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CHAPTER 17

Middle-Range and Situation-Specific Theories

To advance nursing knowledge, we must continue to build a robust scientific base and develop coherent frameworks that drive the science, as well as become a reservoir for the accumulating evidence that results from research. Both these categories, middle-range and situation-specific theories, are at those levels of conceptualization that could inform nursing practice and research and thus continue the cycle of advancing foundational knowledge and enhancing quality care. The theories discussed in this book have had a transformational effect on the entire discipline of nursing. They were conceptualized to answer questions about the overall mission, goals, and nature of the discipline of nursing and to differentiate the substance of the discipline from other disciplines. The theories of Martha Rogers, Dorothy Johnson, and other theorists of their era in nursing helped provide the framework for the discipline, and their theories set the boundaries for the nature of questions to be explored and investigated in the process of building and advancing the discipline. Without these fundamental theories to build on, we would not have been able to progress to the next level: the middle-range and situation-specific theories. Both of these types of theories are defined in this chapter, and exemplars will be provided for each one. The goal for this chapter, then, is to propose strategies and processes that could be used to develop middle-range and situation-specific theories. The strategies described in Chapter 16 will undoubtedly continue to inform the discipline; that is, scientists will use theories to develop research projects, which in turn will modify other theories, and clinicians will propose theories based on their clinical observations. However, patterns of scientific discovery and in the progress of certain disciplines, particularly nursing, tend to demonstrate a more integrated approach to theory development. Similarly, the tendency is to develop middle-range and situation-specific theories, rather than grand theories. The differences between the three types of theories—grand, middle-range, and situation-specific—are illustrated in Table 17-1 on page 408. One equally important difference that reflects the growing level of sophistication in the progress of the discipline is the reliance of its scholars on using a more integrated approach to developing theories. The integrated strategy to theory development is described in the following section.

THE INTEGRATIVE PROCESS FOR DEVELOPING MIDDLE-RANGE AND SITUATION-SPECIFIC THEORIES

Theories that tend to be rich in explaining responses, illuminating situations, enhancing wisdom about events, and providing directions for actions have evolved through an integrated approach. Such theories may have emerged primarily from any one source; however, the complexity of situations that give rise to these theories usually compels theorists to gather clinical evidence, identify exemplars, collect solutions, and garner support from other sources. In using an integrated strategy, theorists combine in any combination experience that is based on clinical practice, evidence from research, and knowledge that is based on theoretical formulations. This knowledge depends on the type of evidence and support that is needed, based on the phenomenon for which they are developing a theory.

Clinical practice has been one of the most significant sources for theory development. Subsequent to the group of nurse theorists discussed in this volume, some more contemporary theories may be deemphasizing the role of practice in theory development and are favoring more the role of research evidence in formulating theories. Theorists who use the integrated strategy, however, recognize the significance of the relationship among practice, theory, and research and understand

TABLE 17-1 PROPERTIES AND EXAMPLES OF GRAND, MIDDLE-RANGE, AND SITUATION-SPECIFIC THEORIES

Properties	Grand Theories	Middle-Range Theories	Situation-Specific Theories
Level of Abstraction	High	Medium	Low
Scope	The nature, mission, and goals of nursing	Specific phenomena or concepts transcending and crossing different nursing fields	Specific nursing phenomena limited to specific populations or to a particular field
Level of Context	Low	Medium	High
Connection to nursing research and practice	Too broad to connect	Limited	Relationship readily apparent (may prescribe for clinical practice)
Diversities, generalizations, and/or universalization	Ensuring universalization and generalization, but negating diversities	Crossing different nursing fields and reflecting a wide variety of nursing care situations, but rarely respecting diversities in them	Respecting diversities in nursing phenomena, but negating universalization and limiting generalization
Examples	Theories by Peplau, Henderson, Hall, Johnson, Abdellah, King, Wiedenbach, and Rogers	Theories by Hagerty, et al. and Mishel	Theories by Braden, Im and Meleis, and Hall, et al.

Reprinted with permission from Im, E. and Meleis, A.I. (1999). Situation-specific theories: Philosophical roots, properties, and approach. *Advances in Nursing Science,* 22(2), 11–24.

that each plays a role in the development of nursing theory. In addition, when using an integrative strategy, the person, theorist, clinician, or researcher also becomes an integral part of the theoretical formulation. Even when a deliberate attempt is made to distance the agent (the theorist or researcher) from the subject matter, and even when such attempts are carefully guarded and implemented, the infiltration of previous experiences in shaping the clinical situation and subsequently the theoretical formulation is inevitable. These experiences are part of a nursing perspective that is then reflected in the evolving conceptualization. All these factors become the context that shapes what we see, how we see it, and how we analyze it. They are part of an integrative strategy.

Phenomena seen from a nursing perspective are not seen in exactly the same way as phenomena seen from a sociological perspective. A nursing perspective is focused on considering the phenomena holistically and dynamically and within a context. Nurses are concerned with phenomena related to the experience of and response to health and illness, such as health, comfort, care, the nursing process, supporting, coping, grieving, mourning, suffering, and monitoring; in other words, phenomena that will eventually make a difference in some aspect of health care. Phenomena are described or explained through the interaction of health–illness events, person–environment relationships, and the human-responses perspective. Different perspectives provide different lenses through which phenomena are viewed. Each perspective identifies the limits within which inquiries are made (Donaldson and Crowley, 1978). (See Chapter 6 for a discussion on nursing perspective.) Another assumption for this strategy is that some kind of reality exists out there, and that there is a pattern and order in the universe around us, as well as, paradoxically, a certain degree of uniqueness. Because we live in an orderly, nonrandom world, this order is comprehensible

to a certain extent and within a certain context. The concept of uniqueness, however, deserves a closer look.

If each event or process of a phenomenon were absolutely unique or occurred randomly, without order or pattern, then no generalizations could be made. Without some degree of generalization, there is no science because all sciences attempt to generalize about recurrent phenomena. Scientists, unlike philosophers, must also assume some logical connection between perceivable events, as well as a certain degree of predictability. In practice, nurses focus on the uniqueness of individuals for the purpose of individualizing care. However, we must consider seriously Ellis' (1982) everlasting admonition against using the uniqueness of man as a crutch to avoid patterning and order, which remain the essential components of theory and science. Uniqueness reminds us to consider patterns of diversity and individuality, which, when examined, could add to the complexity and richness of theory. Therefore, uniqueness and patterning are also significant premises on which the integrative strategy of theory development is based.

With this caveat, and with the necessity of considering a rich contextual background, it may seem difficult to isolate a beginning point for the integrative strategy in theory development. However, like the strategies discussed in the previous chapter, some essential stages and processes may facilitate theorizing.

