

Optimal Healing Environments in Nursing

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ABSTRACT

The purpose of this paper is to explore nursing's historical legacy as a caring-healing profession, and the meaning, significance, and consequences of optimal healing environments for modern nursing practice, education and research. Described are the core foci of nursing as a discipline: what it means to be a person and experience personhood; the meaning of health at the individual, family, and societal levels; how environments create or diminish the potential for the promotion, maintenance, or restoration of well-being; and the caring-healing therapeutics of nursing. Each of these domains are described and discussed in the context of caring, healing environments. It is argued that caring and healing are phenomena difficult to confer or enact in isolation from one another. For nursing, embracing a caring-healing framework incorporates attending to the wholeness of humans in their everyday creation and sustenance of a meaningful life.

INTRODUCTION

Florence Nightingale, the founder of modern nursing, described the duty of a nurse as putting the patient in the best condition for nature to act upon him or her. She suggested there were five essential components to an optimal healing environment: pure air, pure water, efficient drainage, cleanliness, and light.¹ Attending to these dimensions of the environment is as relevant to maintaining or restoring physical and mental health today as it was in the nineteenth century. To this day, nurses are educated to work with internal and external environments to restore individuals, families, and communities to their full potential for wellness.

More recent nursing values expand on Nightingale's descriptions of a physically sound healing environment to embrace the importance of caring and healing in the context of the nurse-patient relationship.²⁻⁸ This viewpoint is incorporated into Kreitzer and Disch's⁹ description of integrative health care: "More than a set of therapies or modalities, integrated healthcare encompasses a philosophy of caring, healing, and wholeness that has the potential of transforming the care of patients as well as the healing of health professionals."

The perspective of nursing grounded in a philosophy of caring sets the goal of nurses' work as healing the whole person and recognition that wholeness embraces biologic, psychologic, social, and spiritual health. An emphasis on wholeness incorporates attention to the culture, values, and beliefs of the one cared for. Furthermore, as Kreitzer and Ditsch described, a caring, healing, integrative approach to health care embraces the importance of sustaining the wholeness of the one caring. Having reviewed sixteen studies focused on outcomes of caring for the nurse, Swanson¹⁰ stated, "Practicing in a caring manner leads to the nurse's well-being, both personally and professionally. Personal outcomes of caring include feeling important, accomplished, purposeful, aware, integrated, whole, and confirmed. Professionally practicing caring leads to enhanced intuition, empathy, clinical judgment, capacity for caring, and work satisfaction. Social outcomes of caring for nurses include feeling connected both to their patients and to their colleagues." Moreover, practicing in a manner congruent with one's values leads to greater satisfaction with practice.¹¹⁻¹³

Over the past decade, there has been a movement in nursing to recognize "magnet hospitals" that create conditions conducive to excellence in nursing practice.¹⁴ When nurses

are more satisfied with the quality of their work and the conditions of their work environment, the risks of burnout and turnover are decreased.¹⁵

Reverby¹⁶ paralleled the advancement of nursing to the women's movement and noted that nursing, an exemplar of "women's work," involves care of the vulnerable, weak, and needy. While essential, the work of nurses so often gets taken for granted and goes underrewarded. She proposes that nurses have been "ordered to care" by a society the existence of which mandates that a sector be prepared to care for those whose ability to care for self is compromised. In many ways, nursing, much like mothering, emphasizes caring for another so as to facilitate their wholeness and healing. Reverby acclaimed the power of caring and healing work, while acknowledging that both its economic and social worth altogether too often remain unnoticed.

In the mid- to late twentieth century, preparation of nurses shifted from clinical apprenticeship to university-based education. Relocating to the academy has ultimately brought recognition of nursing as an organized discipline with a sufficient body of knowledge to support graduate level education that prepares nurses as independent scientists or advanced practitioners. Nurse scholars have expended considerable effort pondering what nurses need to know, who they ought to serve, what they need to do to promote wellness, and how their contributions matter. Influenced by early nurse leaders who received their doctoral preparation in both the human and biologic sciences, and working closely alongside colleagues prepared in medicine, nurses oftentimes struggle to name their unique contributions to society.

