1999

Helping Elderly Persons in Transition: A Framework for Research and Practice

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CHAPTER 1

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Karen L. Schumacher, Patricia S. Jones, and Afaf Ibrahim Meleis

Growing old is not an event. There is not a particular day or a certain birthday that marks a person as old. Growing old is a process of gains and losses that takes time. How this period of time is viewed by gerontological nurses shapes their work with elderly clients and their families. The nature of nursing assessment, the goals established with clients, and the interventions used are embedded in the nurse's perspective on aging. Similarly, the research questions posed by the gerontological nurse are embedded in a particular perspective.

We propose that a transition framework provides a perspective on aging with significant potential for advancing gerontological nursing practice and research. Many transitions are experienced by elderly persons, and these transitions are inherently linked to the older person's health and need for nursing care. Indeed, it often is a transition that brings the older person into contact with professional nursing. The use of a transition framework recognizes the importance of transitions for the health of elderly persons. Thus such a perspective leads to effective strategies for practice and productive lines of inquiry for research.

The purpose of this chapter is to describe a transition framework for use in gerontological nursing practice and research and to demonstrate its use.

We first provide an overview of transitions in elderly persons, briefly reviewing both conceptual work and nursing research on transitions. Next, we turn our attention to transitions and health, identifying characteristics and indicators of healthy transition processes. Finally, we describe several nursing therapeutics designed to facilitate smooth transitions for older clients. The use of this framework is demonstrated with a case example.

THE CONCEPT OF TRANSITION: DEFINITION AND PROPERTIES

A transition is a passage between two relatively stable periods of time. In this passage, the individual moves from one life phase, situation, or status to another. Transitions are processes that occur over time and have a sense of flow and movement. They are ushered in by changes that trigger a period of disequilibrium and upheaval. During this period, the individual experiences profound changes in his or her external world and in the manner that world is perceived. There often is a sense of loss or of alienation from what had been familiar and valued. During transitions, new skills, new relationships, and new coping strategies need to be developed (Chick & Meleis, 1986; Meleis, 1986; Meleis & Trangenstein, 1994).

Late life is a time of multiple transitions. Retirement, loss of spouse and friends, relocation to a new living situation, and the advent of chronic illness or frailty are just some of the transitions experienced by elderly persons. These transitions may be categorized as developmental, situational, or related to health and illness (Figure 1.1). Many of the transitions experienced by older persons involve loss and are undesired. However, some transitions are positive and welcomed. For example, starting a new endeavor or developing new aspects of self are transitions that represent opportunities rather than losses.

What are the properties of a transition? First, a transition is precipitated by a significant marker event or turning point that requires new patterns of response. These markers prompt the recognition that business is not as usual and that new strategies are needed to handle even familiar, daily life experiences, such as managing one's finances, maintaining one's own health, or taking care of daily activities. Such strategies involve the development of new skills, new relationships, and new roles. Another characteristic of transitions is that they are processes that take time. Transitions span the whole period of time from the initial marker event until harmony

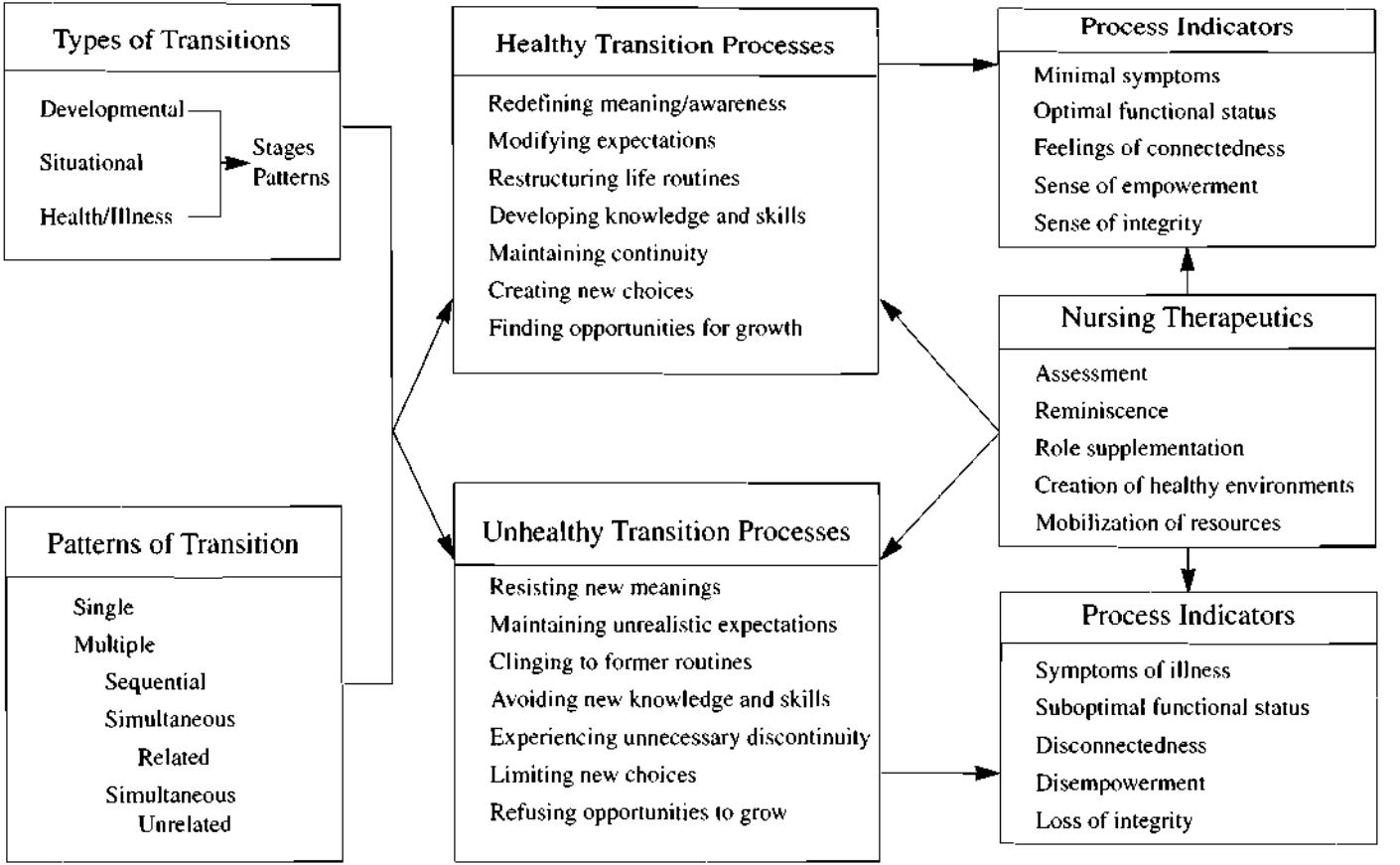

Figure 1.1 Transitions and health: A framework for gerontological nursing.

and stability are again experienced. This time period is needed to experiment with different strategies and patterns of responses and to incorporate them into one's own repertoire. The time required for a transition is variable and depends on the nature of the change and the extent to which that change influences other aspects of a person's life. Another property of transition is that changes in identity, roles, and patterns of behavior occur. Transitions are not fleeting or superficial changes; rather, they involve fundamental changes in one's view of self and the world (Chick & Meleis, 1986; Meleis & Trangenstein, 1994; Schumacher & Meleis, 1994).

