parents of children diagnosed with congenital heart defects (CHD). The analysis was part of a larger exploratory investigation 13-15 of the transitions in health, social relations, and development experienced by adolescents and young adults with CHD and their families. The stories collected from eight parents about the birth and diagnosis of a child with CHD revealed the superimposition of an unanticipated transition with possible negative outcomes (becoming the parent of a child with CHD) on an anticipated transition with an expected positive outcome (becoming the parent of a normal, healthy newborn). As the parents observed health care providers and environments and their own infants, they began to gather evidence that something was wrong. They frequently became confused with the *illusiveness of normality*, as they tried to sort out the sometimes paradoxical meanings and appearances of "normal pregnancies," "normal, healthy babies," and the diagnosis of CHD. For some, the diagnostic event per se came as an abrupt shock. For others, coming to know the diagnosis was a gradual process over time, characterized more by ambivalence and unknowing. The process of coming to know, recognize, and acknowledge the congenital condition in the child was characterized as a *rude awakening*. Eventually, parents' acknowledgment and understanding of the reality of CHD became the *work of managing uncertainty*, which would become one of the hallmarks of their parenting in the ensuing years. As parents reflected back on their experiences, they told of how they *created new meanings* in their own and their children's lives and talked about *taking stock of costs and benefits* of having a child with CHD.

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Migration, work, and health: complex, multidimensional transitions

In another study, Messias 7 explored the lived experiences of transnational

migration, work, employment, and health. Embedded in the narratives of 26 Brazilian women who had migrated to the United States were stories of *multiple transitions, fluid identities, constant comparisons*, and *changing perspectives on class, culture, and women's work*. All of the women in the study experienced some form of work or occupational transition in conjunction with their transnational migration. For some, migration signified the transition from being a Brazilian professional, student, or middle-class housewife to immigrant domestic worker. Domestic work was one of the limited employment options for many, particularly for the newly arrived and the undocumented. Women viewed this occupational transition from different perspectives and found different meanings in the experience. Over time, domestic or food service work was a temporary stepping stone for some; for others, domestic work signified a long-term career change. Such migratory occupational transitions were embedded in social transitions, which in many cases translated into perceived downward social mobility. However, for some of the women who had been employed as domestic workers in Brazil, migration was perceived as an upward social and economic transition. Within the narratives of the women, there were both strong support and interesting challenges for the use of a transition framework to understand and explain migration experiences. What characterized their experiences as transitions was not so much the movement across national borders but the resulting passages between different life phases, conditions, and statuses, accompanied by some degree of self-redefinition. 3 The results of this research support the concept of migration as a transnational transition. However, the study suggested that transnational migration transitions are characterized by movement that is ongoing, recurring, and multidirectional and is between multiple places, spaces, situations, and identities, rather than movement that is linear or unidirectional.

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The family caregiving study

The purpose of this study was to generate a grounded theory of family caregiver role acquisition among caregivers of persons receiving chemotherapy for cancer. 8 Specifically, the study sought to identify patterns of role acquisition and conditions influencing these patterns, using an interactionist perspective. Thus, the study included both family caregivers and the persons for whom they were providing care. A longitudinal design in which participants were interviewed three times across the course of chemotherapy was consistent with a transition perspective. 1 The sample consisted of 19 caregivers and 20 patients with solid tumors or lymphoma. Semi-structured interviews addressed illness care experiences, strategies, and interactions. Although the original intent of the study was to explore caregivers' transitions into the caregiving role, it quickly became apparent that caregiving could not be isolated analytically from self-care by the ill person. Thus, self-care and caregiving by the dyad became the focus for analysis. Patterns of self-care and caregiving were quite fluid and shifted often over the course of chemotherapy as conditions for care changed, leading to the identification of *shifting patterns of self-care and caregiving* as the core concept of the grounded theory. The study revealed the fluidity of care involvement during the transition into illness care roles and the need to study complementary role transitions together.