Traditionally, there exist four key questions that capture the main foci of nursing research, practice, and education. As a discipline nurses ask: What does it mean to be a person/patient? What does it mean to experience health? What constitutes a health promoting/healing environment? What constitutes "good" nursing practice?

PERSONS AND PERSONHOOD

Within nursing, the person (client) has been defined in a variety of ways. In most of her works, Nightingale¹ referred to the client as a "patient," whose internal-spiritual and external environments were controlled by nurses by means of observation, ingenuity, and skillful performance of tasks to restore the client's optimal health or support him/her in a peaceful death. Although there are specific references in Nightingale's writings to the patient doing self-care, she emphasized that it was the nurse's duty to take charge of developing and sustaining a healing environment. Henderson¹⁷ recasted the nurse's role in the health of another from that of "lead actor" to temporary "understudy" in promoting, maintaining, or restoring the other's health. In referring to nurses as the hands, heart, or feet of the patient whose compromised health required temporary substitutive care, Hen-

derson¹⁷ shifted the nurse's role from "taking charge" to "doing for." Orem¹⁸ moved the locus of agency for health one step further, and emphasized each individual's responsibility for self care. Each of these perspectives (nurse as "in charge" [Nightingale], understudy [Henderson], coach [Orem]) are incorporated in modern nursing care and played out in nursing activities of protecting, nurturing, teaching, advocating for, and anticipating needs, and addressing the wants and health preferences of those for whom they care.

Although many of Nightingale's assertions about nursing and patient remain applicable today, as a consequence of secular thinking and rapid scientific and technological advances, recognition of the spiritual dimensions of persons diminished considerably in the late twentieth century.^{19,20} Nonetheless, focusing on development of optimal healing environments provides a starting point for consideration of the traditional ethical values that drive modern day nursing values as described in the current American Nursing Association's (ANA) Code of Ethics for Nurses.²¹ The predominant focus is on advocacy for the individual patient, with nursing responsibility for attending to spiritually healing environments as a seemingly secondary theme.

The Code asserts that "humans (clients of nursing) manifest an essential unity of mind/body/spirit." Thus, the goal of nursing is to pay attention to the full range of human experiences and responses to health and illness, including one's spiritual needs. Moreover, the document broadens the definition of "client" from client as a person to client as community, thus opening the way to consider healing needs of groups of people ranging from dyads to communities and society. Finally, in order to create an environment that facilitates healing, an emphasis on mind/body/spirit highlights the importance of nurses integrating objective data of the physical (cellular to anatomical levels) with knowledge gained from an understanding of the client's subjective experience.

In the mid- to late twentieth century, prominent nurse theorists depicted the client of nursing as a composite of a "whole," that is, a person with bio-psycho-social and spiritual dimensions that are interrelated and in transaction with an ever-changing environment.^{2,17,18,22-24} The work of these nurse scholars provides the discipline with a reference point from which to provide care of a client as a "whole," as well as further inquiry into the multidimensional nature of what it means to be a person. Watson² emphasizes the importance of focusing on what it means to have "personhood" and to allow that awareness to drive the nature of how they work with each patient served. To be whole is to acknowledge that attending to human responses to states of illness or wellness is every bit as important as preventing, diagnosing and treating pathology. In fact, the ANA's Social Policy Statement²⁵ asserts that nurses address human responses to actual and potential health problems. In effect, nursing is measured by the capacity of nurses to promote healing, prevent breakdown, and restore wellness. Each of these components

embrace the importance of working with people, be they ill or well, to achieve their optimal potential for biologic, psychologic, spiritual, and social well-being.

Modern day nursing research focuses on understanding human health at the cellular through epidemiologic levels. For example, Kieckhefer's program of research in three separate ongoing projects emphasizes child and family responses to childhood asthma.²⁶ In each of these investigations the emphasis lies not so much on treating the disease as on understanding ways to support the child in the context of his or her family to live well, optimally heal, and minimize illness related burdens.

HEALTH AND HEALING

Human experience is defined personally (from within), contextually (from one's situatedness), and culturally (from one's tradition). Health and illness are human experiences. The presence of illness does not preclude health nor does optimal health preclude illness.²¹ In 1981, Judith Smith published a classic philosophical analysis of the meaning of health.²⁷ She identified four ways in which health has been traditionally depicted, not just in nursing, but across time, cultures, and healing perspectives. The first view, a traditionally Western biomedical perspective, depicts health as the absence of illness. From this angle achievement of health is managed by diagnosing indicators of disease, preventing further breakdown and eliminating pathology. Optimal health is considered restored when disease is eradicated or, at the very least, further decline is halted.