Transitions often are conceptualized in terms of stages to capture their movement, direction, and flow as they evolve over time. A classic description of the stages of transition is found in Bridges' study (1980). According to Bridges, the first stage of a transition is a period of endings in which there is disengagement from relationships or from ways of behaving as well as a change in the person's sense of self. The second stage, termed the "neutral zone," is an in-between period, a time when a person experiences disorientation caused by the losses in the first stage followed by disintegration of systems that were in place. This is an uncomfortable but necessary period of time. Only by going through the neutral zone can persons become open to new possibilities. The final stage of a transition is that of new beginnings and is marked by finding meaning and experiencing some control. Persons must go through all three stages to deal effectively with the transition. However, the stages of a transition do not necessarily occur in a linear manner. Rather, they may be sequential, parallel, or overlapping.

Transitions also can be described in terms of patterns. Single or multiple transitions may occur within a given period of time, and they may be related or unrelated. Young (1990) alluded to the phenomenon of patterns of transition when she observed that relocation to a nursing home can occur in the context of other transitions and can catalyze further life changes. She also noted that relocation may include elements of situational, health/illness, and developmental transitions. Gerontological nurses often deal with such patterns of transition in clinical practice, but very little work has been done with theory development and research in this area. Fruitful directions for future scholarship would be to name and describe transition patterns and to explore the relationships between different patterns and client outcomes. In this chapter, we suggest three patterns of transition that we believe merit attention: (1) the sequential pattern, (2) the simultaneous/related pattern, and (3) the simultaneous/unrelated pattern. Each pattern is described briefly.

In sequential transitions, there is a ripple effect in which one transition leads to another over time. For example, the death of one's spouse may lead to relocation to a nursing home, or retirement from paid employment may lead to the emergence of new dimensions of self. It is possible for this ripple effect to extend over a long period of time. The instance in which retirement leads to insufficient income, which in turn leads to a decline in health status and eventually to chronic illness and loss of social interaction, is an example of a long-term, cumulative ripple effect.

Simultaneous transitions are clusters of related or unrelated transitions that occur together during a given period of time. In simultaneous, related transitions, a marker event precipitates numerous transitions. For example, the marker event of a stroke may usher in a cluster of transitions in functional abilities, identity, and living arrangements. The complexity of such transitions may be compounded by simultaneous transitions for the older adult's family members, who may take on the caregiving role and undergo changes in work and family roles. Ade-Ridder and Kaplan (1993) alluded to this pattern of transition when they noted that a transition for an older adult creates a variety of countertransitions for the family.

Simultaneous transitions also may occur without being initially related to one another. For example, an older adult may suffer a decline in health at the same time his or her adult child is experiencing the transition to an "empty nest." Such transitions in a given family happen concurrently and, although not directly related at first, may become intertwined over time.

NURSING RESEARCH ON TRANSITIONS

What has nursing research shown about transitions? First, transitions may be accompanied by uncertainty, emotional distress, interpersonal conflict, and worry. Michels (1988) documented the uncertainty experienced by family caregivers of elderly persons during the transition from hospital to home. Johnson, Morton, and Knox (1992) found that nursing home admissions, too, are characterized by uncertainty. In this transition, uncertainty was related to lack of information and knowledge about the nature of nursing homes and the boundaries for family involvement there. Families also described feelings of sadness and anger, as well as a sense of failure when an older adult was admitted to a nursing home. Lack of communication with nursing home staff added to the emotional conflict. The transition to needing assistance with self-care activities also may bring about emotional

distress. For example, Conn, Taylor, and Messina (1995) investigated the transition to needing medication assistance and found that some older adults were frustrated, depressed, or angry about requiring assistance. The researchers noted that nurses should expect some caregivers and care recipients to experience difficulties in their relationship as the caregiver begins assisting the older adult and that they should be encouraged to express their feelings about these transitions in role relationships.

Bull (1992) found that the transition from hospital to home was characterized by worry. In semistructured interviews, participants identified worries ranging from apprehension about learning new skills to distress about disruption in the family's usual activities of daily living. Bull also described the movement from worry to mastery as the transition evolved. By 2 months after discharge from the hospital, participants had established new routines and felt in control of the situation. The movement from worry to mastery found in the interviews was corroborated by quantitative data that showed a steady decline in anxiety and depression (Bull, Maruyama, & Luo, 1995).

The study by Bull and colleagues (Bull, 1992; Bull, Maruyama, et al., 1995) is noteworthy for the way in which the dimension of time was incorporated into the research design. In this study, change over time was documented by collecting data at two points in the transition. Such a design is congruent with the nature of the transition experience. Because transitions are processes, research designs need to be planned so that they capture the evolution of the transition experience.

There is some evidence that older persons and their family members do not always receive the professional support they need during a transition. In Michel's (1988) study, 73% of the older adults returned to their homes with a home care regimen consisting of three or more components, such as prescription medications, dietary changes, assessment of signs and symptoms, and continuing care of an incision, tube, drain, or colostomy. Nearly two thirds had been instructed on how to care for themselves and carry out their prescribed regimen, but only half acknowledged that someone had asked if they had questions or concerns about their care before the transition to home took place. Some family members had difficulties assuming caregiving responsibilities, and they did not always have the opportunity to participate in discharge planning to prepare them for the transition. Bull, Jervis, and Her (1995) also found that some family members of older patients were inadequately prepared for hospital discharge, did not have the opportunity for input into discharge decisions, and encountered problems with the coordination of services. Stewart, Archbold,

Harvath, and Nkongho (1993) investigated a broad range of learning needs of family caregivers and found that health professionals were perceived as sources of information about taking care of the physical needs of the care receiver and setting up services in the home, but that caregivers reported learning very little from health professionals about taking care of the care receiver's emotional needs and handling the stress of caregiving.

TRANSITIONS AND HEALTH

We turn now to a consideration of transitions and health. What are the characteristics of a healthy transition? We approach this question by considering transition processes and process indicators (see Figure 1.1). Transition processes are the cognitive, behavioral, and interpersonal processes through which the transition unfolds. In other words, they are what happens during a transition. In healthy transitions, these processes move the individual in the direction of health, whereas in unhealthy transitions, they move the individual in the direction of vulnerability and risk.

Process indicators are measurable indices of how the transition is going at any point in time. A process indicator can be thought of as a stop-action snapshot of client well-being at a key point in the ongoing transition process. Assessed periodically, process indicators provide a way of tracking client progress through the transition. We use the term "process indicators" rather than "outcomes" because the process should be assessed periodically over the course of the transition, not just at its conclusion. When the older adult's experience is analyzed using a transition perspective, it is difficult to consider outcomes in the same way as when the older adult's experiences are viewed in isolation from time and significant others. From a transition perspective, "outcomes" evolve over the course of the transition and also are connected to life experiences prior to and after the transition. Process indicators could be used as client outcomes in research, but only with the caveat that they are part of the client's ongoing life experiences.

