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## Philosophy, Science, and Theory of Human Caring as a Conceptual Framework for Guiding Community Health Nursing Practice

[Communities and Systems]

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### Abstract<sup>△</sup>

Criticisms of existing nursing theories in relation to community health nursing practice are that they focus on individuals and have been developed primarily for practice within the context of infirmity and disease, making them inadequate to guide community health nursing practice. Despite being developed for individuals, Watson's theory is proposed as a nursing framework that is philosophically congruent with contemporary global approaches to community health and health promotion. An overview of her theory identifies the centrality of caring, holism, and ecology in the theory as it has evolved over the past 20 years. Concepts developed for individual nurse interactions are extrapolated to the community in a discussion of the suitability of the theory to guide community health nursing practice. A community assessment tool based on Watson's theory is provided.

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Commonly, public/community health nursing scholars lament the paucity of nursing conceptual frameworks that are useful in guiding community health nursing practice. Their concern is frequently echoed by public health nursing practitioners who, not uncommonly, dismiss nursing theories as irrelevant to their work. Yet, at the same time, either knowingly or unknowingly, public health nurses inform their practice with theories from other disciplines as diverse as medicine, sociology, psychology, and even business. <sup>1</sup> Because many of those theories emanate from paradigms incongruent with a nursing philosophy, it seems logical to assume that they contribute to the increasing loss of identity and invisibility that has been reported among public health nurses. <sup>2-5</sup> Although the reasons that nursing theories frequently are not perceived as useful to community health nurses and, at the same time, those from other disciplines are enthusiastically embraced are many and complex, the limitations of existing

nursing theories for community health nursing practice are an important factor and bear further consideration.

Two major criticisms of existing nursing theories are that they focus on individuals, and they have been developed primarily for practice within the context of infirmity and disease. They are, thus, inadequate for a population-focused health promotion approach in which the focus of nursing attention moves beyond the individual to the community, population, or group. Although considerable work has been done to extrapolate Neuman's theory to the community, [6](#) and Helvie [7](#) recently developed a systems-based theory for community health nursing practice, a conceptual framework that recognizes the primacy of relationship in community health nursing work and informs an empowering approach to the health promotion of communities is lacking.

This article proposes that Watson's philosophy/science/theory of human caring, although also developed with individuals in mind, has the potential to be such a framework because of its philosophic congruence with community health nursing. That congruence was evident in the first publication of Watson's theory in 1979 when, remarkably for the time, she offered a critique of the medical domination of health care and devoted a whole chapter to nonmedical determinants of health. [8](#) Watson's position at the time was in keeping with those of others that began to surface internationally at approximately the same time and formed the basis for contemporary global approaches to health and the health promotion of communities. [1](#) Watson's critique, however, is grounded as much in Nightingale's legacy and vision of nursing as it is influenced by health care critics such as Illich. As such, it offers the hope of returning community health nursing practice to a nursing center and restoring the strong nursing identity and vision of early community health nursing leaders such as Nightingale and Wald.

My explication of the relevance of Watson's work to community health nursing practice is grounded in my own experiences with using Watson's theory as a practicing public health nurse, examining public health nursing practice through research, and facilitating the learning of students who use Watson's work to guide their community health nursing experiences. Before examining Watson's theory as a conceptual framework for community health nursing practice, however, a brief overview of the theory itself is instructive.

## OVERVIEW OF WATSON'S THEORY OF HUMAN CARING [^](#)

Watson's [8,9](#) theory of human caring has evolved over the last 20 years. First published in 1979 as a basic nursing text for baccalaureate students, Watson later expanded her ideas to "elucidate the process of human caring [and to] preserve the concept of the person in our science." [8](#)<sup>(p ix)</sup> In her latest book, [10](#) Watson continues her visionary quest to move nursing's caring-healing practices from the margins to the center of societal health and healing practices. This work strongly reflects the influences of consciousness theory, noetic sciences, quantum physics, transpersonal psychology, Jungian psychology, and feminist theories, among others, that have gained prominence in her work over the past decade. [11-15](#)