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EMERGING FRAMEWORK

Through our collective research, an expanded theoretical framework emerged consisting of:

* types and patterns of transitions

* properties of transition experiences

* transition conditions: facilitators and inhibitors

* process indicators

* outcome indicators

* nursing therapeutics


Fig 1

In this article the first five components of the framework are addressed. Concurrently with the analysis presented here, implications for nursing therapeutics are addressed; however, a full exposition of this part of the framework is beyond the scope of this article. The relationships between the six components of the framework are illustrated in Fig 1. These components were identified through a collaborative process of dialogue, constant comparison of the findings across the five studies, and analysis. In the following sections each of the components is discussed, focusing in particular on the extensions and modifications of previous frameworks and on the emerging framework.

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TYPES AND PATTERNS OF MULTIPLE AND COMPLEX TRANSITIONS

Types of transitions that nurses encounter in working with patients and families have been identified as developmental, health and illness, situational, and organizational. 1,3,16 The results of our research supported this typology as representative of the transitions central to nursing practice. However, the research also supported the notion of transitions as patterns of multiplicity and complexity. 7 For example, each of the previously described studies involved individuals who were experiencing at least two types of transitions, indicating that transitions are not discrete or mutually exclusive. Migration scholars have called attention to the multiple structural transitions involved in migration, such as transitions in employment, socioeconomic status, culture, and social networks. 17 Messias 7 noted that the migration experiences of Brazilian women were multiple and complex in nature and did not occur in isolation, but rather in conjunction with other situational, developmental, and health-illness transitions. As the women talked about their migration, work, and health experiences, the interrelations and connections of multiple transitions were woven throughout their narratives. Similarly, Im 5 found that the Korean women were not only dealing with the developmental transition of menopause but also situational transitions related to migration and work. In fact, for these women, the menopausal transition was found to be less of a priority than the other transitions they were experiencing.

Messias et al 6 found that the diagnosis of CHD in newborns or infants created an unexpected transition superimposed on other personal and family transitions related to childbirth and parenting. Schumacher 18 found that the transition into the caregiving role could not be understood in isolation from the health and illness transition experienced by the family member with cancer. At the same time the caregiver was experiencing the transition to the caregiving role, the care receiver was experiencing the transition to having a life-threatening illness.

In light of the results of these studies, our analyses of the nature of transitions suggest that nurses need to consider the patterns of all significant transitions in an individual or family's life rather than focusing only on one specific type of transition. Patterns of transition would include whether the client is experiencing a single transition or multiple transitions. Important considerations are whether multiple transitions are sequential or simultaneous, the extent of overlap among transitions, and the nature of the relationship between the different events that are triggering transitions for a client.

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PROPERTIES OF THE TRANSITION EXPERIENCE

Transitions are complex and multidimensional, but several essential properties of transition experiences have been identified. These include

* awareness

* engagement

* change and difference

* time span

* critical points and events

These properties are not necessarily discrete. Rather, they are interrelated properties of a complex process.

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Awareness

Awareness is related to perception, knowledge, and recognition of a transition experience. Level of awareness is often reflected in the degree of congruency between what is known about processes and responses and what constitutes an expected set of responses and perceptions of individuals undergoing similar transitions. Chick and Meleis 3 included awareness as a defining characteristic of transition, and they purported that to be in transition, a person must have some awareness of the changes that are occurring. They posited that an absence of awareness of change could signify that an individual may not have initiated the transition experience. We propose that although awareness appears to be an important property of transition, the lack of manifestation of such awareness does not preclude the onset of a transition experience. For example, some of the Korean women in Im's 5 study did not recognize that they were experiencing a menopausal transition; others recognized the experience only at the cessation of menstruation. However, although the changes related to menopause were not fully recognized, there was evidence that the women were going through a transition related to menopause.

We do not believe that our analysis of these studies has completely resolved the tension between *transition awareness by clients* and *nurses' knowledge of whether clients are in transition*. Thus, the question remains: Whose awareness (nurses or clients) triggers the beginning of the process? These studies provide a context for discussion but do not resolve the paradox.