An integrated approach must be grounded in clinical practice at many different stages in theory development. An integrated strategy requires collaboration and dialogue. The beginning hunches and conceptual schemes are shared and communicated with others to allow for critique and further development. An integrated approach requires the development of a framework and a theoretical vision, as well as opportunities to test these hunches or evolving conceptualizations with colleagues and other participants. Other components of this integrated approach are research (of different designs) and different methods to clarify, support, or test some of the evolving hunches. Research documentation may be supplemented by reflective clinical diaries, descriptive journals, and dialogues about analyses, among other sources and approaches. An example of a theory in which the theorists used an integrated approach is the *Theory of Human Relatedness* (Hagerty, Lynch-Sauer, Patusky, and Bouwsema, 1993). The authors of this theory experienced situations in clinical practice that prompted them to think of various states of connectedness and disconnectedness. They dialogued, observed, kept notes, conducted research in the library, and identified the social processes inherent in relating, as well as the different states of relatedness, including connectedness, disconnectedness, parallelism, and enmeshment. The evolving theory explains, describes, and has the potential for clarifying situations in which nurses relate to others (which is most of the time). The potential power of this theory in enhancing the understanding of such situations is directly related to its integrated approach of development.

TOOLS FOR DEVELOPING MIDDLE-RANGE OR SITUATION-SPECIFIC THEORIES

Theory development includes mental processes that incorporate analysis, discovery, formulation, and validation of uniformities. These may come as a result of sensory observation or as a consequence of a logical or rational analysis of the problem or the phenomenon. They may also result from intuitive reasoning, from an insight that occurs over an extended period of time, or from a "click" that comes as quick as lightning. The thought processes can be spontaneous or premeditated—the timing is never predictable (Sorokin, 1974)—but a conscious effort to look at the phenomenon or the question is infinitely more helpful in bringing the process to closure. It does not guarantee the "click," but it increases its chances.

Just as the process of researching is enhanced by a knowledge of substantive content, a knowledge of research methodology, experience, and the ability to critique research, all processes of theory development are also supported and enhanced by the knowledge of what constitutes theory, knowledge of what major issues confront theorizing, ability to critique theory, knowledge of existing theories, and knowledge of major pitfalls in the development of theory. Knowledge of theory's context, such as the clinical area, is essential. Theorizing is a process that is refined through a deliberate experience. The processes of reflecting, analyzing, questioning, relating,

thinking, writing, changing, and communicating are integral parts of philosophical analysis, essential to theory development, and a prelude to and a consequence of research. Keeping a theory diary or journal in which observations, reflections, and relationships are systematically logged helps the theorist to sort out thoughts, develop documentation, and synthesize empirical reasoning with intuitive reasoning (Zderad, 1978).

Norms used to enhance science also are useful in enhancing theory development and they drive the utilization of other tools. Merton (1968, 1979) identified a number of these norms, two of which are pertinent here: the norms of *communality* and *organized skepticism*. Communality encourages nurses to share developing ideas and expose beginning theories for review by peers, to help sharpen the theory and to allow the norm of organized skepticism to prevail. This latter norm "requires detached scrutiny of work according to empirical and logical criteria" (Meleis and May, 1981, p. 38). Dialogues with colleagues in practice, in theory, and in research promote other ways of looking at concepts—other angles and other perspectives.

Collaboration is another significant tool for theory development. In a human science such as nursing, theory development is increasingly a collaborative effort. Collaboration allows the constant comparison and evaluation of competing ideas, provides the medium for a scholarly dialogue to refine concepts, and enhances the integration of seemingly diverse findings, all of which are important processes in developing coherent theories. Theorists of the future are not individual workers; they are team participants (Meleis, 1992). There is support for this new generation of collaborative theorists: for example, the team that proposed the use of simultaneous concept analysis in the development of concepts started from the assumption of collaboration (Haase, Britt, Coward, Leidy, and Penn, 1992). Other examples of collaborative theories are the evolving theory of unpleasant symptoms (Lenz, Suppe, Gift, Pugh, and Milligan, 1995) and the conceptualization of symptom management (University of California, San Francisco, School of Nursing Symptom Management Faculty Group, 1994).

Intuition is another essential tool that has been discussed in the nursing literature. Intuition is defined as reaching some decision or conclusion without the conscious or apparent availability of information (Rew, 1986; Westcott, 1968). Rew (1986) defines the attributes of intuition as: "Knowledge of a fact or truth, as a whole; immediate possession of knowledge; and knowledge independent of the linear reasoning process" (p. 23). Whether this tool is intuition or the expert speaking (Benner, 1984), recent writings encourage allowing that inner voice to surface, believing in it, and trusting it (Agan, 1987; Rew, 1986; Rew and Barrow, 1987); others argue that intuition is grounded in cognitive science and psychology and could be tested through a combination of soft and hard methods (Gobet and Chassy, 2008).

Closely related to intuition are *introspection* and *reflection*. Silva (1977) reminded us "to value truths arrived at by intuition and introspection as much as those arrived at by scientific experimentation" (p. 62). Reflection is a process of thinking that may or may not be bound by the need for problem solving.

MIDDLE-RANGE THEORIES

The integrative processes for theory development and the tools described above are the cornerstones for developing middle-range theories. Several books have been written to present and describe middle-range theories. Among these analyses are those edited by Smith and Liehr (2003) and Peterson and Bredow (2009). In the book by Smith and Liehr (2003), the middle-range theories of uncertainty in illness, self-efficacy, unpleasant symptoms, family stress and adaptation, community empowerment, meaning, and self-transcendence are presented and discussed. Peterson and Bredow's (2009) intent is to apply these theories to nursing research, and they categorize the middle-range theories in terms of their origin and emphasis. Therefore, they use the broad categories of physiological, cognitive, emotional, and social integrative to discuss the most widely used middle-range theories. Under the physiological framework, they present and analyze two theories of pain: a balance between analgesia and side effects, and unpleasant symptoms. Under the cognitive framework they focus on self-efficacy, and reasoned action and planned behavior.

Within the emotional framework, empathy and chronic sorrow are discussed. Under the social framework, they discuss social support and interpersonal relations. And finally, they create an integrative category under which they include modeling and role modeling, comfort, health-related quality of life, health promotion, deliberative nursing process, planned change, and resilience (Peterson and Bredow, 2009). Although the potential exists for different classifications that could prompt different approaches to advancing knowledge and, therefore, yield different outcomes, there is a clear indication that our discipline has undergone a turning point toward producing more accessible and functional theories that guide productive research programs, as well as providing theory- and research-based evidence to nursing practice. These middle-range theories also support the notion that the discipline of nursing's mission, goals, and focus have been defined and that we are ready for more specific questions about nursing care. The majority of middle-range theories describe and provide frameworks to deal with clients' experiences of symptoms, and they provide the means to understand responses to health and illness situations. The language of these middle-range theories is that used in nursing practice to deal with patient care phenomena such as pain, unpleasant symptoms, empathy, uncertainty, comfort, change, lifestyle, health promotion, relationship, and deliberative planning for care. This language reflects the early theorists' attempts to move the discipline away from adopting biomedical language that focuses on disease, pathology, and malfunctioning and to focus on individuals' responses and experiences within the context of health, illness, and encounters with the health care system.

Definition of Middle-Range Theory

Middle-range theory is defined as the coherent articulation of a set of concepts that describe and explain relationships that are related to a particular phenomenon. Middle-range theories are less abstract than grand theories, are more accessible to researchers and clinicians, but reside at a higher level of abstraction than do empirical findings, and they contain propositions that reflect generalizations that go beyond specific clinical case studies. Middle-range theories were defined by their inventor, the sociologist Merton, in 1968, as lying in the middle—between the hunches developed in a practice situation and the highly abstract, all-encompassing theory. Middle-range theories deal with more specific phenomena (Meleis, 1997); they usually have a limited number of concepts and propositions (Fawcett, 2005), they are more operationable and amenable to testing (Walker and Avant, 2005), they avail themselves more to empirical work (Meleis, 1997), and they provide a limited view of reality (Smith and Liehr, 2003) (Table 17-1).

