

Nursing as Informed Caring for the Well-Being of Others

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Assumptions about four main phenomena of concern to nursing (persons/clients, health/well-being, environments and nursing) are presented and an elaboration is made of the structure of a theory of caring. The issues that arise when nursing is viewed as "informed caring for the well-being of others is also examined."

[Keywords: caring; theory construction/model building; nursing process; nurse-patient relationship]

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Caring is the roar that lies on the other side of silence. When the mist lifts, nurses can find new images of caring (Watson, 1987, p. 16).

Nursing is informed caring for the well-being of others. As Carper (1978) has noted, nurse caring is informed by empirical knowledge from nursing and the related sciences, as well as ethical, personal and aesthetic knowledge derived from the humanities, clinical experience and personal and societal values and expectations.

Assumptions Underlying Caring

Persons/Clients

Watson (1985) proposed that how nurses view persons and define personhood sets the stage for who the clients of nursing are, and what constitutes the practices, environments and goals of nursing care. Persons are unique beings who are in the midst of becoming and whose wholeness is made manifest in thoughts, feelings and behaviors. The experienced life of each person is influenced by a genetic heritage, spiritual endowment and the capacity to exercise free will. Persons in their wholeness are not stagnant; rather, as Travelbee (1971) has noted, they are becoming, growing, self-reflecting and seeking to connect with others. Persons both mold and are molded by the environment in which they exist. The genetic heritage serves as a blueprint for each person's unique human characteristics. The spiritual endowment connects each being to an eternal and universal source of goodness, mystery, life, creativity and serenity. The spiritual endowment may be a soul, higher power/

Holy Spirit, positive energy, or, simply grace. Free will equates with choice and the capacity to decide how to act when confronted with a range of possibilities. While acknowledging free will does mandate that nurses honor individuality, it may also delude us into believing that the "range of possibilities" are equally available, acceptable and desirable to all persons. Practice based on such parochial egocentric assumptions have historically lead health care providers to label wrongfully clients as irresponsible and non-compliant, set up health care delivery systems that are convenient to providers versus accessible to consumers and sacrifice client centered care at the altars of technology, economics and provider egos.

Schultz (1987) has identified that the "other" whose personhood nurses attend to may be individuals or aggregates (i.e., families, groups or societies). Most often, the "other" will be a specified individual or aggregate, however, it may also be a generalized other. For example, the generalized other may be future generations or social issues such as freedom of speech, human rights or access to health care. One last additional class of other/person/or client to whom nurses attend is actually an awkward use of the word other and refers to

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care of self. Self-as-other refers to the well-being of each nurses' self and her/his nursing and the well-being of all nurses and their nursing.

Environment

Environment is defined situationally. For nursing, it is any context that influences or is influenced by the designated client. Realms of influence are multiple, including the cultural, political, economic, social, biophysical, psychological and spiritual realms. When examining the influence of environments on persons, it is helpful to consider the demands, constraints and resources brought to the situation by the participant(s) and the surrounding environment (Klausner, 1971). What is considered client in some situations, may serve as context or environment in other circumstances. For example, in some nursing care situations the community may be the client (i.e., nurses acting politically about the need for safe play areas for inner-city children), at other times it may be the environment (i.e., nurse assessment of how the school system accommodates the needs of a specific child with a chronic health condition.) For heuristic purposes the lens on environment/designated client may actually be further specified to the intra-individual level, wherein the "client" may be at the cellular level and the environment may be the organs, tissues or body of which the cell is a component.

Health/Well-being

Smith (1981) has delineated four views of health that include health as: absence of illness; ability to perform one's roles; capacity to adapt; and as the pursuit of eudemonistic well-being. Nurses focus on how clients are living with whatever illness or wellness condition they may be in. As nurses our focus is not so much on disease amelioration, per se, as it is on assisting clients to attain, maintain or regain the optimal level of living or well-being they choose given their personal and environmental demands, constraints and resources. Well-being is living in such a state that one feels integrated and engaged with living and dying. When nurses focus on health as well-being, our care must take into account what it means to be whole persons who are becoming, growing, self-reflecting and seeking to connect with others.