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Engagement

Another property of transitions is the level of engagement in the process. Engagement is defined as the degree to which a person demonstrates involvement in the processes inherent in the transition. Examples of engagement are seeking out information, using role models, actively preparing, and proactively modifying activities. The level of awareness influences the level of engagement in that engagement may not happen without awareness. The level of engagement of a person who is aware of physical, emotional, social, or environmental changes will differ from that of a person unaware of such changes. Sawyer 4 found various instances of differing levels and types of engagement in the transition to motherhood among the participants in her study. For example, a woman in the early months of pregnancy who is unaware of changes in her body may not be as careful about potentially harmful medications or balancing her diet.

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Change and difference

Change and difference are essential properties of transitions. Although similar, these properties are not interchangeable, nor are they synonymous with transition. All transitions involve change, whereas not all change is related to

transition. 2,19 An example from the study of parents' diagnostic transitions illustrates the difference between change and transition. One of the fathers described the impact of the diagnosis of CHD as having resulted in an abrupt *change* in family focus. However, the *transition* was a long-term process, which involved the father adapting to new roles and situations, coming to terms with the diagnosis, and eventually resulting in new meanings and a sense of mastery when he understood the "whole picture." 6 Transitions are both the result *of change* and result *in change*.

To fully understand a transition process it is necessary to uncover and describe the effects and meanings of the changes involved. Dimensions of change that should be explored include the nature, temporality, perceived importance or severity, and personal, familial, and societal norms and expectations. Change may be related to critical or disequilibrating events, to disruptions in relationships and routines, or to ideas, perceptions, and identities. For example, some parents of infants with CHD perceived the "diagnostic event" itself as the critical disequilibrating event, but for others cardiac surgery was more forcefully disequilibrating. Sawyer 4 noted that the African-American women understood that any changes they experienced in their bodies could affect the development of their babies.

Confronting difference is another property of transitions, exemplified by unmet or divergent expectations, feeling different, being perceived as different, or seeing the world and others in different ways. Messias 7 noted that immigrant women confronted difference on many different levels. Those who had expectations of facile, abundant opportunities and easy money frequently were confronted upon arrival in the United States with the very different reality of restricted and sometimes demeaning employment. However, expectations were varied and individualized, and the disjuncture between expectations and reality was not always for the worse. Whereas some immigrants were stunned, shocked, or disappointed with the reality they encountered, others were pleasantly surprised. Immigrant women also found differences in the food, supermarkets, health care system, social patterns and beliefs, landscape, language, and the way Americans show affection. One woman remarked that it involved a lot of work "*not to be affected by all of these differences*." Some immigrants admitted that they themselves had changed, that they were now different because they had become "*more American*," more impersonal and less socially engaged. Others identified themselves as more independent, responsible, and autonomous. Migration often resulted in a blurring of previously perceived differences such as social class or gendered employment. However, such blurring did not necessarily signify that the differences had been erased. Perceived difference sometimes resulted in changed behaviors or perceptions, but not all differences affected women in the same way or held the same meanings. In examining transition experiences, it may be useful for nurses to consider a client's level of comfort and mastery in dealing with change and difference.

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Time span

All transitions are characterized by flow and movement over time. 2 Bridges 19,20 characterized transition as a time span with an identifiable end point, extending from the first signs of anticipation, perception, or demonstration of change; through a period of instability, confusion, and distress; to an eventual "ending" with a new beginning or period of stability. However, the results of the research examined here suggest that it may be difficult or impossible, and perhaps even counterproductive, to put boundaries on the time span of certain transition experiences. 6 The stories told by parents of infants with CHD indicated that their transition did not always follow the same chronological trajectory. Migration provided another case in point. 7 Immigrants may consider their transition as "temporary" even though they may live in another country for an extended period. Even for those who settle permanently, the migration experience may best be characterized as an ongoing, undulating, unending transition. This does not necessarily mean that immigrants or others experiencing long-term transitions are constantly in a state of disconnectedness, flux, or change. However, such states may periodically surface, reactivating a latent transition

experience. In evaluating transition experiences, it is important to consider the possibility of flux and variability over time, which may necessitate reassessment of outcomes.