Process for Developing Middle-Range Theories

Developing theories is a dynamic process, not based on static steps or strategies. It is driven by different sources, and although it starts at many different points, it always ends with a middle-range theory. While it must start by selecting a particular area of knowledge, either from a specific clinical question or from a research finding, the selection process may be a deliberate one or it may be the result of serendipity. In any case, a critical assessment of the rationale for selection is an essential component of the development process. However, I must emphasize that the process for developing theories is not a linear one, nor does it ever follow any one specific path. The components should be viewed as parts of a segmented puzzle; the full picture becomes manifest when all the pieces of the puzzle are put together. The different pieces of the puzzle may fit together at a different pace and not in any systematic fashion. The theory emerges slowly, just as a very complex puzzle takes shape in slow motion, with different shapes manifesting themselves as several pieces come together to form a recognizable whole. At a certain point when putting a puzzle together, several pieces fit together and a shape begins to emerge faster than expected, then a slow period ensues. Building a theory is also a very dynamic process. Just as shapes and images in a puzzle may project one image midway, the end image may be completely different. The process for developing a middle-range theory is depicted in Box 17-1. The example discussed here is the development of the concept of transition into a middle-range theory (Meleis, 2010).

BOX 17-1 THE PROCESS OF DEVELOPING A MIDDLE-RANGE THEORY

- Clinical observations of different groups to whom nurses were providing care, and facilitation of developing new roles for patients and significant others.
- Identifying similarities and differences in groups and in nursing care provided.
- Developing a conceptually based nursing intervention.
- Testing the intervention clinically and through a series of research studies.
- Integrating the research findings, and finding commonalities and themes.
- Asking the next set of questions to reveal any lack of knowledge about the concept.
- A thorough review of research and clinical publications in nursing about the concept.
- An analysis of commonalities and differences in the literature, and an identification of concepts depicting the nature of questions about theory.
- Communicating and reporting theory at different stages.

In the same way that an emerging shape takes form in a puzzle, different team members develop different parts of the theory at different times in its development. Although the journey, as presented here, may make the process of development appear linear and systematic, it is not. Questions that I asked in the 1960s led to the development of a conceptual framework–based intervention that I called *Role Supplementation*. After testing the intervention empirically, I questioned whether we knew which patient responses may have necessitated such an intervention, and with my colleagues, I began a more systematic approach to developing the experience and outcomes of transitions. We then moved on to a full circle of theory-based intervention.

In the following sections, I reconstruct the components of the theoretical journey that led to developing the middle-range theory of transitions (Meleis, 2010).

Clinical Observations

First, the theorist (who may or may not perceive him- or herself as a theorist) asks questions about a particular client or a situation. For the theory of transitions, the impetus was triggered by clinical observations. It was the experience of people and their responses to changes in their lives—specifically, becoming new mothers—that attracted my intellectual curiosity. My interest was triggered by how nurses facilitate individuals' acquisition of new roles to support healthy lifestyles and diminish the potential for becoming ill in patients facing changes in their lives. In addition, in a world where people are in constant movement and change, and one in which individuals are constantly learning to cope with short- and long-term changes, the human experiences and responses during transition become central to nursing interests. Assisting individuals and communities in dealing with transitions that affect their health emerged as a challenge for nurses, both before a change occurs, as well as during and after the change.

Developing theories is a long, laborious process. My interest in transitions dates back to the mid-1960s, when many support groups evolved to help people deal with a variety of problems. Support groups were initiated by nurses or lay people to help clients deal with the demands of new parenting responsibilities, with loss of family members, or with understanding a devastating diagnosis of mastectomy, as well as with anything in a person's life that was deemed out of the ordinary. As Ph.D. students and new graduates, we found ourselves practicing what was preached, and we asked questions, such as: "What are some common threads among all these groups?" We became aware of the need to consider the presence of some universal features in creating and conducting these groups and in their outcomes. I guess this awareness and the need to find some order in seemingly unrelated events was also driven by a growing interest in theory, and in theorizing about nursing.

This awareness was also nurtured by an interest in the phenomena that surrounded planning pregnancies, in the processes involved in caring for spouses with long-term illness, and in the

experiences of becoming a new parent and mastering parenting roles, which were the subjects of my master's and Ph.D. dissertation researches. I studied the process of decision making in family planning and discovered the significance of spousal communication and interaction in effective or ineffective planning of the number of children in families (Meleis, 1971). Although there were minimal data and interest at the time in the processes of and responses to changes, my colleague and I assumed that the knowledge needed was not about transitions, but rather about how nurses can make a difference in helping people achieve healthy outcomes after their transitions (Meleis and Swendsen, 1978). We focused on nurses' actions, on developing interventions, and on defining outcomes. In doing so, we were influenced by the context of justifying nursing actions to demonstrate that these actions make a difference in patients' outcomes.

Preliminary Research

Therefore, my next research questions were about what happens to people who do not make healthy transitions, and what nursing interventions nurses use to facilitate their clients' healthy transitions. The theoretical background of symbolic interactionism led to a focus on the symbolic world that shapes those interactions and responses that get organized into coherent sets of roles. We began observing people in transition with lenses that could organize and order these observations in terms of the roles enacted by both the actors and reactors. When people are not able to understand and enact particular new roles, they experience deficiencies. Roles, from a symbolic interactionist perspective, are defined in terms of behaviors, sentiments, and goals (Turner, 1962). That is where our clinical observations of health-oriented groups came in. So, first, we defined unhealthy or ineffective transitions as leading to role insufficiency, and we defined role insufficiency as any difficulty in the cognizance and/or performance of a role or of the sentiments and goals associated with the role behavior as perceived by the self or by significant others. Role insufficiency is characterized by behaviors and sentiments affiliated with the perception of disparity in fulfilling role obligations or expectations (Meleis, 1975).

Defining Concepts

In developing the middle-range theory of nursing intellectual capital, so that we could understand the relationship between organizational members' (in one case, nurses) knowledge, skills, and experiences on organizational outcomes, it was necessary to define and differentiate between the key concepts of human, social, structural, and relational capital and potential patient outcomes (Covell, 2008). Similarly, in our work on developing transitions, we defined the goal of healthy transitions as a mastery of the behaviors, sentiments, cues, and symbols associated with new roles and identities and nonproblematic transitions. Although the nature of transitions and the nature of responses to different transitions were still a mystery, this was not a mystery we felt compelled to uncover. We believed that knowledge development in nursing should be geared toward the development of nursing therapeutics and not toward understanding the phenomena related to responses to health and illness situations. In retrospect, we think that it is this belief in the need for developing nursing therapeutics and in finding out what difference nursing makes that may have been the driving force toward our development of role supplementation as a nursing therapeutic and for the research that occupied us during all of the 1970s (Meleis, 1975, Meleis and Swendsen, 1978). The reader should note how a particular philosophy on theory shapes how a phenomenon is defined and the nature of questions asked.