Healthy Transition Processes

Seven healthy transition processes and seven corresponding unhealthy processes are identified (see Figure 1.1). Over the course of the transition, there is a dynamic tension between healthy and unhealthy processes. Both

the future toward which the transition is moving and the past that is being left behind exert a pull on the elderly client. These processes move the client through the "neutral zone" of the transition toward the next phase or situation in his or her life. The gerontological nurse should be alert to the presence of these processes in clients in transition and should monitor the direction in which they are proceeding.

1. Redefining meanings is one process that takes place during a healthy transition (Davis & Grant, 1994; Langner, 1995). The elderly client and his or her family actively engage in exploring the meaning of the transition and in finding new meanings. Previous meanings that do not apply to the new situation are recognized, and new meanings are discovered. The process of creating meaning is complex, and time is needed for the older person to work through it. When the transition is proceeding in a healthy direction, the general movement is toward rethinking and redefining meanings. In unhealthy transitions, there is resistance to redefining meanings. The older person and his or her family do not consider the meaning of the transition and attempt to apply old definitions to the new situation.

2. Modifying expectations is another process that characterizes healthy transitions. Long-standing expectations about self, others, and the future may be called into question during a transition (Dewar & Morse, 1995; King, Porter, & Rowe, 1994; Wilson & Billones, 1994), and the older person may be reluctant to give up these expectations. However, in healthy transitions, previous expectations are gradually modified and replaced with new expectations that are realistic for the new situation. In unhealthy transitions, the older adult and family maintain unrealistic expectations and anticipate a future that probably cannot happen.

3. Another characteristic of healthy transitions is the restructuring of life routines. Routines serve to order daily life and provide predictability, manageability, and even pleasure (Cartwright, Archbold, Stewart, & Limandri, 1994). In healthy transitions, routines are restructured in a way that is congruent with the new situation and allows the person to regain a sense that his or her life is predictable, manageable, and pleasurable (Daley, 1993). In unhealthy transitions, such restructuring does not take place. Instead, the older adult attempts to cling to former routines even though they no longer work in the new situation. If the person's abilities and the environment that sustained daily routines are no longer present, an unhealthy transition may lead to no routine at all. In such instances, daily life may become unpredictable, disordered, or empty, particularly for individuals who have a history of orderliness in their lives.

4. Healthy transitions are characterized further by developing new knowledge and skills (Brown, 1995; Edwardson, 1988). Specific needs for knowledge and skills are identified, and opportunities for their development are sought (Davis & Grant, 1994). Over time, the older adult's knowledge and skills closely fit the demands of the new situation. In unhealthy transitions, new knowledge and skills are avoided. Elderly persons and families try to manage the new situation with knowledge and skills that may have been sufficient in the past, but are no longer useful in the present situation. Opportunities for developing knowledge and skills are not taken, resulting in a gap between the demands of the situation and the knowledge and skills available to meet those demands.

5. Although transitions involve endings and disruptions, not everything in the life of the elderly client and his or her family changes. There are continuities, even as change occurs (Burgener, Shimer, & Murrell, 1992; Cartwright et al., 1994). Healthy transitions are characterized by maintaining whatever continuity is possible in identity, relationships, and environment. Continuity facilitates coping with the changes brought about by the transition and fosters the elderly person's ability to integrate the transition experience into his or her life as a whole. In unhealthy transitions, there is discontinuity and disruption where it does not need to occur. There is lack of awareness of the possibilities for continuity, and change that could be avoided happens anyway. In such instances, transitions become more pervasive than they need to be and older adults sustain losses that could have been prevented.

6. The transitions experienced by elderly persons often are associated with losses, but it is possible that gains occur as well. One of the gains that may be experienced during a transition is the opportunity for new choices (Adlersberg & Thorne, 1990; Happ, Williams, Strumpf, & Burger, 1996). In healthy transitions, the elderly person is open to exploring new choices. He or she engages in seeking and creating new opportunities. Through the exercise of choice, the older adult actively shapes the transition process. Unhealthy transitions are characterized by limiting choices. Older adults themselves may limit the choices available, or choices may be limited by others in the environment (Nick, 1992). The process of limiting choices forecloses possibilities before they are explored. Choices that could be made are passed by, and the elderly person and family are passive with respect to determining the direction of the transition.

7. Finally, healthy transitions are characterized by finding opportunities for personal growth (Langner, 1995; McDougall, 1995; Young, 1990). New levels of self-awareness, new dimensions of identity and relationships, and

new abilities can emerge during transitions. In healthy transitions, such opportunities for growth are embraced in a way that makes personal development and self-actualization possible. In unhealthy transitions, opportunities for growth are rejected. The developmental process is stalled or thwarted in a way that precludes the unfolding and emerging of self.

Process Indicators

As noted previously, process indicators are measurable indices of how a transition is proceeding. Many such process indicators can be used for assessment during a transition. In this chapter, we have identified five for consideration (see Figure 1.1). We present them to exemplify an approach to evaluating the transition process and to stimulate others to identify additional indicators.

1. The elderly person's symptom experience is the first process indicator we consider. During a transition, the older person may experience new symptoms or exacerbation of previously existing symptoms (Ferrell & Schneider, 1988; Kozak, Campbell, & Hughes, 1996). Symptoms should be managed as much as possible so that the elderly person can attend to the transition process itself. If the beginning of the transition is marked by an increase in symptoms, there should be a measurable decline in their frequency and severity over the course of the transition. Although some physical and behavioral symptoms may be inevitable, they should be controlled as much as current symptom management strategies allow. The presence of symptoms that could be controlled suggests that the transition process is proceeding in an unhealthy direction. Patterns of symptoms and the management strategies used by the client should be noted carefully because they provide insight into how the transition is going.

2. Functional status is the next process indicator we propose. For the elderly person, changes in functional status may occur during a transition (Glass & Maddox, 1992; King et al., 1994). However, when a healthy transition process is taking place, the highest possible level of physical and cognitive functioning is achieved over the course of the transition. The elderly person's self-care ability, independence, and mobility are enhanced to the furthest extent possible. A suboptimal level of functioning suggests an unhealthy transition process.

3. Another process indicator is the elderly person's sense of connectedness to a meaningful interpersonal network (Daley, 1993; Rickelman, Gallman, & Parra, 1994; Windriver, 1993). Although disruption in rela-

tionships may occur during a transition, there will be evidence of a regained sense of connectedness when the transition process is proceeding in a healthy direction. If the transition involved loss of one or more relationships, new or transformed relationships should be forged during the transition process to provide a stable source of connectedness by the completion of the transition process. Feelings of disconnectedness or isolation indicate unhealthy transition processes.