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Critical points and events

Some transitions are associated with an identifiable marker event; such as birth, death, the cessation of menstruation, or the diagnosis of an illness; while in other transitions specific marker events are not as evident. 19,20 The various studies involving multiple transitions provided evidence that most transition experiences involved critical turning points or events. Critical points were often associated with increasing awareness of change or difference or more active engagement in dealing with the transition experience. In addition, there were final critical points, which were characterized by a sense of stabilization in new routines, skills, lifestyles, and self-care activities. In each study there was a period of uncertainty marked with fluctuation, continuous change, and disruption in reality. Symptoms related to the transition might also occur. During a period of uncertainty there were a number of critical points depending on the nature of the transition. Each critical point requires the nurse's attention, knowledge, and experience in different ways.

For example, in the family caregiving study, 8 four critical periods were identified:

1. the diagnostic period
2. the side-effectDintensive periods of chemotherapy cycles
3. the junctures between treatment modalities
4. the completion of treatment

These were periods of heightened vulnerability during which participants encountered difficulties with self-care and caregiving. Illness care conditions were changing, self-care and caregiving patterns were shifting, access to health care providers was changing, and participants experienced uncertainty and anxiety.

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TRANSITION CONDITIONS: FACILITATORS AND INHIBITORS

In the discipline of nursing, humans are defined as active beings who have perceptions of and attach meanings to health and illness situations. These perceptions and meanings are influenced by and in turn influence the conditions under which a transition occurs. Thus, to understand the experiences of clients during transitions, it is necessary to uncover the personal and environmental conditions that facilitate or hinder progress toward achieving a healthy transition. Personal, community, or societal conditions may facilitate or constrain the processes of healthy transitions and the outcomes of transitions.

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Personal conditions

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Meanings

The meanings attributed to events precipitating a transition and to the transition process itself may facilitate or hinder healthy transitions. In the Korean menopause study, 5 although the participants had ambivalent feelings toward menopause, menopause itself did not have special meaning attached to it. Most of the women did not relate any special problems they were having to their

menopausal transition. Furthermore, some participants indicated that they went through their menopause without experiencing or perceiving any problems. Therefore, in a sense, "no special meanings" may have facilitated the women's menopausal transition. 5 On the other hand, the African-American women attributed intense enjoyment to their roles as mothers and described motherhood in terms of being responsible, protecting, supporting, and being needed. 4 In these two examples neutral and positive meanings may have facilitated menopause and motherhood.

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Cultural beliefs and attitudes

When stigma is attached to a transition experience, such as menopause in Korean culture, the expression of emotional states related to the transition may be inhibited. Because women in Korean culture tend to regard menopause as shameful to discuss in public, 21 they silently go through menopause on their own, and their menopausal experience becomes a lonely experience. Symptoms then get attributed to their emotional state and become stigmatized. Their psychological symptoms were noted only when expressed physically, through headaches, muscle aches, and exhaustion. Perhaps Asian and Middle-Eastern cultures express psychological symptoms through somatization because of the fear of stigma. 22

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Socioeconomic status

Another inhibitor to healthy menopausal transition was the women's low socioeconomic status. The women's experience of psychological symptoms was significantly affected by their socioeconomic status rather than their menopausal states. As other studies have shown, 23-27 participants who have low socioeconomic status were more likely to experience psychological symptoms.

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Preparation and knowledge

Anticipatory preparation facilitates the transition experience, whereas lack of preparation is an inhibitor. Inherently related to preparation is knowledge about what to expect during a transition and what strategies may be helpful in managing it. For one immigrant Brazilian woman, lack of preparation was particularly stark. 7 The woman's limited knowledge and understanding of geography, language, and culture were transparent, and upon her arrival in the United States, the consequences of her lack of preparation and understanding immediately became evident. She was shocked culturally, physically, and emotionally. The woman had brought only summer clothes and the cold April weather in New York took her by surprise. Crammed into a room with 10 people, she looked out the window on a strange, unknown world and thought she was losing her mind. Her nightmares were a reflection of what life itself had become. Immigration was not only a move to a different place, a different city, a different country, or a different hemisphere; she found herself literally in a different world, a world she had no idea existed.

