

## The Nurse Theorists: 21st-Century Updates—Jean Watson

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*This edited transcript of an interview with Jean Watson presents Watson's recent thoughts about the current state of the discipline of nursing and the emergence of new perspectives; the contributions of her theory of human caring; and her other work on the advancement of the discipline of nursing, complementary and alternative therapies, nursing research, and nursing education.*

Jean Watson had planned to write a book about an integrated curriculum for a baccalaureate curriculum in nursing. Instead, she developed a novel structure for basic nursing processes, which was published in the book *Nursing: The Philosophy and Science of Caring* (Watson, 1979). The work presented in that book solved some of Watson's conceptual and empirical problems about nursing and formed the foundation for the science and art of human caring. Many years later, Watson (1997) explained that her 1979 book was published

before there was any formal movement in nursing related to nursing theory per se. It emerged from my quest to bring new meaning and dignity to the world of nursing and patient care—care that seemed too limited in its scope at the time, largely defined by medicine's paradigm and traditional biomedical science models. I felt a dissonance between nursing's paradigm (yet to be defined as such) of caring-healing and health, and medicine's paradigm of diagnosis and treatment, and concentration on disease and pathology. (p. 49)

The theory of human caring evolved as Watson went on to solve other conceptual problems, as well as philosophic problems about nursing. The theory, which was initially published in Watson's (1985) book *Nursing: Human Science and Human Care: A Theory of Nursing*, focuses on the human component of caring and the moment-to-moment encounters between the one who is caring and the one who is being cared for, especially the caring activities performed by nurses as they interact with others. In 1996, Watson commented that the theory has continued to evolve "until this moment in history" (p. 141).

I first interviewed Jean Watson in February 1989 in Denver, Colorado. That interview is part of *The Nurse Theorists: Por-*

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*traits of Excellence* series of videotapes and compact disks (Watson, 1989). This column presents the edited transcript of a telephone interview I conducted with Jean Watson on March 13, 2000. Dr. Watson contributed additional comments to the transcript during the final editing in February 2002.

### On the Discipline of Nursing

JF: What do you think about the current state of the discipline of nursing?

JW: I think the *discipline* of nursing has to be rethought. We need to clarify what we mean by *discipline*. Although the disciplinary focus has become more distinct within the last two decades through the maturing of nursing theory, further clarification is required. In terms of the nursing profession being informed by the discipline, I think we have a long way to go. I think, too, that we are still in the process of clarifying what is the nature of the disciplinary matrix of nursing science. For example, is caring knowledge a part of the matrix of nursing knowledge?

At a deeper level, the term *discipline* also conveys a sense of personal discipline, that is, the ontological and spiritual development of nurses themselves, the cultivation of deeper levels of our own humanity, human suffering, and healing process. This is needed now more than ever for the authentic human relational nature of nursing's caring-healing work. This view of the meaning of discipline offers another whole twist to nursing maturing as a distinct profession for its practice.

### On the Discipline and the Profession

JF: You referred to both the discipline and the profession of nursing and stated that the profession needs to be informed

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by the discipline. Would you please distinguish between what you mean by discipline and by profession?

JW: By discipline, I mean the body of knowledge, the values, the ethics, the theories, and the boundaries of the structure of knowledge, the foundational meta-narrative of the profession, which informs and guides the actual practice of those theories, ethics, values, and knowledge. The profession then is the professional practice of that broader disciplinary knowledge. The disciplinary knowledge is knowledge that comes from the roots of nursing's history, traditions, and heritage across time, as well as extant theories and knowledge. It is not, however, an either/or situation. Rather, it is an ongoing mutual process between the discipline informing the profession and vice versa.

Historically (and still today, due to nursing's educational-practice issues and history), nursing has been driven largely by medical practices and bureaucratic system issues of institutions, rather than by its own disciplinary paradigm. Disciplinary knowledge becomes knowledge that other disciplines draw from; it becomes public knowledge that benefits the whole. So just as the discipline of nursing has historically been guided by the knowledge, and often the values, of other disciplines, if it is to mature, the disciplinary knowledge of nursing shall in turn inform its own practices and intersect and complement other health professions, and the broader system of care. Thus, if the discipline informs the profession, nursing's knowledge matrix—its values, theories, science, and art—inform its actions in the world. Up until the last decade or two, we have taken from other disciplines, but as nursing disciplinary knowledge matures, that knowledge can be shared with other disciplines, which may increasingly draw from nursing and its extant theories and values. This turn shifts the center of nursing practice from always being reactionary to outer forces to inner mature forces, standing in its own paradigm.