To experience well-being is to live the subjective, meaning-filled, experience of wholeness. Wholeness involves a sense of integration and becoming wherein all facets of being are free to be expressed. Facets of being include the many selves that make us human: our spirituality, thoughts, feelings, intelligence, creativity, relatedness, femininity, masculinity and sexuality, to name just a few. Healing, the process of reestablishing well-being, includes releasing inner pain, establishing new meanings, restoring integration and emerging into a sense of renewed wholeness.

Health, illness, deviance and pathology are socially defined phenomena. As so defined, they are influenced by societal values, political ideations, cultural norms and economic conditions. Socially defined phenomena frequently wreak havoc with the becoming and healing necessary to the realization of well-being. For example, when a woman miscarries a desired

pregnancy her spiritual, maternal, feminine and sexual selves are challenged to reestablish meanings that allow her to experience a renewed sense of integration wherein her personal biography includes the experience of having miscarried a longed-for child. The seeking and becoming of well-being requires a safe space for acquiring information, releasing the pain of sadness and fear and expressing longing for the lost loved one. When no such arena exists and the woman is given socially defined dictums of what is normal (i.e., "At your age, it was a blessing;" "It's been two months, aren't you over that yet?"), her attempts at reestablishing well-being are thwarted. Her many selves are left disintegrated and a feeling of wholeness is replaced with one of inadequacy.

Nurses and Informed Caring

Nurses "diagnose and treat human responses to actual or potential health problems" (American Nurses Association Social Policy Statement, 1980). This description clarifies our functional role to the publics we serve and underscores the importance of nurses providing care to clients (individuals or aggregates) who are currently dealing with or potentially facing health deviations. But this language does not, capture the essence of nursing's values, history, expertise, knowledge, universality and passion. Those whom we serve, how we serve and why we continue to serve mandate an impassioned integration of science, self, concern for humanity and caring. Consummated in transactions among nursing and society and each nurse and client are the profession's commitments to caring, the preservation of human dignity and enhancement of well-being for all.

Informed nurse caring ranges from having novice to expert capacity in practice. As Benner (1984) has noted, novice nurses may care very deeply about the well-being of others, yet their repertoire of caring therapeutics may be somewhat constricted. For example, in order to proceed safely, novice nurses may need to restrict their definition of other to "this patient's wound," and their definition of well-being to "infection and pain avoidance." In contrast, the informed expert nurse would view the other as an individual who is ultimately capable of managing her own wound. The expert would modulate care between what she/he needs do to assure safety and what the client must do to learn self-care. An expert nurse has a deeper understanding of what constitutes well-being, a broader scope of caring practices, and a wider view of who or what constitutes "the other."

The techniques and knowledge embedded in nurse caring often are so subtle as to remain virtually undisclosed to the uninformed observer. For example, when a newborn intensive care unit nurse places a pacifier in a preterm infant's mouth a minute or two prior to diapering (for the compromised infant an energy draining activity), unless one appreciates the importance of non-nutritive sucking as a self-soothing, oxygen conserving infant self-care behavior, the rationale for the nursing therapeutic of pacifier placement would be glanced over. When, in fact, the nursing act was based on esthetics, a sense of the whole of what works for this infant's overall well-being; caring ethics, which raised the child from the

moral status of object to one of a person whose self-soothing abilities mattered; empirical evidence, which demonstrates that non-nutritive sucking can lessen neurobehavioral disorganization in the face of manipulative interventions; and self-knowledge, or the nurses' sense of how she/he would wish to be treated were she/he in the infant's position.

As Reverby (1987) has noted, just as nursing knowledge is hidden in caring acts, the acts themselves are likewise frequently hidden, undervalued and under rewarded. Some of the reasons that nurses, their knowledge and their nursing are so little appreciated and greatly concealed include: The fact that nursing is frequently dismissed as "women's work;" caregiving tasks often are viewed as coming from the heart and not from the brain; nursing is perceived by many as an extension of medicine involving technical skills and a willingness to obey; and our society values curing disease and circumventing death over preventing health problems, enhancing life quality and preserving personal dignity.