The second model described by Smith depicts health as the capacity to adapt. Adaptation means accommodating to the extent that one compensates for, manages, and adjusts to setbacks. From this perspective, an optimal environment for healing would be one that manages the symptoms of disease (pain control), supports bodily processes (effective elimination), sustains life (adequate nutrition, infection control), and enables one to deal with or prepare for deviations from wellness (education).

The third perspective, functional health, emphasizes the importance of role fulfillment. People are considered healthy if they are able to engage in activities of daily living. From this perspective, what matters is the ability to contribute (work, parent) and engage in life (play, sleep well, exercise, study, etc.). Considering a functional model of health, an optimal healing environment would be one that facilitates sustenance of life such as one wants and is expected to live it.

The fourth level of health incorporates the three prior models, and is referred to as the eudaimonistic model of health. The term *eudaimonia* is of Greek (happiness) and French (*eu*—good attention, happy; *demon*—spirit) origins. According to Merriam-Webster's Collegiate Dictionary,²⁸ eudaemonism is a theory that the highest ethical goal is happiness and personal well-being. From this perspective, health

incorporates the importance of wholeness, peacefulness, and meaningfulness. An optimal healing environment, in this circumstance, would embrace a caring perspective, attend to the importance of healing relationships, address unity of mind, body, and spirit, and aim for contentment and happiness.

HEALING ENVIRONMENTS

Watson²⁹ suggests that nurses must recognize the influence that internal (mental and spiritual well-being, and incorporated sociocultural beliefs) and external environments (societal attitudes, cultural expectations, religious doctrines, political climates, laws, social policies, and economics) have on the health status of individuals, families, and society. People are in constant transactions with their environments.^{30,31} In any one given transaction, each participant and the environment in which they act bring to the encounter a set of demands, constraints, and resources that hold the potential for promoting or diminishing the well-being of each participant.³² Furthermore, Darley and Fazio³³ suggest that power imbalances (such as that between standing provider in white coat and patient in recumbent position) retain incredible potential for creating a life-enhancing or life-destroying circumstance. The centrality of respectful relationships to positive outcomes is congruent with ideals expressed by the American Association of Colleges of Nursing,^{34,35} many nursing theorists,³⁶ and the standards of holistic nursing.³⁷

An example of exquisite relationship-centered care is the Parent/Caregiver-Child Interaction Model³⁸ for effective maternal-child health care. This model of effective parenting rests on creating the most advantageous environment for infants to thrive and optimally develop by emphasizing the promotion of human health. Barnard³⁸ begins with consideration of the demands (employment, family size), constraints (cognitive and social limitations), and resources (adequate food, knowledge, energy) that effect parents' abilities to function and the infant's abilities (neurologic, social, and cognitive capacities) to attend to parent caregiving. The model pays equal attention to cue-giving and cue-receiving from the environment (parent) and recipient (child). Using everyday events (play and feeding), Barnard²⁸ has developed a series of observation tools that direct attention to clarity of cues given by the baby (turning away indicating withdrawal), contingency of parent responses (patiently waiting until the infant tries to reengage by focusing his or her gaze on the parent), clarity of parent cue-giving (words and actions match, as pointing at the red ball while saying, "there is the red ball"), and contingency of child response (attending to the parents' words and actions). This relationship-centered model of parent caring and nurse assessing acknowledges the importance of a meaningful, rewarding, growth-fostering relationship as the optimal environment to promote and sustain both child and parent wellness.

NURSING AND CARING

A fundamental and universal component of good nursing is caring for the client's bio-psycho-social and spiritual well-being. Although various nurse scholars have referred to "caring" as an attribute essential to "good" nursing, only a few have described the phenomenon in a systematic way that can be applied in everyday practice and thus, aid in creating healing environments.