4. Another process indicator is a sense of empowerment (Jones & Meleis, 1993; Nyström & Segesten, 1994). The elderly person's sense of autonomy, self-determination, and personal agency may be threatened during the disruption brought about by the transition. However, a new sense of empowerment is found when the transition process is healthy. The older adult regains some control over his or her life. He or she is able to make decisions and put them into effect. For older adults with severe cognitive or physical limitations, there is an appropriate transfer of empowerment to a family member or significant other. Inappropriate disempowerment is indicative of an unhealthy transition process. Disempowerment may be manifested in loss of control, inability to make and carry out decisions, and inappropriate assumption of control by persons in the older adult's environment.

5. The final process indicator we propose is a sense of integrity (Erikson, Erikson, & Kivnick, 1986; Finfgeld, 1995; Mercer, Nichols, & Doyle, 1988). A sense of integrity includes a sense of wholeness and coherence. Personal growth and new insights about self are evidence of a healthy transition. There also is the sense that the transition fits into one's life story in a meaningful way. A loss of integrity indicates an unhealthy transition process. Loss of integrity may be manifested in a sense of fragmentation or meaninglessness in one's life course.

NURSING THERAPEUTICS

The goals of nursing therapeutics from a transition perspective are to facilitate healthy transition processes, to decrease unhealthy transitions, and to support positive process indicators (Meleis & Trangenstein, 1994). Many nursing therapeutics could be used to facilitate transitions. We have selected five for discussion here that we believe have particular relevance for elderly clients (see Figure 1.1). These therapeutics take into account needs specific to this stage of the life cycle, such as the needs for life

review and for integration into new living environments. They also take into account challenges often experienced by elderly persons, such as memory loss and changes in mobility.

Nursing Assessment

Nursing assessment is the basis for all nursing therapeutics. The use of a transition perspective suggests several principles for assessment. First, the nature of transitions as dynamic, ongoing processes suggests that nursing assessment must be continuous (McCracken, 1994; Moneyham & Scott, 1995). As the transition evolves, the nurse needs to address changes and developments in the client's situation. Because it is not possible to predict the course of a transition at its outset, assessment must be ongoing. A linear sequence of nursing actions beginning with assessment and moving in turn through planning, implementation, and evaluation is not congruent with a transition perspective. Rather, assessment must span the whole period of transition so that nursing care can evolve along with the movement of the transition process. Such ongoing assessment requires particular vigilance on the nurse's part plus creation of a health care context that supports frequent contact between the nurse and client.

Continuous assessment by the nurse takes into account patterns of transition. Knowing that multiple transitions often occur for elderly persons leads to the anticipation of simultaneous and sequential transitions. For example, knowing that the death of the spouse of a frail elderly person may mean that the elderly person must move from his or her home shapes the nurse's assessment of resources and options for the future. Knowing that a transition for an older adult often has a ripple effect through the family means that a thorough family assessment should be included in the assessment process.

Although assessment is a continuous process for the nurse practicing within a transition perspective, we suggest assessment of the process indicators identified previously at critical points during the transition. The use of process indicators provides the nurse with a way of tracking client progress and provides for early detection of difficulties at critical points in the transition.

The use of formal assessment instruments aids the nurse in making these periodic evaluations of the transition process. They provide an objective measure of the client's situation, allowing the nurse to identify deviations from population norms as well as deviations from the client's own norm. In Table 1.1, we provide examples of tools that could be used to

TABLE 1.1 Tools for Measuring Process Indicators

Symptom Experience
- State/Trait Anxiety Inventory (Spielberger, 1983)
- Geriatric Depression Scale (Yesavage & Brink, 1983)
- Mini-Mental State Questionnaire (Folstein, Folstein, & McHugh, 1975)
- McGill Pain Questionnaire (Melzack, 1975)

Functional Status
- Index of Activities of Daily Living (Katz, Ford, Moskowitz, Jackson, & Jaffe, 1963)
- Multidimensional Functional Assessment (Duke University, 1978)

Connectedness
- Mutuality Scale (Archbold, Stewart, Greenlick, & Harvath, 1992)
- Adult Attachment Scale (Lipson-Parra, 1989)

Empowerment
- Desired Control Scale (Reid & Ziegler, 1981)

Integrity
- Fulfillment of Meaning Scale (Burbank, 1992)

measure process indicators. The use of process indicators is relevant with family members as well as with elderly persons. The timing and frequency of their use should be determined by the nature of the transition and the extent of the changes it precipitates.

Reminiscence

Reminiscence (Burnside, 1990; Burnside & Haight, 1992) is a nursing therapeutic that facilitates integration of the transition into the life course. Transitions must be viewed within the context of the elderly individual's whole life. Although they involve disruption and change, placing transitions within the context of the life course facilitates the processes of exploring meaning and discovering areas in which continuity with the past is still possible. The articulation of life themes through reminiscing supports the process of growth and development of identity. Reminiscence also can assist the older adult in reinterpreting the meanings of life situations, achieving resolution of ongoing issues, and transcending old pains. Thus reminiscence supports the process of new beginnings as the older adult proceeds through the transition.

Reminiscence is derived from "debriefing," an approach to therapy used with victims of disasters and with individuals who have encountered other crisis situations. Debriefing provides an opportunity to recount the difficult experience and to relive the reactions and emotions that were encountered. Reminiscence is like debriefing in that it provides an opportunity to reflect on important life experiences and to integrate the past into the present. For the person in transition, reminiscence provides an important bridge between the past and present as he or she ends one situation or stage in life and embarks on another.

For older adults with memory loss, the process of reminiscence must be tailored to individual needs. The memories that an older adult has depends on the type and extent of memory loss. Using reminiscence for older adults with memory loss may require innovative strategies (McDougall, 1994; Rentz, 1995). For example, finding a person who serves as a reservoir of memories for an elderly person with memory loss may facilitate reminiscing. The use of prompts, such as photographs or music (Cartwright et al., 1994) also may serve to stimulate memories.

Role Supplementation

Role supplementation is a nursing therapeutic that facilitates the process of developing new knowledge and skills. It is a nursing therapeutic that has been used for parental caregivers (Brackley, 1992), for new parents (Gaffney, 1992; Meleis & Swendsen, 1978; Swendsen, Meleis, & Jones, 1978), for Alzheimer's patients (Kelley & Lakin, 1987), for cardiac rehabilitation (Dracup et al., 1984), and it has much potential for use with elderly persons. Role supplementation provides the support needed to revise continuously skills and capabilities as demands evolve in the new situation. It is defined as the process of bringing into awareness the behaviors, sentiments, sensations, and goals involved in a given role (Meleis, 1975), and it is particularly useful for persons taking on a new role or experiencing a transition in a long-standing role. In the process of role supplementation, information and experiences are conveyed to the role incumbent and his or her significant others so that the role transition can be made smoothly. It includes heightening awareness of one's own role and another's and the dynamics of their interrelationships (Meleis, 1975).

Role supplementation has several components. One is role clarification or the identification of all aspects of a role. For example, role clarification may include a discussion of what is involved in being a nursing home res-

ident. For a family member, it may be the identification of behaviors and feelings associated with the caregiving role. Another component of role supplementation is the process of role taking. Role taking is the empathetic ability to understand the position and point of view of another and to understand how one's role may affect other persons.