### On the Use of Nursing Knowledge

JF: Given the diversity of perspectives used in nursing, many of which are nonnursing perspectives [see Fawcett, 2000b], do you have a sense of to what extent people from other disciplines draw on distinctive nursing knowledge now?

JW: I don't have definitive data but I do see evidence of congruence in such areas as transpersonal psychology, health psychology, behavioral medicine, medical humanities, and the healing arts movements. These trends intersect with some of the evolution and developments that have occurred in nursing theory and research. There also has been an intersection between nursing and medicine with regard to so-called complementary-alternative medicine; mind-body medical science; inner healing models associated with noetic sciences with attention to intentionality, consciousness, energy, spirituality, and meaning; relationship-centered-caring models; and so on. Physicians and institutions who are informed and responsive to the public's de-

sire for this more expanded approach to health and healing are increasingly needing to draw on nurses to contribute to their conferences, system changes, et cetera. These activities are indicators of medicine's and systems' realization of what nursing has to offer to this growing area.

### On Complementary and Alternative Therapies

JF: Do you think that medicine's interest in complementary and alternative therapies is driven by a shift in thinking, or by economics?

JW: Medicine's interest in nonconventional therapies is driven by shifts in the public's consciousness, mindsets, and expectations for a different quality of care, as well as economic pressures. This shift in public consciousness is putting pressure on individual physicians to change or modify their thinking and the nature of their professional relationship. People are abandoning or augmenting conventional practitioners for practitioners of complementary and alternative therapies, which is putting economic pressure on physicians. In addition, I see a genuine, deeper shift among some segments of medicine—not mainstream medicine and not mainstream conventional medical schools—but many of the most prominent medical schools in the country now have formal courses, research, and clinical programs in religion, spirituality, and complementary medicine. These happenings are a dramatic shift in medicine when compared to even 5 years ago. My hope is, whether for economic reasons or public pressure reasons, a shift in consciousness does occur in medicine. Once made explicit, we see there is congruence between the nature and maturing of nursing disciplinary knowledge and theories, and these changes in society and medicine itself. Thus, there is a growing need, as well as an opportunity, for different kinds of mature relationships and shared practices between nurses and physicians, nurses and other health practitioners, and the public itself.

### On the Theory of Human Caring

JF: Where does the theory of human caring come into all of this?

JW: I see the value of human caring theory as a foundational ethic and philosophy for any health professional. Though my work comes from nursing, the current momentum for a focus on caring in several health disciplines is congruent with the caring stance that nursing has had across time. The core of the human caring theory is about human caring relationships and the deeply human experiences of life itself, not just health-illness phenomena, as traditionally defined within medicine [Watson, 2002a, 2002b]. The theory is about a different way of being human, a different way of being present, attentive, conscious, and intentional as the nurse works with another person. All of this perspective has relevance for medicine as well as for nursing or other

health professions. The mature practice of human caring theory is most fully actualized in a nursing model because nursing allows for the continuous caring component that medicine does not have; nurses and nursing working from a human caring philosophy bring a different consciousness and energy of wholeness to any setting, offering a counterpoint to the medicalizing-clinicalizing of human experiences in the conventional institutional industrial models of practice.

JF: Your mention of a nursing model leads me to ask if you regard the work that you published in your book, *Postmodern Nursing and Beyond* [Watson, 1999], as a conceptual model or further elaboration of the conceptual frame of reference you used to develop the theory of human caring?

JW: I see the book entering into caring at the deep ontological level. Though it embraces and is informed by my earlier work, I see it as being beyond theory. I don't know what to call it—a framework, a model, a paradigm, or something else. I was trying to consolidate the components of what a mature structure would look like within the context of a caring and healing framework, in contrast to the dominant medicalized, clinicalized version of our discipline and our profession.

JF: Do you see your work, then, as cross-disciplinary?

JW: I see it as *transdisciplinary*, in that the future calls for all of healthcare to enter into an expanded model of wholeness and healing, beyond conventional medicine. Thus, as I see it, eventually all health practitioners will need to be in an expanded model of caring and healing to serve the changing needs and expectations of the public. The shared caring-healing work from this expanded consciousness transcends any one discipline or profession. Inasmuch as it is beyond cross-disciplinary, it is transdisciplinary.