Research Program

Subsequently, role supplementation as a nursing therapeutic was used in a number of research projects. The major questions in each research project sought to further define the components, processes, and strategies related to role supplementation, and to answer the question of whether it made a difference in helping patients complete a healthy transition. At that time, I defined health as *mastery*, and in different research projects mastery was tested through such proxy outcome variables as "fewer symptoms," "perceived well-being," and/or "ability to assume new roles." Role supplementation was used to help couples assume the new role of parenting

(Meleis and Swendsen, 1978) and to help postmyocardial infarction patients develop an at-risk identity, which led to better compliance with a rehabilitation regimen (Dracup, Meleis, Baker, and Edlefsen, 1984). It was also used to describe how the elderly maintained their sexuality (Kass and Rousseau, 1983) and how parental caregiving roles are acquired effectively (Brackley, 1992). Similarly, it was used to ease the caregivers' roles for Alzheimer's patients (Kelly and Lakin, 1988). The framework was also used to better describe women who were not successful in becoming mothers and who manifested role insufficiency (Gaffney, 1992). Having a coherent framework helped articulate new research questions and provided a reservoir for accumulating the answers and refining the framework. The results demonstrated that nurses' actions tended to anticipate, facilitate, and enhance transitions and healthy outcomes. Having research programs that continue the development of middle-range theories may require the development of new or the refinement of existing research instruments (Räsänen, Backman, and Kyngäs, 2007). By articulating a coherent theory, researchers can continue to refine it through research conducted in other countries.

Clinical Observations Post Research Findings

Once again, it was time to go back for clinical observations. The growing interest in the discipline to uncover the lived experiences of people in health and illness prompted the need for more clinical immersion. Dr. Norma Chick of Massey University, Palmerston North, New Zealand, came to work with me during her sabbatical and agreed to collaborate with me in further developing the phenomena of how people respond to change. We both observed people undergoing changes due to immigration, and due to critical and intensive care. In 1985, we completed and published the results of our findings in an article that we entitled, "Transitions: A Nursing Concern" (Chick and Meleis, 1986). During this phase, "transition" was defined conceptually and was connected to the discipline of nursing. I believe that the result of our analysis positioned transition as a central concept in nursing thought. After developing a conceptualization of a phenomenon, a periodic determination of research and theory gaps may require revisiting care situations. In fact, clinical observations and periodic immersion in clinical situations are vital to the process of developing theories in a human science. This periodic revisiting of caring episodes is one of the hallmarks of an integrative strategy to developing middle-range theories. Theories identify gaps in the science of self-management of chronic health problems through knowledge gained from concrete experiences (Reed, 2006). Ryan and Sawin (2009) developed an individual and family self-management theory to describe and predict quality of life, perceived well-being, and cost. They point out that interventions that are both person- and family-centered must address the context of care by fostering structural conditions or the self-management process itself by enhancing knowledge, beliefs, and self-regulatory behaviors. The need to focus on families is driven by actually working in clinical situations and recognizing that the management of chronic health conditions is both influenced by family and acts to affect families. The authors identified gaps in research and previous conceptualizations that led to a new, more comprehensive middle-range theory.

Integrative Literature Review

Flight nurses have existed since flying became a mode of transportation. The properties of the experiences and actions of those nurses who are involved in the safe care of people in flight are similar in some ways and different in others from those of nurses who care for patients in hospitals or communities. To develop a coherent understanding of these properties, actions, and responses, Reimer and Moore (2010) conducted an extensive review of the literature spanning about five decades. They then developed nine concepts and five propositions that formed the middle-range theory of flight nurses' expertise, skills, knowledge, and subsequent actions.

A vital component in the process of developing a middle-range theory is extensive, comprehensive, and integrative literature review to define concepts or identify the existing evidence. Extensive literature searches should be conducted at different critical points in developing a middle-range theory. In continuing the dynamic and integrative strategies to develop transitions, 10 years marked a critical point to revisit the literature in a more systematic way, and to integrate and analyze it. With Dr. Karen Schumacher, then a doctoral student at the University of California at

San Francisco, I wondered about the extent to which transitions were used as a concept or a framework in nursing literature. A search of the literature yielded 310 articles that focused on transitions. We then analyzed these articles and identified more support for transitions as a central concept in nursing (Schumacher and Meleis, 1994).

During this part of theory development, clinical observations and findings from the literature are integrated. Literature reviews are also used to refine, support, or refute previous formulations. The review and analysis of the literature on transitions (Schumacher and Meleis, 1994) reaffirmed what we previously conceptualized; however, it also provided evidence to refine earlier conceptualizations. Instead of only three types of transitions: developmental, situational, and health–illness (Chick and Meleis, 1986), a fourth type of transition emerged. This new type of transition received much attention in the literature—we called it "organizational transition." Organizational transition was another type of transition explored by nurses, and it also represented an environmental transition. All the results of the literature analysis and interpretation indicated that transition is an area that requires more systematic, scholarly attention in the discipline of nursing.

Reviewing literature should not be confined to nursing literature. In developing and explicating transition, certain authors emerged as important to our continuous development of the theory of transitions. Bridges (1980, 1991), the guru of transitions and author of two significant books (*Making Sense of Life's Changes: Transitions,* and *Managing Transitions: Making the Most of Changes*), described three phases of going through transitions. These are an ending phase, characterized by disenchantment; a neutral phase, characterized by disintegration and disequilibrium; and a beginning phase, characterized by anticipations and taking on new roles. Each one of these phases requires different coping strategies and congruent nursing therapeutics. His work affirmed the significance and universality of transitional experiences and responses, and provided the impetus to continue in our journey to further clarify and develop transition, conceptually as well as empirically.

We then asked the question, "What happens to people during transitions?" We began answering this question through clinical observations, literature reviews, and research findings. Coping with transitions is a dynamic process that includes different processes, some of which are creatively constructed, such as those attached to caregivers' role acquisitions (Schumacher, 1995).

Critical Reviews Through Dialogues

Having established the significance of transitions to nursing, and having demonstrated the extent to which nurses participate in patients' transitions, we were led to extensive dialogues with many colleagues. This is another important component in the process of developing theories. The question presented in these dialogues was: "What nursing therapeutics could be used to enhance healthy outcomes in individuals who are experiencing a transition?" Most of the care that nurses provide happens during individuals' transitions, and the goal of nursing care is to enhance healthy outcomes. Therefore, we defined the mission of nursing within a framework of transition. Developing the concept of transition and supporting its significance through review and analysis of literature related to transition led us to define nursing as the art and science of facilitating the transition of a population's health and well-being. Nursing is also defined as "being concerned with the processes and the experiences of human beings undergoing transitions where health and perceived well-being is the outcome" (Meleis and Trangenstein, 1994, p. 257). Within this definition, areas for knowledge development that have some universality and that could support a more systematic effort in knowledge development were identified. Examples are knowledge related to the processes and experiences of human beings undergoing transitions, the nature of emerging life patterns that result from transitions, the nature of environments that support or constrain healthy transitions, and the nature of nursing therapeutics that could be used to prevent unhealthy transitions, to augment healthy transitions, or to promote wellness during transitions (Meleis, 1993).

The cycle of theory development is informed by practice, the literature, and research, and it subsequently leads to further identification of more integrated and coherent areas of investigation. Strategies used during the cycle for theory development are clinical observations, literature

reviews, critical thinking, analytical dialogue, questioning, empirical testing, describing, searching for and articulating exemplars, and communicating the results. In the following section, I provide research exemplars for utilizing transitions. These exemplars led to further development of transitions as a middle-range theory.