Several strategies are used in role supplementation. One is role modeling or the opportunity to observe someone in the role that is being taken on. Another is role rehearsal, the process of mentally or physically enacting the new role that the person is moving toward. Although there are multiple ways of enacting a given role, there are some aspects of roles that tend to be stable and consistent across individuals. For example, although there are some common features of nursing home roles, how they are enacted by a given individual is a dynamic and creative process. Providing clients and their significant others with opportunities to enact and rehearse both the common and creative features of a role leads to greater comfort with the role. Another strategy that facilitates transition for elderly persons and their families is the mobilization of a reference group that is responsive to the various situational and long-term needs of older adults. Reference groups may be for mobility and exercise, for eating, for recreation, and for dealing with chronic illness.

Creation of a Healthy Environment

Another nursing therapeutic for older persons in transition is creation of a healthy environment. We define "environment" broadly to include the older person's physical, social, political, and cultural surroundings. During a transition, the environment itself or the elderly person's interaction with a familiar environment may change. For example, in relocation or migration it is the environment itself that changes. It is the older person's interaction with the environment that changes when a decrease in mobility or cognition limits the ability to function in a familiar environment.

There are many facets to creating a healthy environment. One is to structure the environment so that it provides safety and security (McCracken, 1994; Taft, Delaney, Seman, & Stansell, 1993). Another is to facilitate access to what the elderly person needs and uses to accomplish daily routines (Daly & Berman, 1993). Honoring cultural traditions is another way of creating a healthy environment (Jones, 1995). Finally, freeing the environment of obstacles to dignity and personal integrity fosters a healthy environment (Magee et al., 1993). The use of a transition perspective

means that the goal of nursing is the creation of an environment that is dynamic and flexible enough to change in synchrony with the elderly person's evolving needs. It also means that the nurse maintains ongoing involvement with the older adult and family as they continuously modify, restructure, and reinvent the environment to meet the needs of the older family member.

Mobilization of Resources

Older adults in transition face new situations and demands for which previously developed resources may no longer be adequate. Therefore, mobilization of resources is an important aspect of nursing practice within a transition perspective. Enhancement of both personal and environmental resources appropriate to the individual's needs is necessary.

Resources include personal, family, and community resources. Specific resources in each category may be stable or changing, ongoing or newly developed. For example, personal resources may change during a transition, necessitating the mobilization of new personal resources. Similarly, the older adult may have long-standing family resources, but may need additional resources to meet the challenges of a transition. The community resources available to older adults differ according to geographic location and political policies, thus necessitating the ongoing mobilization of new community resources. In short, to mobilize resources, the nurse needs to consider not only the availability of resources, but whether or not they are stable or changing. Also, the nurse must consider whether existing resources are adequate or if new resources must be developed.

Mobilizing personal inner resources is one step toward facilitating healthy transitions in older adults. Scholars variously refer to personal resources as adaptability (Jones, 1991), coherence (Antonovsky, 1987), and hardiness (Kobasa, 1979). Magnani (1990) identified "hardiness" as antecedent to successful aging and recommended that nurses help older adults remain independent and optimize normal healthy aging through three strategies: helping to strengthen the older adult's self-concept, helping the older adult to see his or her life events in perspective, and encouraging appropriate forms of activity.

Another personal resource is wellness (Alford & Futrell, 1992; U.S. Department of Health and Human Services [USDHHS] & American Association for Retired Persons [AARP], 1991; Walker, 1992). A healthy lifestyle should be promoted during a transition. The nurse can encourage regular exercise, a nutritious diet, control of alcohol intake, and abstinence

from smoking. Regular primary health care services also are important during a transition.

A strong immune system is another resource that influences the transition process. Exposure to new environmental threats challenges the ability of the immune system to protect the body successfully and maintain physiological integrity. Therefore, promoting activities that strengthen the immune system is one way of mobilizing personal resources. Recent research has demonstrated a variety of behaviors that increase immunocompetence, including laughter (Cousins, 1989), exercise (Nash, 1994), and a positive spirit (Kinion & Kolcaba, 1992). Regular immunizations against influenza and other infectious diseases provide extra immune protection. For some frail elderly persons, a compromised immune system may call for use of antibiotics to prevent as well as to treat infections.

Energy is another personal resource that facilitates smooth transitions. Energy is essential for developing new skills, for pursuing new opportunities for growth, and for maintaining functional status. The mobilization of energy needs to be a deliberate strategy if the older adult is to remain independent and empowered. Proper diet and regular exercise are key factors in energy mobilization. However, energy is holistic; thus psychological, social, and spiritual factors also are significant in its mobilization. These factors influence the older person's motivation to engage actively in life and to seek new opportunities for growth. In the Jones and Meleis (1993) Health Empowerment Model, mobilization of resources is an integral part of promoting energy for health and healthy transitions (see Figure 1.2).

Family resources also may need to be mobilized to assist an aging client in transition. Family resources can be described in terms of structural, economic, and cultural factors. The availability of family members to assist and support an aging person is a primary resource. However, it is possible that even in cultures where caring for aging family members is highly valued, the availability of family caregivers may be limited. In today's global society, family caregivers may be thousands of miles away from the person needing care. Furthermore, whole families may be in transition at the same time, as is the case with immigration. In such instances, the demands on each member are high. Thus consideration of the needs of the whole family is necessary.

Community resources outside of the family may be needed to supplement what the family is able to provide. Some cultural groups tend to do more direct caregiving and to use community services less than others. For example, it has been shown that Blacks and Latinos enter nursing homes at lower rates than do Euro Americans and rely on informal, family-based

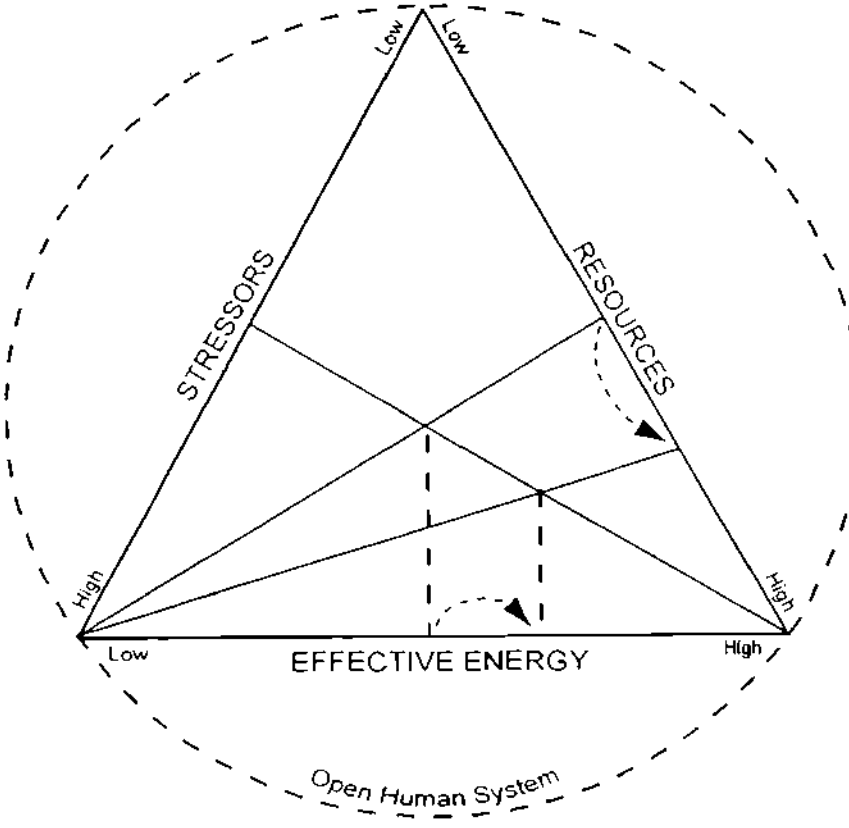

Figure 1.2 Mobilization of resources in the Jones and Meleis Health Empowerment Model (Jones & Meleis, 1993).