At least three factors make Watson's theory unique among nursing theories. First, it stresses the importance of the lived experience not only of the client, but also of the nurse. Both come together in a caring moment that becomes part of the life history of each person. Second, the theory acknowledges the unique dimensions of mindbody-spirit without compromising the wholeness of the person. Although some critics insist that acknowledging dimensions of a whole is tantamount to reducing it to parts, Watson's approach may be viewed as similar to appreciating the unique contribution of each color of a rainbow to the beauty of the whole or each musical note to the grandeur of a symphony. Her assertion of acknowledging parts without compromising the whole is based on the holographic paradigm that suggests the whole is in the parts. [12](#) Third, Watson's theory of nursing values and explicitly acknowledges

multiple ways of knowing, including empirical, aesthetic, ethical, and personal knowing.

Watson's humanistic, existential, and metaphysical conceptualization of human beings underpins her view of both the transpersonal caring relationship that is central to her theory and her conceptualization of health-illness. She views human beings as beings-in-the-world with dimensions of mindbodysoul that, in health, exist in harmony. 9 Conversely, illness results from conscious or subconscious disharmony and may lead to disease. Inherent in Watson's conceptualization of human beings is the metaphysical potential for self-healing and transcendence to higher levels of consciousness. From her perspective, the patient/client is the agent of change and is primarily responsible for allowing healing to occur with or without external coparticipant agents of change (of which the nurse may be one).

Watson describes her concept of soul as "spirit, or higher sense of self" 9<sup>(p45)</sup> and notes that it most closely resembles the psychologic concept of self-actualization. Unlike Maslow's theory, however, in which the need for self-actualization is only activated after all other needs are met, striving for actualization of one's spiritual self is for Watson the most basic human need to which all other needs are subservient. Spirit is "greater than the physical, mental, and emotional existence of a person at any given point in time" and is tied to a "higher degree of consciousness, an inner strength, and a power that can expand human capacities ... and cultivate a fuller access to the intuitive and even sometimes allow uncanny, mystical, or miraculous experiences." 9<sup>(pp45-56)</sup>

The human potential for self-healing and transcendence to higher levels of consciousness informs Watson's vision for nursing, which is "to help persons gain a higher degree of harmony" 9<sup>(p49)</sup> through a transpersonal caring relationship. She characterizes this relationship as one of mutuality in which the whole nurse engages with the whole client, each bringing her or his own experience and meaning to an actual caring occasion. The transpersonal caring relationship at once recognizes the value and importance of both the client's and the nurse's subjectivity. As a result, a number of the 10 carative factors identified in Watson's theory focus on preparation of the nurse prior to interaction with the patient/client.

The carative factors in Watson's theory are not linear "steps" to human caring but represent the *core* of nursing (in contrast to the *trim*). 15 Watson described the carative factors further as "those aspects of nursing that actually potentiate therapeutic healing processes and relationships; they affect the one caring and the one-being-cared-for." 15<sup>(p50)</sup> Although the carative factors are the attributes of caring that characterize the transpersonal caring relationship, 9 some more clearly focus primarily 9 on the nurse, the relationship, or the processes of caring. Important to note is that the 10 carative factors are based on a knowledge base, clinical competence, and healing intention. 8

#### Preparation of the nurse<sup>^</sup>

Watson values and attaches importance to both the nurse and the client in the transpersonal caring relationship. Caring-healing within her caring framework begins with the preparation of the nurse as indicated in the first three carative factors: a humanistic-altruistic system of values, faith-hope, and sensitivity of self and others.

Human caring, according to Watson, is based on human values such as "kindness, concern, and love of self and others." 8<sup>(p10)</sup> She differentiates altruism from self-sacrifice and describes it as a fullness of being that allows the nurse to be authentically present with clients. 16 Watson states that a humanistic-altruistic value system begins early in life but continues to be influenced through interactions with parents, family, friends, and others, including nurse educators. Furthermore, she asserts that such values can be developed through consciousness raising and introspection. Watson believes that the

carative factor she labels as "faith-hope" interacts with the first to enhance caring-healing. <sup>8</sup> From the perspective of the nurse's belief and value systems, this involves gaining knowledge of mindbodyspirit integration and valuing the therapeutic effects of faith-hope.