The transition to motherhood provides another example of the importance of preparation and expectations. 4 When a pregnancy was not planned, or when the mother had a history of either miscarriage or illness, the transition through the stages toward developing a maternal identity was delayed. In the menopause study, lack of knowledge about menopause was found to inhibit the menopausal transition. Women who lacked knowledge often visited clinics because of changes in their menstruation. When their physicians recommended surgical treatment, the women silently followed the physicians' suggestions because they rarely knew about other alternatives.

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Community conditions

Community resources also facilitate or inhibit transitions. For example, to deal with their immigration transition, Korean immigrants turned to restaurants, laundries, and/or grocery shops in the Korean community seeking the support of other immigrants. 5 However, because of the need for privacy and the mistrust within the Korean immigrant community, women rarely used these readily available community resources for issues related to health and illness. Thus, distrust within immigrant communities may prevent women from using familiar resources to support their various transitions. Until they become familiar with and have access to host country resources, they may get inadequate community support during critical times in their transitions. 5

African-American women also described community-level conditions that both facilitated and inhibited their transitions to motherhood. 4 Facilitators included:

* support from partners and families, especially from the woman's mother and other significant women in her life

* relevant information obtained from trusted health care providers and from classes, books, and other written materials

* advice from respected sources

* role models

* answers to questions

Inhibitors of a healthy transition for these mothers included insufficient resources to support pregnancy and motherhood. Planning and offering classes that were inconvenient for the women was also an inhibitor. As one woman said, "Well, actually, all the classes were at the hospital, and I don't have a car. And they're at night. And I didn't have a coach." Other inhibitors of a healthy transition for these mothers included inadequate support, unsolicited or negative advice, insufficient or contradictory information, and the hassles of being stereotyped, facing negativity from others, or being treated like "public property." 4

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Societal conditions

Society at large could also be a facilitator or inhibitor for transitions. Viewing a transitional event as stigmatized and with stereotyped meanings tends to interfere in the process of healthy transition. For example, gender inequity is a constraint at the societal level that influences a woman's menopausal transition. In patriarchal Korean culture, the position of women in the family structure is well known. 28 Women's position in the family explains why their own health care needs are put behind other family members' needs, and why they sacrifice time for themselves. Therefore, viewing the menopausal transition alone without considering gender inequities embedded in the daily experiences of women cannot be adequate.

Marginalization was another societal inhibitor to the Korean immigrant women's menopausal experience. Because they were in the margin both in the host society and in their own culture, they neglected and ignored their menopausal experiences. They rarely recognized menopause as a health problem. Rather, they gave priority to their family matters and made their own needs secondary. Cultural attitudes toward women's bodies and experiences were yet another societal inhibitor to a healthy menopausal transition. 21

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PATTERNS OF RESPONSE

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Process indicators

Meleis and Trangenstein 2(p257) state that "nursing ... is concerned with the process and the experiences of human beings undergoing transitions where health and perceived well-being is the outcome." Based on the studies described in this article, a healthy transition is characterized by both process and outcome indicators. Because transitions unfold over time, identifying process indicators that move clients either in the direction of health or toward vulnerability and risk allows early assessment and intervention by nurses to facilitate healthy outcomes. 29 In each of the studies, methods were used to uncover the processes inherent in healthy transitions. Some of the observations about the indicators or patterns of response that characterized healthy transitions are discussed below. These patterns of response included feeling connected, interacting, being situated, and developing confidence and coping.