support systems to a greater degree than Euro Americans (Angel, Angel, & Himes, 1992). This means that Black and Latino families caring for elderly family members may need more assistance in mobilizing and accessing community resources to support caregiving at home.

Throughout their lives, individuals participate as members of many different communities. Church and community service organizations are examples. In late adulthood, continued contact with members of these communities contributes to a sense of connectedness. The respect, common history, and affirmation that come with membership in these groups contribute to meaning, life satisfaction, and self-esteem.

CASE STUDY

We demonstrate the use of a transition framework in practice by describing a case study. Mr. Adams is a 76-year-old widower whose wife died 1 month following the diagnosis of leukemia. With her illness and death, Mr. Adams entered a period of transition that lasted for over a year. This transition involved his daughter, Gloria White, as well as Mr. Adams. Mrs. White is a middle-aged woman who lives in another country with her husband and teenage children. Prior to her mother's death, Mrs. White visited her parents about once a year. Because of her family responsibilities and the expense of international travel, most of the communication between the Adamses and their daughter had been by telephone.

Mr. Adams had a long history of transient ischemic attacks that occasionally were accompanied by loss of consciousness. These episodes were followed by mental confusion and difficulty with activities of daily living. Prior to her death, Mrs. Adams had provided the assistance that he needed at these times.

After Mrs. Adams' death, family and friends encouraged Mr. Adams to move into a retirement center for increased assistance and social contact. However, he strongly resisted such a move. Throughout his home were pictures, paintings, furniture, and other items that represented significant memories, not only of his wife, but of his own parents and childhood. On the property was a small workshop that housed an elaborate electric train, his lifelong hobby. In the garden were flowers and flowering shrubs that he and his wife had carefully chosen. Mr. Adams became angry and agitated when people encouraged him to move away from this familiar and meaningful environment.

Mr. Adams' health problems, compounded by his grief, emotional distress, and geographical distance from his daughter, worried his next door neighbor. She contacted a gerontological clinical nurse specialist who worked with a local parish nursing program and asked for her advice. With Mr. Adams' permission, the nurse made a home visit and began providing nursing care using a transition perspective. Her initial assessment revealed the physical and emotional symptoms he was experiencing as well as his difficulties with activities of daily living. He felt isolated and alone. He also felt as if his autonomy and rights were being taken away and that he was going to be forced to leave his home. The initial nursing assessment included calls to Mrs. White and a com-

plete assessment of her family responsibilities and resources. The nurse learned that Mrs. White was in the process of getting a divorce and thus was going through a simultaneous transition.

After the initial assessment, the nurse began to assist Mr. Adams with mobilizing community resources to enable him to remain in his home. Obvious needs included assistance with activities of daily living, socialization, and supervision to prevent harm. Assessment of resources also included identifying his own strengths as well as what was necessary to supplement those strengths to continue living independently. Arrangements were made for home care attendants to assist with activities of daily living, domestic chores, grocery shopping, and transportation. Meals on Wheels were arranged, medications were organized for easy administration, and an electronic personal alert system for use in an emergency was set up.

The nurse also helped Mrs. White negotiate the transition in her relationship with her father by assisting her to take on the caregiving role from a distance in the context of multiple family responsibilities and limited financial resources. Areas in which she could provide assistance and support to her father were identified. Also identified were realistic caregiving expectations for her. During this time, Mrs. White was a resource to her father and at the same time was a family member needing support for her own transitions.

Because she realized that major transitions such as loss of one's spouse often are followed by further transitions, the nurse maintained ongoing assessment with Mr. Adams and Mrs. White. For about 6 months, the initial arrangements provided the support Mr. Adams needed and he continued to live at home. Then Mr. Adams' physical health began to decline. His episodes of transient ischemia increased, and he had several falls that caused injuries. It became clear that he could not continue to live alone, and Mrs. White came to help him make decisions and arrangements for a new living situation. He decided to enter a group living center where he could have his own two bedroom duplex, but also would have all the assistance he needed.

In preparation for the move, extensive time was allowed for Mr. Adams to reminisce about the life he had enjoyed in his home. Possessions with special meaning were selected for relocation with him to the new environment. Role supplementation prepared him for his new role in the retirement center. Because the move was another major transition, arrangements were made for his daughter to be present to provide added support during this time.

The move to the assisted living center was difficult for Mr. Adams. He missed his home a great deal and initially had difficulty identifying the new environment as home. For a while his health problems continued with frequent fluctuations in his functional abilities and mental status. However, as the months passed his health stabilized. His emotional well-being increased, and his cognitive status improved. He was able to engage in more self-care and began to participate in activities with other residents. Four months after his relocation, Mr. Adams felt at home in the retirement center. He had made friends there and found that he still had an acceptable degree of autonomy. Also, he had found meaning in assisting a blind resident who needed a companion to accompany him on outings. Mr. Adams expressed to his daughter and friends that the move had turned out to be the right decision after all.

IMPLICATIONS FOR PRACTICE AND KNOWLEDGE DEVELOPMENT

The framework that we have proposed extends our previous work with the concept of transition (Chick & Meleis, 1986; Meleis, 1986; Meleis & Trangenstein, 1994; Schumacher & Meleis, 1994) by identifying specific transition processes, by suggesting indicators of client progress through transitions, and by identifying nursing therapeutics with particular relevance for older clients in transition. We have related transition processes to health by identifying processes that lead to well-being and those that lead to increasing vulnerability. This work is based on the premise that the mission of nursing is to facilitate healthy transitions and to prevent the risks to health that can arise during transitions (Meleis & Trangenstein).

How can this framework be used in clinical practice?

1. It has implications for nursing assessment in that it identifies transition processes with enough specificity to guide observation and interview. The identification of healthy and unhealthy transition processes and indicators provides the nurse with greater ability to assess the direction of the transition and to identify clients at risk.

2. The nursing therapeutics included in the framework can be used to assist clients in many types of transition.

3. The framework can be used to advocate for an approach to practice that values continuity, family centeredness, and wellness.