### On Research and the Theory of Human Caring

JF: What do you think that the theory of human caring and the work you published in *Postmodern Nursing and Beyond* can do to continue the advancement of the discipline of nursing? For example, how would the theory be used to guide nursing research?

JW: This goes back to some of the major debates we still have in nursing, as part of our maturing. One question is, Why do we need to continually deconstruct medicine and science? Why do we need an alternative to modern Western science and modern medicine's influence on nursing science? How do we reconcile the paradox of this incredible dissonance, and yet have the intersection that is beginning to occur? On the one hand, we are continually rejecting the dominant discourse, but at the same time, we are embracing the dominant discourse—nursing is caught in the flux between these two directions. I am at a point where I want to say that we have to acknowledge that nursing is

multiparadigmatic [see Fawcett, 1993; Newman, 1992; Parse, 1987]. However, I think that the higher, deeper paradigm for nursing and the emerging model for the future is what Newman called the unitary-transformative paradigm. If nursing acknowledges this unitary perspective, and takes it seriously, nursing research and theories will continue to explore this expanded view. Disciplinary phenomena that are located within the unitary models [for example, the works of Rogers, Newman, and Parse as cited in Fawcett, 2000a] hold meaning for all the other perspectives within other paradigms. However, caring can and still must be honored as a core value, knowledge, and moral-ethical foundation for disciplinary knowledge development and practices related to healing and wholeness.

We cannot stop the direction toward the emerging paradigm because it represents the very nature of the evolution of humanity. All disciplines are evolving to see this oneness that is emerging in the universe. We are beginning to realize that we have to pay attention to what is happening in the universe; we are not separate from the environment, nature, and other humans. There is a transcendent, spirit domain, including consciousness, intentionality, nonlocal happenings, energy, and other related phenomena. Scientists and theorists are using these new concepts to describe the oneness and connectedness of the universe. In summary, I think that nursing is paradoxically multiparadigmatic, with different branches of nursing operating within the different paradigms. I also think that we are moving toward a consolidation of the paradigms, toward the unitary-transformative paradigm [Newman, 1992]. In the meantime, though, we have to honor all paradigms. So, by calling upon a postmodern perspective of caring and healing, we enter into a larger unitary framework to accommodate some of the most conventional and contemporary scientific and research happenings in the fields of both medicine and nursing, as well as happenings among the public.

JF: Do you see your work as moving toward the unitary-transformative paradigm?

JW: Absolutely! That is what I was trying to get at in *Postmodern Nursing and Beyond*. When you get into transpersonal caring and healing, you are in the unitary-transformative perspective. And that brings in consciousness, intentionality, energy, evolution, transcendence, process, relativity, and things that transcend our conventional medical and modern conventional science models. Although we don't quite have the methodologies, the language, or the tools to be fully into this new paradigm, we are moving in that direction. Pointers along the way include, for example, research on consciousness and some of the energy- and energetic model-based research and modalities. When we move to this other paradigm, I think we more clearly can see the intersection between arts and humanities and science; we can see the artistry of practice and the artful manifestation of human experiences. This is

evident in the work of Carol Picard in Boston [Picard, 2000; Picard, Sickul, & Natale, 1998] on dance, art, and movement, and some of the postmodern work by Fran Biley in Wales [Biley, 1998, 2000, 2001]. Their work reflects a dramatic shift from conventional perspectives to put us into another place, another space, to shake up our reality, to see the world in a different way. That is part of what we are faced with at this turn in our history.

JF: In listening to what you are saying, I wonder if when we get into the unitary-transformative paradigm, our distinction between qualitative and quantitative methods becomes artificial?

JW: Yes, when we reach this level of what has sometimes been referred to as an upward model of science, it is beyond the dualistic nature of qualitative-quantitative debates. In addition, I think that as we evolve within the next decade, we will have an entirely new approach to quantifying some soft, qualitative phenomena that we have not been able to quantify in the past, giving even more credence to nonphysical as well as physical phenomenon. I think, for example, that there is great potential for quantifying energy or vibration or consciousness. I think that we will begin to see how the whole is in the parts, regardless of what approach is used.