Influenced by the work of Carl Rogers, Watson asserts that a balanced sensitivity to one's self is foundational to empathy. <sup>8</sup> Sensitivity to self includes reflection on one's own thoughts, feelings, and experiences in the clinical setting and development of one's own potential. It allows the nurse to be fully present to the client, not hidden behind professional detachment. Developing sensitivity to self involves values clarification regarding personal and cultural beliefs and behaviors such as racism, classism, sexism, ageism, and homophobia, among others, that might pose barriers to transpersonal caring. Finally, sensitivity to self includes an awareness of the interconnectedness of all things and beings and of the social, historical, and political context that shapes nursing practice and nurses' vision of what is possible. <sup>10</sup>

### The transpersonal caring relationship<sup>^</sup>

Four of Watson's carative factors focus on the transpersonal caring relationship. <sup>9</sup> Two, which have been discussed from the perspective of the nurse, are also important to the client-patient relationship. Faith-hope extends beyond the nurse's understanding of the integration of mindbodyspirit and also involves fostering faith and hope in clients, based on the client's, and not the nurse's, belief systems. <sup>16</sup> Whereas sensitivity to self is clearly important in the preparation of the nurse to care, sensitivity to others refers to a way of being in relation to clients and is critical to the caring relationship. It allows for the nurse to be changed through the caring relationship and is fundamental to facilitating authentic communication.

Two carative factors relate to interpersonal communication as the basis for the therapeutic relationship. Establishing a helping-trusting, human care relationship is pivotal to Watson's theory and is informed by the first three carative factors. <sup>16</sup> Watson states that the development of a helping-trusting relationship involves intentionality and a consciousness directed at preserving the integrity of the person. As noted, she credits much of her thinking on therapeutic relationships and communication to the work of Carl Rogers and identifies congruency, empathy, and warmth as foundational to a caring relationship that facilitates the client's expression of emotions. Congruency refers to authenticity and genuineness, empathy reflects understanding of both the content and emotion the client is communicating, and warmth is the degree to which the nurse conveys caring to the client. <sup>17</sup> Gazda, Childers, and Walters <sup>17</sup> note that warmth reflects respect and acceptance and is communicated extensively by nonverbal behaviors.

### Caring processes<sup>^</sup>

The remaining five carative factors address those aspects of caring that primarily involve assessing client health priorities and needs, planning to address those priorities, contributing to meeting client health goals, and evaluating the effectiveness of the caring processes in promoting client health and healing. These carative factors, as do the others, occur within a context of mutuality in which both patient and nurse together decide not only what caring processes will be used but also the role each will assume. <sup>18</sup>

Watson identifies the creative, reflective use of problem solving as a carative factor. <sup>16</sup> However, she stresses that this is not a linear, cause-and-effect approach to problem solving, but it is a creative process that allows interaction of multiple factors and requires not only scientific knowledge but also personal or intuitive, aesthetic, and ethical knowledge. In addition, the whole process is reflective, suggesting that evaluation is constantly occurring and influencing the assessment, caring process, and

caring relationship. Watson prefers the term "caring process" to "intervention," because she notes the latter has a mechanistic connotation that is inconsistent with her ideas. <sup>9</sup>

Each carative factor interrelates with the creative, reflective use of the problem-solving (nursing) process and guides the process and content of assessment and evaluation, the nature of planning, and the direction of nursing actions. The last three carative factors are particularly helpful in guiding content and organizing assessment of clients and are discussed in more detail below. Watson rejects the connotations of power conveyed by diagnostic language as well as the diagnostic process in which nurses assess and judge other human beings. <sup>10</sup> Instead, the nurse and client mutually determine conclusions about client strengths, goals, and needs. This requires that the nurse create an opportunity for active participation of the client in the caring process to the extent that the client is able/willing. In this process, in contrast to a consumeristic approach, nurses actively facilitate clients' authentic self-determination, including making their knowledge, expertise, and professional judgment available to clients for use in making health decisions. <sup>19</sup> Nurses help clients express realistic health goals, facilitating clients' empowerment to assume as much of the responsibility for health work as they are willing or able.