It takes a person schooled in "nursing appreciation" to fully see the beauty in expert nursing practice. For some, the appreciation comes from having been the recipient of expert nursing. In those instances, the appreciative audience has a non-indexical way of defining care and resorts to superlatives (Great! Wonderful! So caring!) to capture the beauty of their experience. For others, nurses, appreciation comes from formal education and clinical practice wherein we know good nursing when we see it; yet we, too, may be without words if good nursing is what we routinely practice. In other words, good nursing is the cultural norm and as such is difficult to describe from within the culture. Disseminated nursing appreciation must come from those (nurses and non-nurses) who deliberately observe and in the words of their own disciplines say back to nurses and their care recipients just what is precious about nursing. Some of the products of "nursing aficionados" have included *Notes on Nursing*, (Nightingale, 1859); *Ordered to Care* (Reverby, 1987); *The Cancer Unit: An Ethnography* (Germain, 1979); *Intensive Care* (Heron, 1987); *Midwife and Other Poems on Nursing* (Krysl, 1989); *From Novice to Expert* (Benner, 1984); *A Family Caregiving Model for Public Health Nursing* (Zerwekh, 1991) and *Providing Care in the NICU: Sometimes an Act of Love* (Swanson, 1990). Not all of these "nursing appreciation majors" are nurses, thus suggesting that nursing (informed caring for the well-being of others) may be observed, understood and interpreted by those who are willing to thoughtfully observe and inductively describe nurses and their practice.

Making the claim that nursing is informed caring for the well-being of others does not mean that only nurses are caring, and that all nursing practice situations may be characterized as caring. It also does not suggest that nursing is the only profession whose practice involves informed caring. What it does claim is that the therapeutic practices of nurses are grounded in knowledge of nursing, related sciences, and the humanities, as well personal insight and experiential understanding and that the goal of nurse caring is to enhance the well-being of its recipients. It is the blend of knowledge/

information and the goal of practice that distinguishes nursing from others whose practices includes caring.

The Structure of Caring

In 1991, I described a middle range theory of caring that was empirically derived through phenomenological inquiry in three perinatal nursing contexts. Citing corroborative nursing and non-nursing literature, it was postulated that the theory may have generalizability beyond the perinatal contexts studied and beyond the practice of nurses only. Since publishing the theory of caring, it has become apparent that a limitation is a lack of structure to the theory as to how the five proposed caring processes relate to each other. In this section, in addition to reviewing the major components of the theory of caring, a structure is proposed and justified for my theory of caring.

The five caring processes and sub-dimensions are not suggested to be unique to nursing, they are proposed as common features of caring relationships. Caring is defined as "a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (1991). Key words in this definition include: nurturing (growth and health producing); way of relating (occurs in relationships); to a valued other (the one cared-for matters); toward whom one feels a personal (individualized and intimate); sense of commitment (bond, pledge, or passion); and responsibility (accountability and duty). Whereas this definition applies to all caring relationships, relationships of central concern for nursing include nurse to client, nurse to nurse, and nurse to self. In keeping with the overall purpose of this manuscript (to deal with the claim that nursing is informed caring for the well-being of others) the remaining discussion of the caring theory is restricted to its applicability to nursing.

Maintaining Belief

An orientation to caring begins with a fundamental belief in persons and their capacity to make it through events and transitions and face a future with meaning. As illustrated in **Figure 1**, maintaining belief in persons is at the base of caring, it is from this stance that nurses define what matters and where to address care. Whether nurses articulate it, clients are approached with a conviction that there is personal meaning to be found in whatever health condition or developmental challenge the person is facing.