Researching Again

Once again, it is time to ask specific research questions. The transitions framework, as conceptualized in the analyses I have provided thus far, was then used as a conceptual framework in a number of studies. It has been used as a framework for transition in the elderly (Schumacher, Jones, and Meleis, 2010), and to describe immigrants' transitions (Meleis, Dallafar, and Lipson, 1998), the experience of women living with rheumatoid arthritis (Shaul, 1995), the process of recovery from cardiac surgery (Shih, 1995), the process of developing family caregiving roles for patients in chemotherapy (Schumacher, 1995), the experience of early memory loss for patients in Sweden (Robinson, Ekman, Meleis, Wahlund, and Winbald, 1997), and the experience of African American women's transitions to motherhood (Sawyer, 1999).

I asked some of the authors of these studies to describe in their own words how they used transitions as a framework. Here is how Karen Schumacher described her interest in transitions and how transitions shaped her work:

> As a doctoral student, I conceptualized the process of taking on the caregiving role as a transition, specifically as a transition that involved the acquisition of a new role. Using the nursing and social psychology literature on transitions, I developed a model of caregiver role acquisition. In this model, caregiver role acquisition is conceptualized as a role transition that involves creative role-making through interaction with the role partner (the care receiver) within a particular social structural context. The model emphasizes the interactional processes that occur in taking on the family caregiving role. The model was published in *Scholarly Inquiry for Nursing Practice* in an article entitled "Family Caregiver Role Acquisition: Role-Making Through Situated Interaction."
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> In the dissertation, I also identified critical periods in the cancer experience in which caregivers and patients had difficulty in managing cancer-related care. These critical periods were times of disruption and disconnectedness, in which both emotional stress and uncertainty about what to do occurred. Four critical periods were identified: the diagnostic period, the side-effect intensive period in the chemotherapy cycle, the junctures between treatment modalities, and the end of treatment. An interesting finding was that access to nurses was limited or nonexistent during these critical periods. The support and continuity of care that are nursing ideals do not appear to be made available to patients and caregivers at critical periods in the cancer experience. The findings raise questions about what nursing care organized from a transitions perspective, rather than in relation to medical treatment, might be like.
>
> During my postdoctoral fellowship at Oregon Health Sciences University, I turned to skill development as one aspect of the transition into the caregiving role. Family caregiving skill has not been systematically conceptualized, although assisting caregivers to develop skill in taking care of an ill person is a routine part of home care nursing. Nine caregiving processes were identified (monitoring, interpreting, making decisions, taking action, making adjustments, providing hands-on care, accessing resources, working together with the ill and family members, and working with health care providers). For each of these processes, indicators of the caregiver's level of skill were identified. These indicators will be used as the basis for an instrument that nurses will be able to use for assessment with family caregivers. The instrument will enable nurses to develop a profile of caregiving skill with their clients, which then could be used to target interventions. A long-term goal is to develop an instrument with which to measure family caregiving skill in research. Such an instrument would make it possible to measure changes in family caregiving skills during transitions in the caregiving experience. It could also be used to measure the effect of nursing interventions. (Schumacher, personal communication, 10/18/96)

Petra Robinson is another graduate student who worked with me on the analysis of data from patients with early memory loss. It became apparent to us that realizing and coming to grips with memory loss is a long process that includes stages, in-between stages, and periods of spillover and overlap. The major experience could be captured in the category of "suffering in silence." While they suffer in silence, people losing their memory go through stages for which they develop different strategies. These we called "forgetfulness," "something is wrong," and "in search of meaning." These stages occur before patients receive care congruent with their needs. During the stage of forgetfulness, individuals try their best to normalize their experience, gloss over it, and not take it seriously, but they suffer from it nevertheless. They watch and analyze as soon as they become aware that something is wrong. Finally, they use the strategy of avoidance and vigilance as they search for a meaning. Their experience is characterized by solitary suffering, and we believed that, by uncovering that suffering, we could support the strategies they use, share in their suffering, and enhance their resources until a definite diagnosis is made (Robinson, Ekman, Meleis, Wahlund, and Winbald, 1997).

The process of developing mothering in African American women was described by Sawyer as getting diagnosed with pregnancy, getting ready, dealing with reality, settling in, dreaming, and ending up becoming an engaged mother (Sawyer, 1996). She defined *engaged mothering* as "an active, involved, and mutual process in which a woman is preparing to be a mother, caring for herself and her infant, and dreaming about and planning for the future" (Sawyer, 1996, p. 73). Sawyer found that the identity women develop of being a mother was reflected by being engaged on many levels:

> [E]ngaged with baby, partner, parent, family, friends, coworkers, and the general community; engaged with their care during pregnancy; engaged in sorting through information and advice and choosing a role model; engaged in dealing with the daily hassles they faced in society; engaged in handling problems during the pregnancy and after the baby was born; engaged in figuring out the baby and adapting to changes in their lives; and engaged in planning for and dreaming about a 'good life' for their child and family. Motherhood is incorporated into the women's sense of self and is a synthesis of motherhood into the woman's identity rather than merely the attainment or addition of a role. Engaged mothering is dynamic and interactive and embedded within the context of the woman's family, history, life experiences and dreams. (Sawyer, 1996, pp. 73–74).

Understanding women's roles and how they mother their babies, which is part of nursing's mission, cannot be understood without understanding the process that women go through to develop this mothering identity. Nursing actions to support the process are more effective when they are matched to the different stages and critical points in the process.

Here, Linda Sawyer (personal communication, 1996) describes how she used transition to guide her study and interpretations:

> In this study on African American women, transitions theory provided a framework which allowed motherhood to be studied as a complex, longitudinal, and multidimensional process, focused on patterns of response over time. Common themes in the definition of transitions are disruption, disconnectedness, and emotional upheaval—certainly themes common to expectant and new mothers. Compared to all transitions, which are of interest to nursing, the transition to motherhood has received the most attention in the nursing literature. Maternal role attainment (MRA) is the construct used in nursing to describe the transition to motherhood. MRA has focused on the dyad of mother and child, on motherhood as a role, has not described the meaning of motherhood, has been studied through quantitative methods using multiple tools, and has not been tested cross culturally. Since the construct of MRA has not been studied cross culturally, this theory cannot be generalized to all mothers, and the cultural equivalence of this construct needs testing.
>
> This grounded theory study described the transition to motherhood for a group of African American women as a longitudinal process which 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. For some women, the transition was planned and hoped for, and for others it occurred earlier than planned but was still welcome. In this study, women exhibited success in the transition through their active involvement in preparing, caring, and dreaming. Women developed a sense of comfort in caring for their child, sought out sources of support and connection within their families and the community, and planned for and actively pursued their dreams and vision for a good future for themselves and their child.