Swanson^{6,10,39,40} empirically developed a theory of caring that offers clear explanation of what it means for nurses to practice in a caring manner. She emphasizes that the goal of nursing is to promote well-being. Her theory includes five basic processes that provide meaning to nursing acts labeled as caring: knowing, being with, doing for, enabling, and maintaining belief. She defines caring as "a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility."³⁹ Knowing means striving to understand an event as it has meaning in the life of the other. It involves avoiding assumptions, focusing on the other's reality, assessing thoroughly, seeking cues, and engaging the self of both the caregiver and the one cared for. Being with means being emotionally present to the other. It involves being emotionally and physically present for the client, conveying ongoing availability, sharing feelings, and not burdening the one cared for with the caregivers' responses to his or her plight. Doing for means doing for others what they would do for themselves if it were at all possible. Doing for acts including anticipating needs, comforting, performing skillfully and competently, protecting, and preserving the other's dignity. Enabling means facilitating the other's passage through life transitions and unfamiliar events. It includes focusing on the other, informing, explaining, supporting, validating, generating alternatives, thinking things through, and providing constructive feedback. Maintaining belief, sustaining faith in the other's capacity to get through an event or transition and face a future with meaning, involves believing in others and holding them in high esteem, maintaining a positive attitude, offering realistic optimism, helping the other to find meaning, and standing by the other no matter how their situation unfolds.^{6,10,39}

Swanson's program of research began with asking women who miscarried how they wished to be cared for and what it felt like to miscarry.⁴⁰ She has subsequently focused on examination of the effectiveness of caring-based interventions on promoting healing for women who have miscarried and their partners. Healing in this context has been translated to mean restoration of mental health, resolving grief, finding meaning, and sustaining the couple relationship.^{7,10,41,42}

Although Swanson's theory of caring was generated from a phenomenological study of women who miscarried, the caring processes have been applied in diverse nursing settings. Furthermore, Swanson claims that caring, as a nurturing way of relating to another human being, is not the sole domain of nursing. In fact, she purports that knowing, being with, doing for, enabling, and

maintaining belief are essential components of any healing relationship.¹⁰

Nurse caring is manifested when a nurse performs such a simple task as feeding breakfast to an elderly gentleman recovering from a stroke. The nursing act of slowly feeding, while monitoring the man's cues ("Let me know if this is too hot"), and gently talking about his responses ("Hmm, looks like you don't care too much for sweet cereal, would you prefer toast?") incorporates all five caring processes. The act involves doing for (feeding him as he would otherwise have done himself), the unrushed timing conveys willingness to be with, and the observing and querying engages the man in his own care (enabling) while acknowledging that the patient's preferences and tastes matter (maintaining belief and knowing). In carrying out this seemingly mundane, simple act, the nurse has created an optimal environment for preserving wholeness (honoring the man's dignity and his worthiness to make decisions about his own care while leveraging mealtime as an opportunity to engage in a meaningful social encounter). Unobservable but ongoing in the nurse's care is assessment of nutritional status, cognition, and overall physical well-being; fostering of hope for recovery; and recognition of the man as a person of dignity and worth. Thus, the nursing task of patient feeding is a complex, dynamic whole of reciprocal emotional participation, caring interactions, and safe, effective healing ministrations.

Watson²⁹ suggests a transpersonal ontologic caring-healing model of nursing. According to Watson's caring-healing model, nurse-client relationships that promote healing are based on mutual trust. Watson²⁹ suggests that relationships between nurses and clients allow for the formation of a humanistic-altruistic value system, instill hope, cultivate sensitivity, and aid in the development of trust, thus, allowing for the expression of both positive and negative feelings by care-receiver and provider. Moreover, Watson²⁹ asserts that working in a trusting relationship enables use of scientific problem solving, promotion of interpersonal teaching and learning, creation of a healing environment, gratification of human needs, and allowance for thought-provoking experiences that lead to better understanding of self and others. Consequently, an atmosphere of pure caring emerges, which allows the nurse to go beyond the physical surface and enables access to the core of the client's humanness.

Nursing care that embraces a caring-healing framework incorporates meeting client's needs through creation of a comfortable environment that is conducive to healing. For example, when a nurse is bathing a client, her action is far more than a mechanical act of tidying up. Although it could be argued that bathing is a task, which can be done by anyone, when a nurse performs this clinical task, an opportunity is created for deliberate clinical assessment, healing through touch, and motivating through therapeutic use of self. Integral to caring is establishment of a trusting relationship that honors personhood, preserves dignity and worth, sustains hope for a meaningful future and, thereby, facilitates healing of *both* nurse and client.