These nursing values are threatened by a health care climate in which cost cutting is leading to significant constraints on practice. This transition framework provides a way to articulate the complexity of transitions and the resulting need for nursing care that is holistic and continuous.

The framework also can be used to guide knowledge development through theory and research. Questions it suggests include: (1) How do different patterns of transition influence transition processes and process indicators? (2) What are the critical periods in the various patterns? (3) What are the relationships between patterns of transition and patterns of nursing intervention? To address these questions, preliminary work will be needed, including further description of transition patterns, processes, and process indicators; identification or development of additional tools for measurement; and continued specification and refinement of nursing therapeutics.

We conclude by emphasizing the importance of a transition perspective in gerontological nursing. Older adults experience multiple transitions related to their health and well-being. These transitions are not short-lived events. Rather, they are complex processes that evolve over a period of time and usually involve a number of individuals. To make nursing practice congruent with the experiences of older adults, the nurse must view their needs from a perspective that takes into account the complexity and temporal characteristics of the experience. We argue that a transition perspective provides the gerontological nurse with a powerful means of understanding and responding to the needs of older adults. We challenge gerontological nurses to use, refine, and extend the framework we have described.

REFERENCES

Ade-Ridder, L., & Kaplan, L. (1993). Marriage, spousal caregiving, and a husband's move to a nursing home: A changing role for the wife? *Journal of Gerontological Nursing, 19* (10), 13–23.

Adlersberg, M., & Thorne, S. (1990). Emerging from the chrysalis: Older widows in transition. *Journal of Gerontological Nursing, 16*(1), 4–8.

Alford, D. M., & Futrell, M. (1992). AAN working paper: Wellness and health promotion of the elderly. *Nursing Outlook, 5*, 221–226.

Angel, R. J., Angel, J. L., & Himes, C. L. (1992). Minority group status, health transitions, and community living arrangements among the elderly. *Research on Aging, 14*, 496–521.

Antonovsky, A. (1987). *Unraveling the mystery of health*. San Francisco: Jossey-Bass.

Archbold, P. G., Stewart, B. J., Greenlick, M. R., & Harvath, T. A. (1992). The clinical assessment of mutuality and preparedness in family caregivers to frail older people. In S. G. Funk, E. M. Tornquist, M. T. Champagne, & R. A. Wiese (Eds.), *Key aspects of elder care: Managing falls, incontinence, and cognitive impairment* (pp. 328–339). New York: Springer.

Brackley, M. H. (1992). A role supplementation group pilot study: A nursing therapy for potential parental caregivers. *Clinical Nurse Specialist, 6*, 14–19.

Bridges, W. (1980). *Transitions*. Reading, MA: Addison-Wesley.

Brown, D. S. (1995). Hospital discharge preparation for homeward bound elderly. *Clinical Nursing Research, 4*, 181–194.

Bull, M. J. (1992). Managing the transition from hospital to home. *Qualitative Health Research, 2*, 27–41.

Bull, M., Jervis, L. L., & Her, M. (1995). Hospitalized elders: The difficulties families encounter. *Journal of Gerontological Nursing, 21*(6), 19–23.

Bull, M. J., Maruyama, G., & Luo, D. (1995). Testing a model for posthospital transition of family caregivers for elderly persons. *Nursing Research, 44*, 132–138.

Burbank, P. (1992). Assessing the meaning of life among older adult clients. *Journal of Gerontological Nursing, 18*(9), 19–28.

Burgener, S. C., Shimer, R., & Murrell, L. (1992). Expressions of individuality in cognitively impaired elders: Need for individual assessment and care. *Journal of Gerontological Nursing, 19*(4), 13–22.

Burnside, I. (1990). Reminiscence: An independent nursing intervention for the elderly. *Issues in Mental Health Nursing, 11*, 33–48.

Burnside, I., & Haight, B. K. (1992). Reminiscence and life review: Analyzing each concept. *Journal of Advanced Nursing, 17*, 855–862.

Cartwright, J. C., Archbold, P. G., Stewart, B. J., & Limandri, B. (1994). Enrichment processes in family caregiving to frail elders. *Advances in Nursing Science, 17*(1), 31–43.

Chick, N., & Meleis, A. I. (1986). Transitions: A nursing concern. In P. L. Chinn (Ed.), *Nursing research methodology: Issues and implementation* (pp. 237–257). Rockville, MD: Aspen.

Conn, V. S., Taylor, S. G., & Messina, C. J. (1995). Older adults and their caregivers: The transition to medication assistance. *Journal of Gerontological Nursing, 21*(5), 33–38.

Cousins, N. (1989). *Head first: The biology of hope*. New York: E. P. Dutton.

Daley, O. E. (1993). Women's strategies for living in a nursing home. *Journal of Gerontological Nursing, 19*(9), 5–9.

Daly, M. P., & Berman, B. M. (1993). Rehabilitation in the elderly patient with arthritis. *Clinics in Geriatric Medicine, 9*, 783–801.

Davis, L. L., & Grant, J. S. (1994). Constructing the reality of recovery: Family home care management strategies. *Advances in Nursing Science, 17*(2), 66–76.

Dewar, A. L., & Morse, J. M. (1995). Unbearable incidents: Failure to endure the experience of illness. *Journal of Advanced Nursing, 22*, 957–964.

Dracup, K., Meleis, A. I., Clark, S., Clyburn, A., Shields, L., & Staley, M. (1984). Group counseling in cardiac rehabilitation: Effect on patient compliance. *Patient Education and Counseling, 6*, 169–177.

Duke University Center for the Study of Aging and Human Development. (1978). *Multidimensional functional assessment: The OARS methodology*. Durham, NC: Duke University.

Edwardson, S. R. (1988). Outcomes of coronary care in the acute care setting. *Research in Nursing & Health, 11*, 215–222.

Erikson, E. H., Erikson, J. M., & Kivnick, H. Q. (1986). *Vital involvement in old age*. New York: W. W. Norton.

Ferrell, B. R., & Schneider, C. (1988). Experience and management of cancer pain at home. *Cancer Nursing, 11*, 84–90.

Finfgeld, D. L. (1995). Becoming and being courageous in the chronically ill elderly. *Issues in Mental Health Nursing, 16*, 1–11.

Folstein, M. F., Folstein, S. E., & McHugh, P. R. (1975). Mini-Mental State: A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research, 12*, 189–198.

Gaffney, K. F. (1992). Nursing practice model for maternal role sufficiency. *Advances in Nursing Science, 15*(2), 76–84.

Glass, T. A., & Maddox, G. L. (1992). The quality and quantity of social support: Stroke recovery as psycho-social transition. *Social Science and Medicine, 34*, 1249–1261.

Happ, M. B., Williams, C. C., Strumpf, N. E., & Burger, S. G. (1996). Individualized care for frail elders: Theory and practice. *Journal of Gerontological Nursing, 22*(3), 6–14.

Johnson, M. A., Morton, M. K., & Knox, S. M. (1992). The transition to a nursing home: Meeting the family's needs. *Geriatric Nursing, 13*, 299–302.

Jones, P. S. (1991). Adaptability: A personal resource for health. *Scholarly Inquiry for Nursing Practice, 5*, 95–112.