Conditions for transitions usually include meanings, expectations, level of knowledge and skill, the environment, level of planning, and emotional and physical well-being. Women described their meaning of becoming a mother, which evolved out of their experiences and dreams. Expectations were formed from hearing other women talk about their experiences and observing other mothers, reading or watching videos, and by fantasy. The level of knowledge was high among this group of women because of their active involvement in preparing during pregnancy through classes, written materials, role models, questioning, obtaining advice, and seeking formal prenatal care. Mothering skills were developed through figuring out the baby, "maternal instinct," and for some women, through previous experience in caring for children. The environment for this group of women increased their stress during pregnancy. Women were faced with and dealt with incidents of racism, stereotyping, and negativity frequently in their daily lives. The environment mediated the transition through both providing support and increasing stress. The level of planning, illustrated by the condition of intentionality of the pregnancy, affected the transition, since women who were actively trying to get pregnant proceed through the transition easier. A second condition of prior miscarriage or history of health problems of the mother diminished the woman's sense of both emotional and physical well-being and was an inhibitor of the transition.

Several critical points in this transition may require nursing intervention. Early in the prenatal period, an assessment needs to occur regarding the woman's history of prior miscarriage or health problems and the intentionality of the pregnancy. Worries will need to be solicited and appropriate reassurance and support provided. Nursing interventions may not be successful if offered before the woman has passed the critical point—i.e., after the time the previous miscarriage occurred. Additional options to prepare for motherhood may need to be utilized for women with a history of previous problems, since this group of women was less likely to attend traditional classes. Special care or additional support may also need to be provided for the women with prior problems. Nurses need to ensure that care is provided in a culturally congruent manner and be sure that African American women receive information about the progress of the pregnancy and the size and condition of the baby at each visit. Labor and delivery is a particularly stressful time, and nurses need to intervene to ensure that mothers receive support and that their birth plans are respected as much as possible. After the baby was born, women had many questions and a need for reassurance. This is a time when nursing interventions are welcome and heeded. Nursing support from a consistent person with whom the woman is comfortable is important to assist new mothers in settling-in until they gain confidence in making decisions regarding the care of the baby, usually at four months postpartum.

Shaul (1995) found in her doctoral dissertation research that women with rheumatoid arthritis (RA) went through three stages before settling into the business of caring for themselves. The first stage is becoming aware, when the symptoms are nagging but are still ignored. The second stage is learning to live with RA. During this stage, women felt alienated from their environment while trying to cope with the many symptoms they experience, such as fatigue, stiffness, depression, and swelling. During stage three, they master the new knowledge and know that the condition has its ups and downs, but they have a sense of control that comes from knowing about the disease and knowing how to manage their own daily care.

Integrative Findings

The next step in our journey toward developing a middle-range theory for transition was to analyze the research findings related to transition experiences and responses. Similarities and

differences in utilizing transitions as a framework and in the findings were then compared, contrasted, and integrated. Extensive reading, reviewing, and dialoguing about each research study and finding led to the final stage of developing transition as a middle-range theory, complete with components, conditions, responses, outcomes, and nursing therapeutics. One of the nursing therapeutics thus identified is role supplementation, which was the very early impetus for finding a coherent way to facilitate clients' transitions and enhance their mastery of their roles and health in a new situation. The middle-range theory was then articulated and published (Meleis, Sawyer, Im, Schumacher, and Messias, 2000). By communicating the theory in literature and exposing it for critique and utilization, other researchers and clinicians can complete the cycle of theory development.

Summary of Process

The process we used to develop transition as a middle-range theory is depicted in Box 17-1. The impetus for this process was triggered by clinical observations. Generalizations about these observations were articulated in a more coherent whole within a conceptual framework. The conceptual framework evolved from a "lens" that was colored by symbolic interactionism as a philosophy and role theory as a theoretical framework. Empirical research, as well as clinical observations, drove the development of a more modified conceptual framework. Extensive review of the literature helped build on previous conceptualization by refining, extending, modifying, and developing a more nuanced framework. Clinical exemplars illustrated the rationale for the changes. Several empirical research studies used the most recent conceptualizations. Critical analyses of the findings, dialogue about the researchers' experiences with the framework, and reframing of the findings in comparison to other findings led to a more refined middle-range theory. Concepts then were defined using the most recent findings, with exemplars provided from the completed research. Box 17-1 summarizes this process, which ends with communication and reporting of the middle-range theory.

SITUATION-SPECIFIC THEORIES

The discipline of nursing is at a level of maturity that allows theorists to develop theories that are more congruent with the nature of nursing, the diversity of nursing clients, the complexity of experiences, the responses of human beings in the face of illness situations or calamities, and the dynamic nature of environments. These theories answer more specific questions and provide frameworks that are more accessible to researchers and clinicians. The future of the discipline lies in situation-specific theories. Therefore, the next level in developing theories is developing conceptualizations that are closer to the clinical realities of caring for clients, as well as reflective of variations in the contexts and situations of populations. A number of concepts were attached to lower abstract theories. Merton may have called them *single-domain theories* or *microtheories* if he chose to write about theories that are at a lower level of abstraction than middle-range theories (Merton, 1968). In nursing, these are called *practice theories* (Jacox, 1974). The practice theory's point of departure is practice, and the goal of a practice theory is to affect practice. Situation-specific theories are theories that may be developed from other theories, from research findings, and/or from practice (Meleis, 1997). They are differentiated from grand and middle-range theories by level of abstraction, degree of specificity, scope of context, level of accessibility to clinical practice and research findings, extent of reflection of population diversity, and by the extent to which they limit or claim generalizability (Table 17-1). Im and Meleis (1999a) provided a useful comparison between the grand theories of Peplau, Henderson, Hall, Johnson, Abdellah, King, and Wiedenbach, the middle-range theories of Hagerty et al., and situation-specific theories of Braden, Im, and Meleis, and Hall, et al. (Meleis and Im, 2000; Im and Meleis, 1999b). Im (2006) continued to develop the integrated strategy and to use in it developing several situation-specific theories.

Definition of Situation-Specific Theories

Situation-specific theories are coherent representations and descriptions of a set of concepts, an explanation of the relations between those concepts, and a prediction of outcomes related to

these relationships. The representation is grounded in clinical, teaching, policy, or administrative situations. It is focused on a specific set of phenomena, more subscribed situations, and has a limited set of conditions. Situation-specific theories are less abstract than middle-range theories and are limited in the number of concepts described, in the range of explanations offered, in the scope of research propositions they drive, and in the outcomes claimed. These limitations are not a reflection of the significance of the potential contributions to the science that may be generated, but rather are a reflection of the depth of explanation that such theories offer the user for a particular, specific area or field of concern. Depth and richness also emanate from the consideration of such significant contextual conditions that are thought to be vital for the explanatory power of a situation-specific theory, and that may otherwise be perceived as noise and deviation in a middle-range theory. A consideration of the marginalization of clients due to racism is required when developing a situation-specific theory on pain experience and management, but is less vital in a middle-range theory about pain experience and management. Situation-specific theories are more tolerant of multiple truths and more congruent of an increasingly integrative theory of truth, as presented in Chapter 8.