I think, too, that different paradigms or levels of consciousness point toward different practices or different ways of knowing or different levels of knowledge. For example, Ken Wilber [1998, 2000], whose work focuses on transpersonal psychology and perennial wisdom, uses terms such as *symbolic knowledge* and *intimate knowledge*. Symbolic knowledge, which is similar to conventional empirical nursing or medical science knowledge, manifests itself in some kind of a code or analysis or numbers. Intimate knowledge, in contrast, does not necessarily submit itself to codification or analysis. The phenomenon is lost, at least to some extent, when an attempt is made to codify or analyze some kind of deep knowledge. Wilber's work points out that we need all spheres of knowledge in order to have a complete science, which includes spiritual knowledge.

JF: Is intimate knowledge similar to what Carper [1978] called aesthetic knowledge?

JW: It could be, or even ethical knowledge. Intimate knowledge is that *behind the scenes* subjectivity that is going on. As soon as we try to get at it, we tend to take it and replace it with an empirical perspective. But I don't know if we are losing or gaining something by trying to quantify the subjective. Wilber [2000] says the problem is that all the higher [unitary] modes of knowing have been brutally collapsed into monological and empirical science. The unitary perspective moves us past that as the only way, opening up new explorations of wholeness science [Harman, 1991].

JF: To use a statistical analogy, I wonder if we have to accept that there is some unknown variance that we will never be

able to identify. I wonder if we have to give up the mechanistic idea that if we can identify all of the relevant factors, we can account for 100% of the variance, and move toward an organismic idea that some variance can never be accounted for. I wonder, then, if we have to accept that we will never be able to express in any discursive or even in any artistic way everything that we know or think we should know.

JW: I think that is a good way to clarify that tension. Now, in the more mechanistic, conventional Western worldview, we think we either *do* know or *can know* everything. If we move toward a more evolved level of our understanding of life and knowledge, we honor the unknown and mystery, and we embrace that which we cannot know, along with that which we can know.

### On Nursing Education

JF: Given the knowledge needed to use the theory of human caring and your other work, what is the appropriate entry level for professional nursing?

JW: Although the bachelor's degree is considered still the [unresolved and impossible to implement] minimal entry into the professional practice of nursing, the mature practice of nursing, as a career health professional, ideally should be at the professional doctoral level, or at least the graduate level. Why should nursing differ from every other practicing discipline [for example, dentistry, medicine, pharmacy, psychology, law]. It is so ironic and amazing to me that, even as we enter the 21st century, we who are the oldest of the caring/health/healing professions, and we, who deal with the most complex human experiences and health-related phenomena, have never made the connection for the need for additional education to deal with these complex, technological, and evolving human phenomena. Instead, we talk about less education or the same education, resist upping the ante for required higher education for entry.

We are, I think, in such an incredible trap of what John Paul Sartre termed *ontological insecurity*; that is, we still do not know who and what we are as a people, as a profession, as a discipline. And yet, on some deep level, we do know that we are about all these deep, complex existential, metaphysical, spiritual dimensions of humanity itself, and that we require incredible human and scientific and technological skills and knowledge for our professional practice [Watson, 2002b]. But we don't act on this; we don't bring it to a level of informed social-professional action in a unified way. I cannot explain that. If I had my way, I think every major academic health science center nursing program should convert its baccalaureate nursing programs into nonpractice degrees in caring science and health, or at least make that degree a major in the field. Such a framework for a general undergraduate degree could be preparatory as premed or prenursing. But this hard transition into

professionalism would entail letting go of the baccalaureate degree as entry level into nursing, moving quickly to graduate-doctoral level, parallel with all other health professionals. Almost all other practicing professions have made this turn—witness pharmacy's quick shift in the last decade, from baccalaureate degree to Pharm.D. [doctorate of pharmacy]; similar shifts have occurred in physiotherapy, psychology, law, and so on.

JF: Do you make a distinction between levels or types of nursing, such as technical and professional nursing?

JW: Yes and no. If, for example, we reexamined the Montag [1951, 1959] model of the associate degree [AD], for entry into technical nursing practice, and put that with the doctor of nursing [ND] degree, for postbaccalaureate entry into professional practice, we might have a really nice complement of technical nurses and mature professional nurses. Nurses prepared with an ND would become the attending nurses, attending to the whole of patient-family care, working in and out of institutions, attending to the caring-healing needs. Nurses prepared with an AD would assist with carrying out a whole range of care practices. However, we mixed up and diluted any differentiation that could have occurred by mixing up the AD and the baccalaureate degree, rather than going to a more mature professional model of education, which would have been at the ND level. We then moved to the master's degree—prepared clinical specialist, and later to the nurse practitioner [NP], for clinical specialization. But that type of clinical specialization is similar to and defined by medical specializations and does not get us to the mature professional practice of the discipline. Incidentally, if nurse practitioners were prepared at the ND level, the NP could also become the mature professional practitioner. NPs would, however, have to shift their paradigm and become nursing theory-guided, and use advanced caring-healing modalities to complement their medicalized preparations.