Maintaining belief is a foundation to the practice of nurse caring. It is sustaining faith in the capacity of others to get through events or transitions and face a future with meaning that initiates and sustains nurse caring. Such an orientation fuels nursing and nurses to a commitment to serve humanity (in general) and each client (in specific). On the societal level, it is belief in the rights of all people to get through events and face a meaningful future that motivates nurses to political activism around such matters as access to care and the need for health care reform. On the interpersonal level, maintaining belief is evident in the case of a nurse who cares for a couple laboring to birth their stillborn daughter. In this example, the nurse's care centers on monitoring the mother's

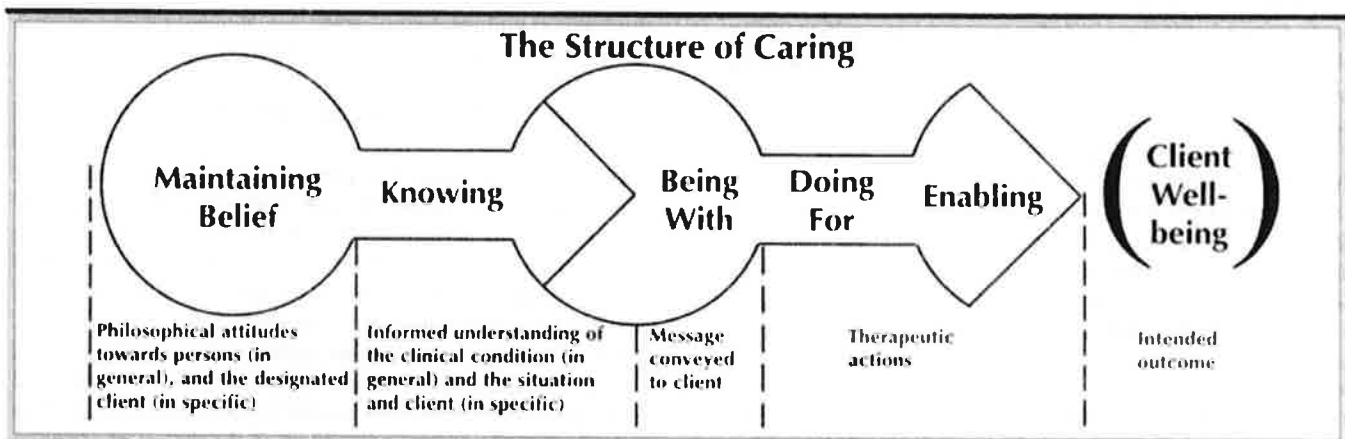


Figure 1: The structure of caring as linked to the nurses' philosophical attitude, informed understandings, message conveyed, therapeutic actions and intended outcome.

physical and emotional safety while assuring the couple's long-term healing. The nurse sustains faith that the couple, with her guidance, will safely and humanely get through the immediate birth and death. Fundamentally, the nurse believes in the family's capacity to create both a dignified passage for their child and a meaning-filled future for themselves: a future wherein their daughter and her birth and death will have a peaceful, permanent meaning in their family's day to day existence.

Knowing

If maintaining belief is at the base of nurse caring, knowing is the anchor that moors the beliefs of nurses/nursing to the lived realities of those served. Knowing is striving to understand events as they have meaning in the life of the other. Knowing translates the idealism of belief maintenance into the realism of the human condition. It involves avoiding assumptions, centering on the one(s) cared for, thoroughly assessing all aspects of the client's condition and reality, and ultimately engaging the self or personhood of the nurse and client in a caring transaction. In effect, nurse knowing sets the potential for the nursing therapeutics of being with, doing for and enabling to be perceived as relevant and, ultimately, effective in promoting client well-being.

The efficiency and efficacy of knowing as a caring therapeutic is enhanced by empirical, ethical and aesthetic knowledge of the range of responses humans have to actual and potential health problems. Formal nursing education that includes content on physical, cultural, spiritual, and emotional responses to conditions of wellness and illness prepare nurses to throw a wide net when casting for any one client's lived reality. Experience with clients with similar conditions, or a given client under differing conditions, hones a nurse's capacity to know the meaning of an event in a given client's life. A nurse's knowledge of self sets the stage for how willing a nurse is to truly know another's reality and just how capable she/he is to contain her/his needs and center on the client's lived reality. On a disciplinary level, nurses' clarity on our

own perspectives and contributions, sets the agenda for nursing scholarship and promotes the potential for truly knowing and serving the health needs of society.