Sources and Properties of Situation-Specific Theories

The sources of situation-specific theories are multiple. Whether the impetus is research, practice, or theory, the integration of all sources is the hallmark of these theories. The context and the population tend to be the criteria for the development of such theories; generalizations tend to be limited, and a specific time in history may be integral to developing situation-specific theories. Im (2005) goes even further in suggesting that the integrated approach to theory development proposed by Meleis (1997) is the strategy of choice when developing situation-specific theory. In the 21st century, the integrated approach described in this chapter is the strategy of choice for both middle-range and situation-specific situations. However, it is imperative to include the history of the clinical situation, the involvement and engagement of the theorist, a clear nursing perspective, a holistic dynamic, the changing framework, and the phenomenon (described and explained through the interaction of health–illness events, personal environment, relationships, and human response), as well as the context in a situation-specific circumstance. As described in this chapter, the integrative strategy also includes research findings and other data from clinical experiences or other theories. This integrated strategy contrasts with practice-to-theory strategy, research-to-theory strategy, and theory-to-theory strategy. It combines the best of all in an integrative way. Im (2005) is explicit in including the criteria of "multiple truths" as an essential assumption for using the integrated approach to developing situation-specific theories.

Process for Developing Situation-Specific Theories

Grounding in Nursing Domain and Perspectives

In developing a situation-specific theory that could enhance nursing science, the theorist must be grounded in the discipline of nursing, scope of practice, and the discipline's domain and perspective, as discussed in Chapter 6 (Im and Meleis, 1999a). Identifying the phenomenon and the problematics that need to be explicated, as well as the population for which the theory will be developed, are important aspects to be considered in theory development. Being cognizant of and driven by the goals and the mission of nursing will require immersion and understanding of the clinical situation and the conditions for which the theory is developed. In developing a situation-specific theory on breastfeeding, Nelson (2006) was inspired by clinical observations of the maternal effort to breastfeed and the limited support these mothers received from their providers. She became aware that existing theories did not help in achieving the desired outcomes.

Another example is elderly transitions. Although the starting point for this situation-specific theory was the transition model (Schumacher and Meleis, 1994; Johnson, Morton, and Knox, 1992), the clinical experiences of the authors and their research findings in the literature helped them develop a more specific model in which healthy and unhealthy processes in elderly transitions were articulated, reflecting the aging situation and the experiences of gains and losses that

occur through the biological, social, and psychological aging processes. The literature reviews, combined with clinical experiences of working with the elderly experiencing transitions, were integrated to produce seven healthy processes that could be the triggers for healthy outcomes.

This situation's specific theory proposes that those elderly who are aware of the transition, experiences, and responses, and who positively and realistically redefine the meaning of their transition, modify their expectations of themselves and others, and engage and modify the daily routines of their lives to become more congruent with new demands in their lives. Similarly, those who are not only willing, but who actually develop new skills and competencies that are based on knowledge of the situation, and who maintain some continuity in their lives, go on to also create new choices, find opportunities for growth, and tend to have a healthier transition outcome. It does not matter whether the transitions they are experiencing are developmental, situational, or one of health and illness. The outcome of a healthy transition is the experience of minimal symptoms; these people tend to have optimal functional status, and they tend to feel connected and to experience a sense of empowerment and integrity. These outcomes are mediated by the patterns of transition and are a function of whether the events that triggered the transition are single or multiple occurrences, and whether the transitional events are sequential, simultaneously related, or simultaneously unrelated. Unhealthy transition processes, in their extremes, are apposite from the healthy processes, and the process indicators will include compromised functional status and feelings of disempowerment, in addition to a tendency to experience a variety of symptoms (Schumacher, Jones, and Meleis, 2010). A coherent approach to elderly care and scholarship was suggested by utilizing the transitions framework, and immersion in clinical observations shaped this situation-specific theory.

Selection of a Theory

Study and analysis of middle-range theory is the usual starting point for developing a situation-specific theory. During such review, it may be determined that the theory does not quite allow a comprehensive and inclusive explanation of clinical situations for scientists or clinicians. Riegel and Dickson (2008, 2010) found that no integrated and coherent set of explanations of self-care existed for patients with heart failure. They identified several concepts that specifically reflect this population of patients and several propositions that were tested and offered preliminary support for the theory. Their starting point was self-care theory; they pointed out the existing confusion between the various self-care concepts, and they opted to further clarify self-care from a number of other concepts. Several related situation-specific theory examples that emerged from other theories exist in the literature: Im (2005) describes Falk-Rafael's (2001) empowered caring, LaCoursiere's (2001) online social support, and Poss' (2001) synthesis of health belief model and theory of reasoned action as examples of situation-specific theories based on other theories.

Situation-specific theories are usually developed after a middle-range theory is reported in the literature. By using the middle-range theory of transitions in research studies and practice situations, it was apparent that more specificity was needed to describe and explain how certain populations (Korean American women experiencing menopause, and the elderly experience of transition) experience transition within the context of immigration or within the context of other types of change (Im and Meleis, 2010; Schumacher, Jones, and Meleis, 2010; Im, 2006). These contexts shape people's experiences and their responses to them, and thus require more specific theories. Dialogue, analysis, critique, identifying exemplars, affirming and/or modifying assumptions, defining and redefining concepts, and explaining relationships are processes used in developing situation-specific theories. Providing a narrower scope for power of explanation by defining more conditions and contexts limits the utility of the theory for other types of populations, as well as for other repertoire conditions. Therefore, defining and specifying the population are essential to the process of developing situation-specific theory.

Specifying Populations Within a Context

Developing a coherent situation-specific theory that drives science and practice requires detailed specificity about the populations for which the theory is developed. Furthermore, it

requires attention to, and incorporation of, the sociocultural and historical context to explain the clinical situation, as well as the conditions that affect care. Additionally, it requires attention to a particular set of genetic markers that may characterize this population. Many examples illustrate this population focus.

A situation-specific theory of breastfeeding included a broad contextual history surrounding breastfeeding and the sociocultural norms that influenced whether women breast- or bottle-feed. Few would deny the influence of the media, society, and the bottle-feeding industry in influencing the decisions of women and their families. Therefore, a review of these conditions, as well as other factors, is vital in developing a theory about women's choices, options, decisions, and actions (Nelson, 2006). Another example is the menopausal transition of Korean immigrant women (Im and Meleis, 2010, pg. 121). Unlike women who are not recent immigrants, Korean immigrant women tended to pay less attention to menopause and tended not to attribute changes in their lives to menopause, but rather more to work and the immigration transition. Menopause was a silent experience for them, either normalized or ignored. In a research study exploring how new Korean immigrants tended to experience and respond to menopause, the findings indicated a need for developing a more contextual and specific conceptualization of the menopausal transition. The research findings by Im (1997) then led to developing a more specific conceptualization of transition, one that embraced menopause as a transition, the immigration experience, and the centrality of gender, context, and socioeconomic status, as well as the ability to manage symptoms (Im and Meleis, 1999b). These concepts then helped to modify the middle-range theory of transitions and made it more specific for the purpose of illuminating the situation and experience of immigrant women. Such specificity leads to more focused future research questions, as well as to a different level of understanding (for example, Korean immigrant women's experiences in the health care system as they manifest resistance and reluctance to discuss what may be symptoms of menopause). A diagram depicting the situation-specific theory is presented in Figure 17-1, with asterisks indicating how specificity to the Korean immigrant women uncovered by research led to modifications or extensions of the Schumacher and Meleis (1994) model. Within the immigration transition framework, Clingerman (2007) further modified the transition middle-range theory by adding the context for migrant farm workers. She sharpened the propositions by considering immigration documentation, citizenship status, and personal U.S. identity; this led her to consider a sense of peace as a more congruent outcome for this population.