One of the nursing activities that the client and nurse may decide will be helpful for the client in achieving health goals is the carative factor related to transpersonal teaching-learning. Although an understanding that the nurse and client both teach and learn from each other is implicit in the label for this carative factor, teaching-learning is concerned with enhancing a client's response to health concerns. <sup>8</sup> It is not the didactic giving of information, but it includes an exploration of the meaning of the situation for the client. <sup>16</sup> Teaching-learning is based on the tenets of teaching-learning theory and involves the acquisition of knowledge and skills that are important in the development of self-efficacy. It often contributes to clients' empowerment by enabling them to gain or regain some control over their health.

Action contributing to a supportive, protective, or corrective mental, physical, sociocultural, and spiritual environment is the carative factor that has perhaps undergone the most dramatic change in emphasis over the last 20 years. Although environment was broadly conceptualized in Watson's earliest work to include mental, physical, social, and spiritual environments, her early emphasis was much narrower than her more recent work. Discussion of internal and external environments focused on stress, comfort, privacy, safety, and clean aesthetic surroundings. <sup>8</sup> In broadening the focus of the immediate environment, Watson revisited Nightingale's model and reframed her discussion from the perspective of Nightingale's wisdom regarding the importance of the environment in facilitating healing. Watson has brought each of the tenets of Nightingale's 19th-century model into the 21st century by illustrating them with contemporary and futuristic nursing actions to create healing environments. <sup>10</sup>

In her most recent works, Watson also developed further the notion of spiritual environment. Drawing on sources as diverse as Eastern philosophy, 12th-century mystic Hildegard von Bingen, and 20th-century artist Alex Grey, Watson situates body within spirit within a field of consciousness that is connected and integral to all consciousness. <sup>10</sup> Within this conceptualization, the nurse moves beyond creating healing environments to becoming a healing environment through the intentional use of consciousness. <sup>20</sup> Watson believes consciousness can be shared, creating new energy fields with healing potential in the process. <sup>10</sup> The implications she draws from the interconnectedness of all things do not stop with human interactions but extend to issues that are critical to the health, healing, and survival of the earth and all life on it, revealing an ecologic aspect to her theory.

The sociocultural environment of the patient/client is the least developed aspect of this carative factor. Although issues traditionally associated with sociocultural concerns, for example, economic status, ethnicity, cultural values, norms, and healing practices, are not explicitly discussed, Watson's emphasis on interconnectedness, mutuality, and the nurse's goal to facilitate client self-determination implies their

consideration. Aspects of the social, cultural, and political environments that are discussed at length relate to a postmodern analysis of the place and value of caring, healing, and women's voice in a patriarchal society. [10,13](#) Clearly this discussion, although focused largely on the implications for nurses and nursing, also has significance for clients.

To frame her discussion of human needs assistance, Watson initially drew on the work of Maslow. She described this carative factor as being a systematic way of attending to an individual's comfort and well-being, including symptom management. [16](#) Depending on the role that the nurse and client negotiate, the nurse may advocate for the client with other health professionals and health care agencies and may assist the client in advocating for himself or herself. In her earlier work, Watson categorized human needs in terms of biophysical needs such as food and fluids, elimination, and ventilation; psychophysical needs such as activity, rest, and sexuality; psychosocial needs such as achievement and affiliation; and intrapersonal-interpersonal needs such as self-actualization. [8](#) This framework for human needs, along with a systematic review of internal and external environments and consideration of existential-phenomenological-spiritual forces, provides a useful schema for organizing an assessment.

The allowance for existential-phenomenological-spiritual forces is perhaps the most difficult of all carative factors to understand. Watson notes that this factor is closely related to self-actualization, but whereas self-actualization is concerned primarily with the pursuit of life goals, this factor focuses on a person's search for meaning in experience and purpose in life. Carative processes related to this carative factor center around being fully present with clients and helping them explore the meaning of an experience, the means by which they transcend life's predicaments, the meaning of life and death, and belief systems through which they find a sense of purpose.