JF: I wonder if we need the AD at all; perhaps we only need the ND, for professional practice, and then the PhD, for research [see Fawcett, 1999].

JW: I think you are correct. I use the AD-ND as an example of how we have gone awry by staying at the first level, rather than at the mature academic-professional level. Let us use another profession as an exemplar. Psychology, for example, has the doctor of psychology for practice, and the PhD for research, as well as a baccalaureate-level major in the field. The baccalaureate degree does not, however, prepare the student for the practice of psychology. Thus, the idea of graduate-level entry-level preparation for career professional nursing practice mirrors what is done in psychology.

A strong case could be made for the ND and PhD model of nursing education, especially for major academic health science centers, on the basis of the dwindling numbers of nurses and fewer places where nurses can be hired. In such a situation, a greater need exists for those who are prepared at the highest level, rather than the lowest level. Rather

than dribbling away our resources through the continuing layers of nursing education and practice, we should put all of our mature knowledge, energy, passion, inspiration, excitement, and joy into preparing the finest nurses, at the doctoral level [ND and PhD].

JF: There certainly is a market for the ND. Think of all the students in baccalaureate programs who already have a baccalaureate degree in another discipline. I just do not understand why we cannot come to agreement about this.

JW: I agree that there is a strong market for the ND-prepared nurse. Those entering into ND programs want to be nurses, but not in the industrial model in which nurses now work and practice. Instead, they want truly health professional practice careers.

As I mentioned earlier, there also is potential for the development of a baccalaureate degree with human sciences or caring sciences as a major. That type of major could prepare diverse students for the ND program, as well as for medicine and other postbaccalaureate health-related professional programs.

JF: As we come to the end of this interview, is there anything else you would like to tell us?

JW: I want to say that I am in a different place now and am asking new questions about my work and where it may go. It is as if the work is taking me, rather than me trying to take it someplace. I am in a place of personal reflection and inner explorations to find out where this thinking really takes us as we enter a deeper ontological level of personal development of our own humanity and our own healing. I think my own life crises of traumatic injury, losses, and the sudden death of my husband have obviously informed my journey toward the future. Some of my own personal, spiritual growth and healing seems to mirror the healing needs of the profession. The processes and learnings all intersect with and through the disciplinary task of knowledge development and advancement of caring science. This task might, however, result in pursuing a different kind of knowledge, from the inside out. I am much more into what might be called the ontological development and healing of the discipline, which involves preparing the practitioner within a more contemplative, reflective practice model, a model that offers a true presence, an approach that leads back to wisdom traditions or perennial philosophy about how to live life and bring this to bear in our normal day-to-day work. Finally, I seek to bring my work into a more meaningful level for how we live our lives and how we bring this caring-healing to our day-to-day existence [Watson, 2000, 2001, 2002a, 2002b].

I continue to hold interest in exploring human caring theory at the theoretical, intellectual, paradigm level. As part of this effort I am working [with my colleague here at the University of Colorado, Dr. Marlaine Smith] on creating some trans-theoretical discourses for the discipline; this direction entails identifying congruence and intersections between transpersonal caring science and Rogers'

science of unitary human beings [see Watson & Smith, 2002]. I think a trans-theoretical turn allows for some necessary convergence of extant theories to better solidify and inform nursing's metaparadigm. Such a new discourse at this point in our history connects us with our past as well as offering a hopeful opening for the future. Perhaps it is here in this intersection that the personal and professional become truly unified as one.

JF: Thank you very much for this stimulating and thought-provoking interview.

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**The Correct Sequence of Epithets** — According to Bartholomew (1948, p. 80) the following order should be used in placing epithets after one's name. Abbreviations for licensure in an area are the first to follow immediately after the name. A semicolon follows to separate these abbreviations from those of the educational degrees. Educational degrees appear in order of their issue. Abbreviations for professional societies are always the last of the epithets and are separated from the educational degrees with a semicolon. Example: Helen Doe, RN; BSN, MSN, PhD; FAAN.

Bartholomew, C. A. (1948). *Epithetology*. Red Bank, NJ: Commercial Press.