Being With

Being with, being emotionally present to other, is the caring category that conveys to clients that they and their experiences matter to the nurse. Emotional presence is a way of sharing in the meanings, feelings and lived experience of the one-cared for. Being with assures clients that their reality is appreciated and that the nurse is ready and willing to be there for them. Being there includes not just the side-by-side physical presence but also the clearly conveyed message of availability and ability to endure with the other. For inpatient nursing, the call bell that is accessible and readily responded to is a type of being there. For nurses who work in community or outpatient settings there are several methods of conveying "you are not alone, what happens to you matters and that we are here for you." Some of these methods include sharing clinic phone numbers and permission to call anytime, giving nurse pager instructions and assurance of immediate access, and even arranging for electronic mail computer linkages between rural home-bound clients and urban health care facilities.

To be with another is to give time, authentic presence, attentive listening and contingent reflective responses. In many ways to be with another is to give simply of the self and to do so in such a way that the one cared for realizes the commitment, concern and personal attentiveness of the one caring. Being with ranges from offering a joyful cheer at birth, to crying with the bereaved, to sharing the frustration of a family caregiver, to carrying a 24-hour beeper so that the adolescent with leukemia knows that his nurse is just a phone call away.

When being with nurses do so, with a sense of responsibility toward both the client and self, remaining ever aware of who is provider and who is recipient in any given clinical situation. There is a fine line between sharing the other's reality and taking on that reality as your own. When such boundaries are crossed, painful outcomes are bound to ensue. Failure to remain

responsible to client and self results in nursing care that burdens clients, lessens the nurse's well-being and ultimately diminishes the nurse's personal and professional relationships and role performance. Given that nurses work in settings where the best and worst life has to offer can be commonplace, nurse administrators must set up organizations that take into account the need to care for and promote caring among nurses. In order to care without burdening themselves, their clients or their families, nurses must get their work related needs met through self-care and communities of caring in which the interpersonal work ethic is to be there for each other.

Doing For

Virginia Henderson captured the essence of doing for in her often quoted definition of nursing:

The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. (Henderson, 1966).

Doing for, simply put, is doing for the other what they would do for themselves if it were at all possible. Doing for involves actions on the part of the nurse that are performed on behalf of the client's long term well-being. There is an efficaciousness to these actions, wherein the nurse acts ultimately to preserve the other's wholeness. Short-sighted, misplaced efficiency occurs when the actions are solely toward immediate preservation of the caregiver's time, energy or finances. Classic health care examples of not doing for include administering prematurely an episiotomy on behalf of the obstetrical care provider's over-booked schedule, quickly bathing and dressing an elderly client who is perfectly capable of slowly dressing herself or hastily hauling infants off to the newborn nursery versus leaving them in proximity to their mother's loving gaze, nurturing milk and bodily warmth.

Doing for includes comforting the other, anticipating their needs, performing competently and skillfully, protecting the other from undo harm and ultimately preserving the dignity of the one done for. Although it may appear that doing for actions are primarily psychomotor nursing ministrations, this is not always the case.

In the psychosocial realm of care, doing for generally involves not so much physical ministrations, per se, as the employment of interpersonal therapeutic communication skills as well as setting up opportunities, programs or systems that provide safe arenas within which people can bring about their own healing. When nurses set up groups for teen-age incest survivors, women who miscarry or bone marrow donors, they are doing for clients what they would do for themselves, if at all possible. Recently, a group of maternal-child public health nurses from the Seattle-King County area shared some beautiful examples of psychosocial doing for. They delineated levels of supportive assistance they perform on behalf of new mothers experiencing substance abuse problems. When mothers indicate a desire to "get clean," the nurses describe assessing how