A brief overview cannot possibly reflect the intricacies of Watson's philosophy, theory, and science of caring. It can, however, serve as a basis for extrapolating key concepts into a framework that may be used to guide community health nursing practice.

## **WATSON'S THEORY OF HUMAN CARING AS A CONCEPTUAL FRAMEWORK FOR COMMUNITY HEALTH NURSING** [^](#)

Resistance to using Watson's work to guide community health nursing practice is usually related to the centrality of the transpersonal relationship to her theory and the question of how it can translate into nursing practice in which communities are the focus of attention. Gadow, who significantly influenced Watson's conceptualization of the nurse-patient caring relationship, believes the philosophy underpinning a person-to-person relationship extends to a person-to-community relationship (Personal communication, July 1993). Her work with Schroeder [21](#) explicated that relationship in a reconceptualized notion of community as partner, in which the goal of the nurse is to enhance community self-determination. That idea of partnership is congruent with the concept of mutuality that is central to a transpersonal caring relationship. It is equally congruent with global approaches to health articulated in the tenets of primary health care, [22-24](#) the principles of health promotion, [25,26](#) and models of community development and empowerment. [27-29](#)

The centrality of relationship to effective public health nursing practice also has been documented in recent community health nursing research. [2,30](#) These studies not only show the integral connection of the nurse with the community, but they provide evidence that effective public health nursing practice cannot dichotomize the community from the individuals within it. Although such a statement may seem self-evident to community health nurses, external pressures on community health nursing practice have in some instances shifted nurses' practice away from communities to individuals, [5](#) and in others from individuals and families to communities and populations. [1](#)

A holistic approach that recognizes the interconnectedness of a community's health with that of its constituent members would not be congruent with a view of holism that denied attention to parts. Watson's theory, which recognizes the whole in the parts, supports a focus on the wholeness of a community, aggregate, or population, while still attending to the individuals and families within it. In extrapolating ideas such as mindbodyspirit to community, it is not difficult to see how "body" of a community may refer to physical attributes of the environment, the services it offers, and the demographics of a community. "Mind" might well refer to a community's cultural norms, laws, and political structures. Community spirit may be exemplified in the community's value systems. Yet each of these dimensions of a community are not parts that can be summed to represent the whole community any more than the sum of mind, body, and spirit represent a whole person. Rather, consistent with the holographic model, individual parts provide information about the whole that in themselves produce a less-detailed and coherent projection of the whole than they do together. [31](#)

Health, according to Watson, is unity and harmony within bodymindspirit and with the world. Likewise, harmony within the various aspects of the community described above, as well as its relationship to the outside world (other jurisdictions and the environment), reflects health, while disharmony is indicative of illness. Disease is qualitatively different from illness but is more likely to occur in a state of disharmony. A community example might be that an outbreak of disease is less likely to occur when a community is in harmony, that is, when services such as immunization are in place to prevent anticipated diseases. "Disease" in the community extends beyond biologic epidemics. Community problems also may be thought of as a form of community disease. Homelessness and crime are more likely to occur in communities that do not have an established social safety net or what might be considered harmony of the various dimensions of a community. Watson's conceptualizing of health is consistent with the World Health Organization (WHO) definition of health as "a positive concept emphasizing social and personal resources, as well as physical capacities." [25](#)

The qualitative differentiation of health and disease in Watson's theory marks a significant departure from the dominant biomedical model. An example of the latter, the Leavell and Clark model, continues to be used widely in public health and situates health promotion as a prepathogenic strategy. [32](#) One study revealed that this model had been used widely to support the elimination of public health nursing services that were not considered to be primary prevention because disease (such as mental illness or heart disease) was already present, and therefore health promotion was deemed not possible. [1](#) Nurses in that study expressed the ethical dilemmas they faced because of administrative directives that, in the opinions of several, amounted to patient abandonment. Most nurses, however, did not recognize that the basis for the directives was a medical model, and the reason for their discomfort was, at least in part, related to the incongruence of that model with their own nursing paradigm. Consciously informing practice with a nursing theory in which health promotion can occur whether or not disease is present may strengthen nurses' voice to advocate for services that meet expressed community health needs and enable them to resist external pressures to eliminate those services.