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Feeling connected

The need to feel and stay connected is a prominent theme in many transition narratives. For example, making new contacts and continuing old connections with extended family and friends were an important part of Brazilian women's migration experiences. 7 Similar to what has been documented by other researchers, 30-34 the immigrant women in this study utilized social and kinship networks as important sources of information, housing, transportation, employment, and social support. Personal contacts and connections were a primary source of information about health care services and resources. Feeling connected to health care professionals who could answer questions and with whom they felt comfortably connected was another important indicator of a positive transition experience. 7 This emerging dimension of transition supports the clinical evidence that providing culturally competent care in hospitals requires continuity in relationships between health care providers and patients. 35

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Interacting

Among people with cancer and their family caregivers, 8 intra-dyadic interaction was a critical dimension of the transition experience. Through interaction, the meaning of the transition and the behaviors developed in response to the transition were uncovered, clarified, and acknowledged. Although the diagnosis of cancer was seen by all as a crisis event, the meaning of self-care and caregiving varied from one dyad to another. In some dyads, the involvement of the caregiver was resisted as the person with the diagnosis of cancer struggled to maintain self-care. In other dyads, the involvement of the caregiver was welcomed as a supportive gesture. These strategies were clarified through interaction and reflection about the new and emerging relationship. Through interaction, dyads created a context in which self-care and caregiving could take place effectively and harmoniously.

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Location and being situated

Location is important to most transition experiences, although it may be more obvious in some than in others, such as migration, where location often implies a unidirectional movement from one place to another. For immigrants, there is a constant actual or imaginary migration back and forth between home and host country, between their pre- and postmigration lives. 7 In their stories, the Brazilian women constantly made comparisons. They compared their lives, experiences, practices, and attitudes pre- and postmigration, from when they first arrived, and after they had lived in the United States for a while. They compared almost anything: health care, food, diet, nutrition, family relationships, child rearing, prices, domestic work, climate, weather, employment and work opportunities, and gender and class relations. The women also brought diverse perspectives to their migration experiences. One of the characteristics of

transitions is the creation of new meanings and perceptions. Comparisons were one of the ways the immigrant women presented, examined, and made meaning of their experiences. They understood their new life by comparing it to the old.

Making comparisons was also a way of "situating" themselves in terms of time, space, and relationships; a way to explain and perhaps justify how or why they came, where they are and where they have been, and who and what they are. The comparisons were multidirectional in the sense that some were favorable toward Brazil or the premigration experience, and others were favorable toward the United States or the postmigration experience. Such comparisons most certainly served different purposes for different women at different times, but they highlight the multiplicity of perspectives in immigrants' experiences, something that nonmigrants may find difficult to understand or may misinterpret as criticism or condemnation. 7

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Developing confidence and coping

Another dimension that reflects the nature of the transition process is the extent to which there is a pattern indicating that the individuals involved are experiencing an increase in their level of confidence. Developing confidence is manifested in the level of understanding of the different processes inherent in diagnosis, treatment, recovery, and living with limitations; in the level of resource utilization; and in the development of strategies for managing. The dimensions of developing and manifesting confidence are progressive from one point to the next in the transition trajectory. As one participant in the African-American pregnancy study 4 put it, "So I figured … I guess he's getting enough milk. He's gaining weight. It must be OK. So I didn't worry." Another participant in the same study was more confident because, as she put it, "I have a schedule, and I'm just so in tune with his schedule." Participants demonstrated cumulative knowledge of situations, more understanding of critical and turning points, and a sense of wisdom resulting from their lived experiences.

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Outcome indicators

Two outcome indicators emerged from the studies examined in this analysis: mastery of new skills needed to manage a transition and the development of a fluid yet integrative identity. The levels at which these outcomes are experienced may reflect by proxy the quality of life for those who are experiencing transitions. The determination of when a transition is complete must be flexible and variable depending on the type of change or the event initiating the transition, as well as the nature and patterns of transition. If outcomes are considered too soon in a transition process, they may be process indicators. If they are examined too long after a transition is complete, they may be related to other events in the client's life. In some transitions, it is easier to determine a beginning and an ending point. In all transitions, there is a subjective element of achieving a sense of balance in one's life. In the studies reported here, mastery and having a new sense of identity reflected healthy outcomes of the transition process.