capable the woman is to act on her own behalf. If it is clear that the woman is in danger and that it took all the woman had within her to even voice a desire to "quit using," the nurse might dial the substance abuse hot line for her and hand her the phone (being aware that while the woman herself must talk, she needed that extra boost to access help). If, on the other hand, the woman states she is ready to quit and would like to know where to begin, the nurse might assess whether to offer the woman a narrow range of choices ("Here are pamphlets on two treatments programs within your city. I will check back tomorrow to see which one you called."); broad options ("Look in the yellow pages under "A" for alcoholism. Call me Thursday morning and we can talk about your decisions."); or simply a wide open response, such as "How may I be of assistance to you?" In each case, the level of nurse directiveness is the result of balancing the nurse's recognition that the woman must act on her own behalf with an understanding of the demands, constraints, and resources offered by the woman's life and environment. Doing for in each of these public health nursing examples is a balancing act between doing for the woman what she would do for herself if she had the knowledge and/or resources to do so and facilitating the woman's ultimate desire to realize life long sobriety.

Enabling

Ultimately nurse caring is about enabling others to practice self care. Enabling is defined "as facilitating the other's passage through life transitions and unfamiliar events" (1991). Enabling includes: coaching, informing and explaining to the other; supporting the other and allowing her/him to have her/his experience; assisting the other to focus in on important issues; helping her/him to generate alternatives; guiding her/him to think issues through; offering feedback; and validating the other's reality. As with doing for, the goal of enabling is to assure the other's long-term well-being.

Unfortunately, the term enabling has come to have a negative meaning in the popular vernacular of the mental health community. The term enabling often connotes a negative action in which the provider sets up or maintains a situation in which the other may sustain an unhealthy way of being. This popular use of the term enabling suggests that the provider may actually act as co-dependent to the other's pathological choices. Whereas this was never the intention of Swanson's labeling of this category, the term does, nonetheless, lend itself to offering a built-in warning to the potential pitfalls of caring. In many ways "enabling" highlights the two sides of the caring coin: one in which the self of both caregiver and recipient are enhanced by the care provider's actions and the opposite in which the self of provider and recipient are diminished by the provider's misdirected actions. Any discussion of caring in nursing must begin and end with the awareness of where professional responsibilities lie (to self and other); what constitutes nurturance versus diminishment (of self and other); how the boundaries of personal and professional roles are delineated; and when and where to seek support for the demands of caring.


The ultimate goal of nurse caring is to enable clients to achieve well-being. The potential for well-being rests on the capacity to practice self-caring to the fullest extent possible. As Orem (1980) and Henderson (1966) have suggested, sometimes enabling involves substitutive care (doing for the other what they are unable to do for themselves)—but doing no more than is necessary to conserve the client's energy or preserve the client's dignity. At other times enabling involves creating an environment in which self-healing can occur (similar to Nightingale's [1859] notions of providing an environment in which the body's inherent healing tendencies can operate). Sometimes it is the client's internal environment (i.e., self concept, knowledge or skills level) that is altered in order to enable healing; at other times it is the external environment that is manipulated (i.e., provision of safety devices, removal of physical, social or emotional threats or obstacles). No matter what form the enabling intervention might take, it gains the title "enabling" by virtue of its intended function: to facilitate the other's passage through difficult events and life transitions.

Conclusion

My dual purpose has been to justify the claim that "Nursing is informed caring for the well-being of others" and to further explicate an empirically derived theory of caring.

This theory delineates five overlapping processes that are best discussed as dimensions of one over-arching phenomenon: caring. Mutual exclusivity amongst the processes does not exist and, in fact, their relationship to each other may be hierarchical. The proposed structure for the theory depicts caring as grounded in maintenance of a basic belief in persons, anchored by knowing the other's reality, conveyed through being with, and enacted through doing for and enabling.

When time is taken to observe and interpret nurses' actions, it becomes clear that nursing practice is the result of blended understandings of the empirical, aesthetic, ethical and intuitive aspects of a given clinical situation and a nexus of maintaining belief in, knowing, being with, doing for and enabling the

other. Several examples were offered that illustrate that nurse caring frequently consists of subtle, yet powerful, practices which are often virtually undisclosed to the casual observer, but are essential to the well-being of its recipient. 

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