Clearly, caring and healing are complex integrated phenomena, difficult to discuss or enact in isolation from one another. Thus, teachers of modern day nursing initiate students into the profession by immersing them in the language of what it means to experience wholeness as a bio-psycho-social-spiritual being and what constitutes the role of nurses in promoting, restoring, or maintaining optimal wellness in each of these spheres. Humane and altruistic caring ranges from the simplicity of bathing and feeding an incapacitated elder, to the complexity of safely monitoring and managing the recovery of a postsurgical patient, to planning for the health needs of a rural remote county. Nurse caring recognizes that optimal healing includes attention to health as not just the amelioration of illness, or facilitation of adaptation, or restoration of function, but also the importance of attending to the wholeness of humans in their everyday creation and sustaining of a meaningful life.

DISCUSSION

Authors making claims to knowledge from the perspective of one discipline incur the risk of appearing ignorant of the contributions of other disciplines. Moreover, authors claiming expertise and understanding from the perspective of fields beyond their own incur the even bigger risk of sounding naïve in more than one discipline! Although nursing and medicine have a different focus, both have developed from a Western philosophy of what it means to be healthy. Evidence of the scientific paradigm and the values of evidence-based practice are apparent in both fields. While the highest ideals of nursing and medicine may be deeply rooted in caring, curing, and healing traditions, in recent decades, the delivery of care has been highly influenced by a health care system steeped in the biomedical model. In addition, social-political values that elevate autonomy, personal accountability, and cost containment, further fragment care by failing to address the devastating effects of poverty, as well as the needs of populations characterized by diversity in race, education, religious backgrounds, gender, sexual orientation, and access to care. Unfortunately, finding the time to support and create optimal healing spaces in a health care system structured to streamline and contain cost creates tremendous threats to practitioners' ability to practice from a deliberate, knowledge based, intuitive, patient-centered perspective.

Examination of human experiences of health within modern day health care structures from a feminist perspective challenges us to examine the dominant lens through which humans and their health are framed. A feminist perspective calls into play examination of how our very language constructs what it means to be human, healthy, and deserving of care as well as what represents relevant care knowledge, who owns and has the right to act on such knowledge, and who has the right to determine what constitutes care effectiveness or indicators of healing.

For example, depression, when understood from a biomedical perspective, may be viewed as a physiologic condition or inability to cope in an external world deemed "normal" by societal standards. When providers use such interpretations and manage symptoms through pharmacologic and cognitive restructuring or behavioral modification therapies, yet fail to deal with the messiness of clients' economic, social, or familial realities, chances are care will prove, at best, temporary. In effect, treating symptoms, patient by patient, and not addressing the oppressive social realities of poverty, abuse, and stigmatization of the mentally ill keeps alive a discourse on mental illness that places experiences of depression in a framework that reduces depression to a treatable illness versus a preventable fallout of a society that refuses to acknowledge humans as physical, emotional, social and spiritual beings. Unfortunately, prevalent discourses on health fail to recognize that social realities, the physical environment and interpersonal relationships all influence what it means to experience the self as healthy. Although the meanings that individuals attribute to their lived experience are what matters most, their voices are often silenced. For example, McIntyre et al.,⁴³ in a feminist study of women's experiences with abortion, explicated the ways in which women absorb a biomedical perspective on their decision to terminate. Women perceive that their providers (and society) hold them accountable for having failed to prevent an unwanted pregnancy. Hence, the woman's healing and resolution of potential grief is overridden by societal discourses of blame, shame, and moral accountability for her behavior.

CONCLUSION

When we look at people through biomedical lenses, we interpret health as a variety of symptoms indicative of potential diseases that need to be treated. Such a perspective fails to fully acknowledge the realities that make up what it means to be human, live well and experience a life with meaning. In this paper, we have discussed optimal healing environments and how they relate to the four domains of nursing inquiry. We claim that caring and healing begin within each of us and become manifest in the way we relate to our patients, their families, and our colleagues. Caring and healing are rooted in a deep valuing of what it means to be a person and a commitment to honor the wholeness of self and others.

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