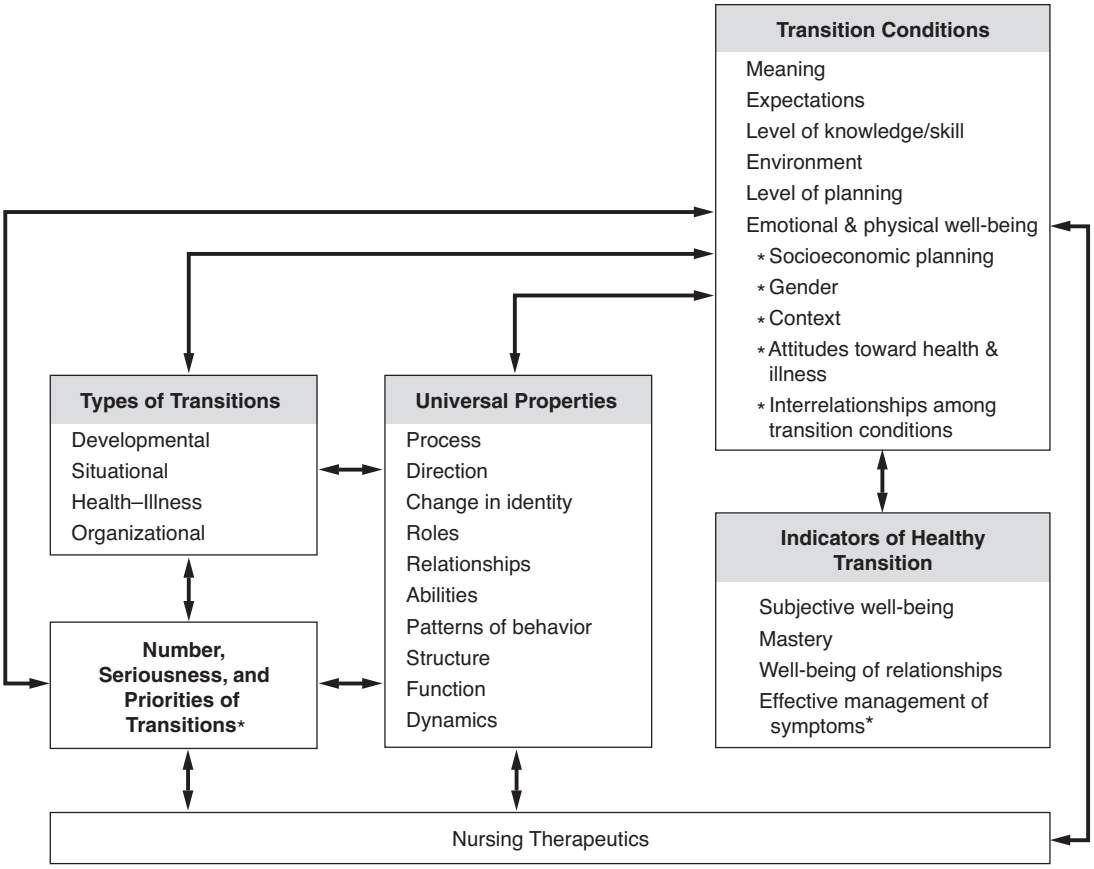
Using population characteristics as a starting point for the development of situation-specific theories is another productive approach. Im used her cumulative wisdom from research evidence about vulnerable women and their health to develop several situation-specific theories to explain different phenomena and generate propositions for further research. Among them are situation-specific theories about the cancer pain experience (Im, 2008) and women's attitudes toward physical activity (Im, Stuifbergen, and Walker, 2010).

Review of Literature

An integrative review of literature that encompasses the theory, research, and practice research will illuminate the emerging situation-specific theory throughout the process of development. Although Sakraida (2005) did not call her conceptualization of the divorce transition of midlife women a situation-specific theory, the results of her research program could eventually lead to a coherent situation-specific theory. She offers an example of an extensive review of divorce transition literature, the transition for midlife women, and the determinants of outcomes based on initiators and noninitiators of the divorce.

Developing Situation-Specific Theory

Grounding the theory in a particular population's responses; completing an analytical, integrative, and well-synthesized review at different points in theory development; and conducting preliminary studies could lead to the development of a situation-specific theory. (Review the beginning of this chapter.) This process is well described and applied in the transition of siblings



*Additions to the model of Schumacher and Meleis (1994).

FIGURE 17-1 ◆ Model of a situation-specific theory: The menopausal transition experience of Korean immigrant women. Reprinted with permission from Im, E.O. and Meleis, A.I. (1999). Situation-specific theory of Korean immigrant women's menopausal transition. *Image: Journal of Nursing Scholarship,* 31(4), 333–338.

of children with cancer (Wilkins and Woodgate, 2006), as well as in the transition of Taiwanese nurse practitioners (Chang, Mu, and Tsay, 2006).

Summary of Process for Developing Situation-Specific Theories

The starting point may be clinical practice or research, but a situation-specific theory must have another theory as a reference point. That theory most probably is a middle-range theory. As summarized in Box 17-2 on page 424, specifying the phenomena and the characteristics of the population are essential in situation-specific theory. Another vital component of this process is considering the population within the psychological, social, cultural, and political context and within a historical context. Similarly, the phenomena and the relationships it encompasses must be described and explained within a context. Assumptions, concepts, relationships, outcomes, and consequences are driven by these properties and their place in history, community, society, and culture. Dialogues and critiques inform the process and outcomes of situation-specific theories.

CONCLUSION

The integrative process for theory development and the tools used are described and discussed in this chapter. The future for advancing nursing knowledge depends on the extent to which we are

BOX 17-2 THE PROCESS OF DEVELOPING SITUATION-SPECIFIC THEORIES

- Study middle-range theory.
- Use middle-range theory in research.
- Use middle-range theory in practice.
- Specify the characteristics of a population and the conditions of their experiences.
- Provide and describe a limited scope of experiences for that population.
- Ground assumptions to reflect the population's experiences and responses.
- Review research and practice literature, redefine assumptions, and redefine concepts.
- Develop a framework with assumptions, concepts, antecedents, outcomes, and propositions.
- Provide clinical and research exemplars.
- Critique the emerging theory through dialogue.
- Communicate the emerging theory through different media.

willing to commit to developing coherent frameworks to drive future research programs and practice models. The future theoretical development in nursing is in presenting our science in middle-range and situation-specific theories. I strongly believe that the nature of nursing as a human science focused on the experiences and responses to health and illness lends itself far better to the development and use of situation-specific theories (American Nurses Association, 2003). The use of middle-range theories is a step in the right direction in the journey and moves our discipline toward a trajectory of more focused situation-specific theories. In this chapter, I provide the process used to develop theories and give many examples of each component of the process. In particular, the integrative approach to theory development was used to describe the journey toward the development of middle-range and situation-specific theories of transition, as well as in developing other theories.

REFLECTIVE QUESTIONS

1. What are the relationships between grand theories, middle-range theories, and situation-specific theories?
2. Should middle-range theories be developed and tested before developing situation-specific theories? Why?
3. Compare and contrast a middle-range and a situation-specific theory. What are the similarities and differences in the processes of development, the sources, and the testing?
4. Select a middle-range theory in your field and develop a situation-specific theory using the guidelines outlined in this chapter. How would you refine these guidelines?

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