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Mastery

A healthy completion of a transition is determined by the extent to which individuals demonstrate mastery of the skills and behaviors needed to manage their new situations or environments. 36 In the motherhood study, 4 one participant described mastery by indicating that "At about 2 months I started making my own decisions." Another described mastery as taking charge of her care: "I had to ask for that test you know. I would think that the doctors would know … she had forgotten." Skills needed to achieve mastery in the caregiving situation included monitoring and interpreting symptoms, making decisions, taking action, providing hands-on care, making adjustments, accessing resources, working collaboratively with the care receiver, and negotiating the health care system. 37

The results of the family caregiving study suggest that mastery results from blending previously established skills with skills newly developed during the transition process. Also, skill develops over time with experience. Thus, mastery is unlikely to be seen early in a transition experience. However, by the time clients are experiencing a new sense of stability near the completion of a transition, their level of mastery will indicate the extent to which they have achieved a healthy transition outcome.

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Fluid integrative identities

Transition experiences have been characterized as resulting in identity reformulation. 3,38 The results of Messias' 7 research support the conceptualization of immigrants' reformulated identities as *fluid* rather than static, as dynamic rather than stable. Some degree of ambiguity is also a part of the notion of a fluid migrant identity. The concept of fluid migrant identities as identified in the stories of these Brazilian immigrant women also supports the incorporation of a transnational perspective within a transition framework of migration. For the women in this study, one of the characteristics of the "new identity" that came with migration was that their perspectives were now bicultural rather than monocultural.

In moving to, settling in, working, and interacting within another social, political, economic, and cultural environment and context, the migrant acquires added baggage, in that she begins to carry around the baggage of two (or more) cultures, two (or more) different ways of being. At different times and in different spaces in a migrant's life, she may carry more baggage from the home or host country or culture. In terms of space, she may have more home country baggage in her domestic or social arena, in contrast to the workplace where she may have adapted more to the host country. However, there is no set pattern or formula. Because the migration transition is dynamic and ongoing, over time an immigrant may periodically pick up or leave behind different pieces of this identity baggage. Situations that may trigger a change in focus or perspective include developmental, situational, or health-illness transitions such as marriage, pregnancy, personal or family illness, or a change in employment. These transitions are then likely to be viewed from a bifocal perspective. 7

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CONCLUSION

Knowledge is empowering to those who develop it, those who use it, and those who benefit from it. Understanding the properties and conditions inherent in a transition process will lead to the development of nursing therapeutics that are congruent with the unique experiences of clients and their families, thus promoting healthy responses to transition.

Theories provide frameworks for understanding complex situations such as vulnerable clients' processes and responses to transitions. A middle-range theory of transitions emerged from the analyses of the studies presented here. Middle-range theories are characterized by more limited scope and less abstraction than grand theories. Also, they address specific phenomena or concepts and reflect practice. 9 Because diverse types and patterns of transitions were considered in this theoretical development, we believe that the emerging framework gives a more comprehensive view of transitions, providing more specific guidelines for practice and driving more systematic and coherent research questions.

As the studies presented in this article indicate, transition experiences are not unidimensional. Rather, each transition is characterized by its own uniqueness, complexities, and multiple dimensions. Future endeavors should be directed toward defining the diversities and complexities in transition experiences through research with diverse populations in diverse types and patterns of transitions.

Each concept proposed here needs to be further developed and refined. Similarly, research to discover the levels and nature of vulnerability at different points during transitions could be driven by this middle-range theory. Finally, nursing therapeutics that reflect the diversities and complexities of the transition experiences need to be identified, clarified, developed, tested, and evaluated.

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Key words: middle-range theory; research based theory; transition

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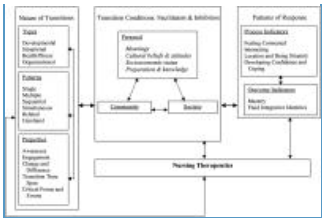

Fig 1

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