Not surprising, given that Watson's conceptualization of health is consistent with WHO's definition, health-promoting nursing practice guided by her framework also is consistent with the definition of health promotion articulated in the Ottawa Charter [25](#) and affirmed most recently in the Jakarta Declaration, [26](#) which is "the process of enabling people to increase control over, and to improve, their health." The centrality of empowerment to health promotion is as clear in the WHO definition as it is in Watson's strikingly similar assertion that caring involves "helping a person gain more self-knowledge, self-control, and readiness for self-healing." [9](#)<sup>(p35)</sup> Health-promoting actions identified in the Ottawa Charter, such as strengthening community actions, are consistent with this aspect of caring. Another of

the Charter's five health promotion actions, the development of personal skills, is demonstrated in Watson's carative factor related to transpersonal teaching-learning. The other three-creating supportive environments, building healthy public policy, and reorienting health services toward a health promotion approach-are encompassed by the carative factor that attends to the support, protection, or correction of sociopolitical environments.

Health promotion practices that flow logically from Watson's theory and her early attention to nonmedical determinants of health are also supported by nursing literature. One aspect of health according to Watson <sup>9</sup> is harmony with the world or environment. It is easy to see how her theory guides the community health nurse to examine and address social, economic, political, and other environmental determinants of health. In fact, the carative factor relating to nursing activities that support, protect, or correct mental, physical, sociocultural, and spiritual environments in community health nursing encompasses the social or political activism that has been advocated in nursing literature for some time. [33-36](#) Broadening a nursing focus from individual determinants of health to include sociopolitical determinants also addresses the challenges issued in nursing literature over the last decade to reconceptualize both the environment [37,38](#) and health promotion to be consistent with nursing's legacy and paradigm. [39-43](#)

Expanding community health nursing practice to include broad determinants of health is also congruent with contemporary global approaches to health. The Ottawa Charter identified nine prerequisites to health: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity. <sup>25</sup> More recently, the Jakarta Declaration added social security, social relations, the empowerment of women, and respect for human rights to the initial nine, acknowledging poverty as the single greatest threat to health. <sup>26</sup> Identifying such sociopolitical issues as prerequisites to health recognizes that although they may greatly affect the health of individuals and communities, the supportive, corrective, or protective measures to address them must be directed beyond the individual to societal social and political structures.

Many other of Watson's carative factors are helpful for community health nurses working within her framework. Several factors focus on the nurse's part of the caring relationship in clarifying values and being authentically present to clients. Understanding one's self and being sensitive to others is as important in caring for communities as individuals. Community caring occurs within a helping-trusting relationship and is directed toward protecting and enhancing the dignity of others.

The reflective and creative use of the problem-solving process is consistent with contemporary ideas of health promotion because, according to the theory, it occurs within the context of a relationship of mutuality where the community's health goals are paramount, and there is at least an opportunity for the community's active and equal participation in the process. Watson's theory informs not only the process of assessment but also its scope and focus. The community assessment tool proposed in the [Appendix](#) to this article reflects Watson's emphasis on strengthening the client's resources or capacities, as well as mutuality, in planning, taking, and evaluating health actions. As with individual clients, the nurse and client together decide on the role each will play in working toward health goals. (It should be noted that this assessment tool was recently developed to assist students to assess communities holistically and to make the abstract notion of broad determinants of health more concrete. At this point, it is an untested tool.)

Transpersonal teaching-learning is an important part of the health education in which community health nurses frequently engage. As with individuals, this refers not to the didactic giving of information but to an exploration of the meaning of the situation for the community and the provision of information and development of skills that client and nurse identify as necessary to enable the client to gain greater

control over health. Health education is an important health promotion activity in facilitating the development of personal skills. It is important that it be guided by the same empowering approach that characterizes other caring/health-promoting actions.