Jones, P. S. (1995). Paying respect: Care of elderly parents by Chinese and Filipino American women. *Health Care for Women International, 16*, 385–398.

Jones, P. S., & Meleis, A. I. (1993). Health is empowerment. *Advances in Nursing Science, 15*(3), 1–14.

Katz, S., Ford, A. B., Moskowitz, R. W., Jackson, B. W., & Jaffe, M. (1963). Studies of illness in the aged. The index of ADL, a standardized measure of biological and psychosocial function. *Journal of the American Medical Association, 185*, 914–919.

Kelley, L. S., & Lakin, J. A. (1987). Role supplementation as a nursing intervention for Alzheimer's disease: A case study. *Public Health Nursing, 5*, 146–152.

King, K. B., Porter, L. A., & Rowe, M. A. (1994). Functional, social, and emo-

tional outcomes in women and men in the first year following coronary artery bypass surgery. *Journal of Women's Health, 3*, 347–354.

Kinion, E. S., & Kolcaba, K. Y. (1992). Plato's model of the psyche: A holistic model for nursing interventions. *Journal of Holistic Nursing, 10*, 218–230.

Kobasa, S. C. (1979). Stressful life events, personality, and health: An inquiry into hardiness. *Journal of Personality and Social Psychology, 37*, 1–11.

Kozak, C. J., Campbell, C., & Hughes, A. M. (1996). The use of functional consequences theory in acutely confused hospitalized elderly. *Journal of Gerontological Nursing, 22*(1), 27–36.

Langner, S. R. (1995). Finding meaning in caring for elderly relatives: Loss and personal growth. *Holistic Nursing Practice, 9*(3), 75–84.

Lipson-Parra, H. (1989). Development and validation of the Adult Attachment Scale: Assessing attachment in elderly adults. *Issues in Mental Health Nursing, 11*, 79–92.

Magee, R., Hyatt, E. C., Hardin, S. B., Stratmann, D., Vinson, M. H., & Owen, M. (1993). Institutional policy: Use of restraints in extended care and nursing homes. *Journal of Gerontological Nursing, 19*(4), 31–39.

Magnani, L. E. (1990). Hardiness, self-perceived health, and activity among independently functioning older adults. *Scholarly Inquiry for Nursing Practice: An International Journal, 4*, 171–185.

McCracken, A. L. (1994). Special care units: Meeting the needs of cognitively impaired persons. *Journal of Gerontological Nursing, 20*(4), 41–46.

McDougall, G. (1994). Mental health and cognition. In P. Ebersole & P. Hess (Eds.), *Toward healthy aging: Human needs and nursing response* (4th ed., pp. 612–657). St. Louis: Mosby.

McDougall, G. J. (1995). Existential psychotherapy with older adults. *Journal of the American Psychiatric Nurses Association, 1*, 16–21.

Meleis, A. I. (1975). Role insufficiency and role supplementation: A conceptual framework. *Nursing Research, 24*, 264–271.

Meleis, A. I. (1986). Theory development and domain concepts. In P. Moccia (Ed.), *New approaches to theory development* (pp. 3–21). New York: National League for Nursing.

Meleis, A. I., & Swendsen, L. A. (1978). Role supplementation: An empirical test of a nursing intervention. *Nursing Research, 27*, 11–18.

Meleis, A. I., & Trangenstein, P. A. (1994). Facilitating transitions: Redefinition of the nursing mission. *Nursing Outlook, 42*, 255–259.

Melzack, R. (1975). The McGill Pain Questionnaire: Major properties and scoring. *Pain, 1*, 277–299.

Mercer, R. T., Nichols, E. G., & Doyle, G. C. (1988). Transitions over the life cycle: A comparison of mothers and nonmothers. *Nursing Research, 37*, 144–150.

Michels, N. (1988). The transition from hospital to home: An exploratory study. *Home Health Care Services Quarterly, 9*(1), 29–44.

Moneyham, L., & Scott, C. B. (1995). Anticipatory coping in the elderly. *Journal of Gerontological Nursing, 21*(7), 23–28.

Nash, M. S. (1994). Exercise and immunology. *Medicine & Science in Sports & Exercise, 26*, 125–127.

Nick, S. (1992). Long-term care. Choices for geriatric residents. *Journal of Gerontological Nursing, 18*(7), 11–28.

Nyström, A. E. M., & Segesten, K. M. (1994). On sources of powerlessness in nursing home life. *Journal of Advanced Nursing, 19*, 124–133.

Reid, D. W., & Ziegler, M. (1981). The desired control measure and adjustment among the elderly. In H. M. Lefcourt (Ed.), *Research with the locus of control construct: Vol. 1. Assessment methods* (pp. 127–157). New York: Academic Press.

Rentz, C. A. (1995). Reminiscence: A supportive intervention for the person with Alzheimer's disease. *Journal of Psychosocial Nursing and Mental Health Services, 33*(11), 15–20.

Rickelman, B. L., Gallman, L., & Parra, H. (1994). Attachment and quality of life in older, community-residing men. *Nursing Research. 43*, 68–72.

Schumacher, K. L., & Meleis, A. I. (1994). Transitions: A central concept in nursing. *Image: Journal of Nursing Scholarship, 26*, 119–127.

Spielberger, C. D. (1983). *Manual for the State-Trait Inventory (STAI) Form Y.* Palo Alto, CA: Consulting Psychologists Press.

Stewart, B. J., Archbold, P. G., Harvath, T. A., & Nkongho, N. O. (1993). Role acquisition in family caregivers for older people who have been discharged from the hospital. In S. G. Funk, E. M. Tornquist, M. T. Champagne, & R. A. Wiese (Eds.), *Key aspects of caring for the chronically ill: Hospital and home* (pp. 219–231). New York: Springer.

Swendsen, L. A., Meleis, A. I., & Jones, D. (1978). Role supplementation for new parents: A role mastery plan. *American Journal of Maternal Child Nursing, 3*, 84–91.

Taft, L. B., Delaney, K., Seman, D., & Stansell, J. (1993). Creating a therapeutic milieu in dementia care. *Journal of Gerontological Nursing, 19*(10), 30–39.

U.S. Department of Health and Human Services, & American Association for Retired Persons. (1991). *Healthy older adults 2000.* Washington, DC: AARP Health Advocacy Services.

Walker, S. N. (1992). Wellness for elders. *Holistic Nursing Practice, 7*(1), 38–45.

Wilson, S., & Billones, H. (1994). The Filipino elder: Implications for nursing practice. *Journal of Gerontological Nursing, 20*(8), 31–36.

Windriver, W. (1993). Social isolation: Unit-based activities for impaired elders. *Journal of Gerontological Nursing, 19*(3), 15–21.

Yesavage, J. A., & Brink, T. L. (1983). Development and validation of a geriatric depression screening scale. A preliminary report. *Journal of Psychiatric Research, 17*, 37–49.

Young, H. M. (1990). The transition of relocation to a nursing home. *Holistic Nursing Practice, 4*(3), 74–83.