Human needs assistance is described by Watson as a systematic way of attending to a client's needs and, again, can be applied to communities. The promotion of self-responsibility and development of personal skills are an integral part of this carative factor and are consistent with similar principles in the Ottawa Charter. <sup>25</sup> A community's salient health needs may or may not initially be expressed explicitly. Farley noted that the involvement of others outside the community is sometimes necessary "for citizens to recognize and meet the needs of their community ... because the citizens may have become insensitive to the great need in their own backyard, or may feel helpless in the face of apparently overwhelming need." <sup>22</sup>(p247)

It is quite possible that even initially explicit expressions of need later will be augmented as the nurse, in partnership with the community, systematically assesses the community. The role of the nurse in facilitating authentic community self-determination, as with individuals, involves making professional knowledge, expertise, and judgment available to the community, thereby enabling it to express and achieve health goals, and facilitating its empowerment to assume as much responsibility for health as it deems appropriate. <sup>21</sup>

Allowance for existential-phenomenological-spiritual forces in community health promotion acknowledges the wholeness of the community. One way this carative factor may become part of community health nursing practice is in helping a community find meaning in the face of disaster. Although community health nurses are often involved in responding to crises such as storms and disease outbreaks, they also frequently participate in debriefing sessions in which they can help strengthen the community's capacity to respond to future crises, as well as help the community make sense of the events.

Watson's theory of human caring is philosophically congruent with contemporary empowering approaches to community health. The primacy of caring, holism, and ecology to her theory is clear and mirrored in the Ottawa Charter, which asserts that they are "essential concepts in health promotion." <sup>25</sup> Concepts related to caring for individuals can be readily extrapolated to communities in a manner consistent with nursing literature and community health nursing practice. Using Watson's theory to guide community health nursing practice may assist community health nurses to withstand the pressures to shift their practice to reflect every passing theoretical fad and political trend <sup>4</sup> and return their practice to a nursing center, that is, to a practice that is consistent with the philosophy and practices of the founders of public health nursing. <sup>1</sup>

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## **Appendix Community Assessment Guided by Watson's Theory**<sup>△</sup>

### COMMUNITY IDENTITY<sup>△</sup>

1. Who makes up the community (population, age distribution, ethnicity, family types)?
2. What makes this a community (eg, shared geography, common characteristic, shared problem, relationship of community members with one another)?
3. What is this community's history? If this is a temporary community (eg, a group), how long have members been together, and how long are they likely to stay together? Is the community membership stable, or does membership change frequently?
4. What are the community's sources of pride? What does it believe it does well?
5. What barriers to health does the community identify?
6. What is the community's self-image?
7. What vision does this community have for its future?

### COMMUNITY SPIRIT<sup>△</sup>

1. What values are evident?
2. What is the community spirit and how is it evident?
3. What belief systems are most prevalent, including presence of worship centers and organized religions?
4. What are common community explanations for events, such as natural disasters, that are beyond human control?

### INTERNAL AND EXTERNAL ENVIRONMENTS<sup>△</sup>

1. Describe the physical setting in which this community is located. (In a geographical setting, use information from a "windshield" survey. What do you see as you drive through this community: parkland,

terrain, dense housing, industry, pollution, climate, etc. For communities confined to a single location look at facilities and resources, eg, in a classroom you might look at size, layout, light, noise, temperature, and adequacy and state of repair of desks)

2. What is the economic status of the community?

- \* What are income levels, unemployment rates, industry, and sources of employment?
- \* How equitably is income distributed across the community?
- \* What is the relative wealth of this community in comparison with national, state/provincial, or regional levels of wealth?
- \* What are major sources of revenue (eg, taxes, exportable resources, tourism), and how sustainable are they?
- \* What proportion of children live below the poverty level?

3. What is the political structure of the community (or power dynamics of a group)? How are leaders/representatives chosen? What is the community's perception of how well this political/power structure represents and advocates for its members outside of the immediate community?

#### COMMUNITY CAPACITY TO MEET BASIC NEEDS OF MEMBERS<sup>^</sup>

1. What housing types predominate (eg, high density, single-dwelling)?

- \* How affordable is housing?
  - \* To what extent is homelessness a problem, and how is it addressed?
2. How does the community address nutritional needs?
- \* To what extent is food home grown or purchased?
  - \* How do community members purchase groceries (eg, small specialty stores, superstores, corner stores)?

- \* How accessible and affordable are groceries?
- \* What labeling regarding nutritional content, additives, genetic engineering is required?
- \* What mechanisms govern the safety of food?
- \* What food supplemental services exist (eg, breakfast programs, food banks)?

3. How does the community meet needs for clean air and water?

- \* What are the adequacy, safety, and sustainability of water supplies?
- \* How are biologic and industrial wastes disposed?
- \* What is the air quality: are advisories frequently issued, what are sources of pollution, and what mechanisms are there for dealing with polluters?

4. To what extent do community health services (promotive, preventive, curative, rehabilitative, and emergency) meet the health needs of community members?

- \* How affordable and accessible are health services to community members?
- \* How acceptable are health services to community members, ie, to what extent have they emerged from the community's involvement in identifying needs and planning to meet those needs?

5. What public policies or programs promote and support health?

- \* How well do laws protect public safety (eg, seat belt laws, nonsmoking areas, access for physically challenged members)?
- \* To what extent is health promoted in public places (eg, breastfeeding friendly workplaces, restaurants, shopping malls; identification of healthy food choices on restaurant menus)?
- \* How are families supported in promoting the healthy growth and development of their children?
- \* To what extent is health promoted in schools (eg, comprehensive school health programs, school-based clinics)?
- \* What sectors besides health are involved in promoting health and how?

6. How does the community ensure the safety of its members (eg, police, fire, rescue services)?

7. What crisis services does this community have in place depending on nature of the community (eg, disaster plan, tornado warning system, fire drills, sprinkler systems)?

#### COMMUNITY CAPACITY TO CARE FOR ITS MOST VULNERABLE MEMBERS<sup>^</sup>

1. What social services are provided to community members through tax dollars (eg, daycare, income assistance, welfare, pensions)? What additional user-paid services are available?
2. How are the needs of older residents met?
  - \* To what extent do families care for elderly family members at home?
  - \* Are there sufficient and appropriate living environments that promote maximum independence while providing adequate supports to meet older adults' health and safety needs?
3. How are needs of diverse community members met (eg, culturally sensitive services, translators, support for in-tegration into the educational system, English as a second language courses)?
  - \* How does the community integrate new members?
  - \* To what extent is diversity welcomed and supported?
  - \* To what extent are some community members advantaged or disadvantaged by virtue of race, ethnicity, gender, class, or sexual orientation?

#### COMMUNITY CAPACITY TO MEET SOCIAL NEEDS OF MEMBERS<sup>^</sup>

1. How do community members communicate with each other and outsiders (eg, newspapers, newsletters, media, person to person, posters, key informants)?
2. What social programs and activities exist within the community, and what facilities exist to promote them (eg, community centers, churches)?
3. What is the major mode of transportation within the community and to other communities?
  - \* To what extent are services accessible to all members of the community (eg, how disadvantaged is someone who does not have a car)?
  - \* Is public transportation adequate and accessible?

#### COMMUNITY CAPACITY TO PROMOTE GROWTH AND DEVELOPMENT OF ITS MEMBERS<sup>^</sup>

1. How does the community promote the growth of its members?
  - \* What educational programs are provided, eg, preschool, prekindergarten, kindergarten through 12th grade, and postsecondary education?
  - \* To what extent are these educational opportunities accessible to all community members (eg, public versus private funding)?
  - \* What continuing education opportunities are provided?
2. What supports exist in the community for recreational activities?
  - \* playgrounds with equipment
  - \* organized sports/fitness activities across the lifespan
  - \* hobby groups/classes, card clubs, etc
  - \* facilities (eg, swimming pools, hockey rinks, tracks, tennis courts)
3. To what extent are recreational supports accessible to all community members?
4. To what extent are the arts and culture promoted in the community, and how accessible are such events to community members?

#### SUMMARY<sup>^</sup>

- \* Nurse/community perceptions of community strengths
- \* Nurse/community perceptions of challenges to community health
- \* Community health goals
- \* Nurse/community plan for achievement of health goals

[\[Context Link\]](#)

Key words: community empowerment; community health nursing; health promotion; Watson's theory of human caring

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