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Interactionality

Willfully Extending the Boundaries of Participatory Research in Psychiatric-Mental Health Nursing

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The concepts of somatization and hysteria have been used in nursing, medicine, and healthcare to describe and explain the "unfounded attributes" of women's expressions of pain and discomfort. This study, grounded in poststructural ideologies, extends the boundaries of participatory research in psychiatric-mental health nursing and, thus, developed a series of methodological techniques coined "Interactionality" that then challenged the concept of somatization. This article focuses on the philosophical and conceptual assumptions of Interactionality, and introduces the notion of a double-voiced discourse as a means of communicating the analysis and findings of critical research. **Key words:** *critical theory, hysteria, participatory research, qualitative inquiry, somatization*

CLARIFYING THE SIGNIFICANCE FOR DESIGNING PARTICIPATORY RESEARCH IN PSYCHIATRIC-MENTAL HEALTH NURSING

In participatory research, participants make decisions rather than function as passive subjects.[1(p185)]

Participatory research (PR) is an important method of qualitative inquiry within the discipline of nursing as it fundamentally endeavors to promote and support the many diverse roles of nurses, as they work with individuals, groups, families, and communities, promoting the health, wellness, and culturally competent nursing care of the sick and dying. PR not only assists and encourages nurses to revere the notions of collaboration, observation, reflection, and action as research tools, it also ignites the nurse-facilitator and the participants to work together to coidentify, councover, cochallenge, and potentially cotransform the ways information, concerns, and needs are defined, demonstrated, and "lived out" among the individuals, groups, and families who have no control over the authority and power of that "information" and/or knowledge. To this end, PR is particularly useful in psychiatric-mental health nursing inquiry and practice, as its methodologies and methods resonate with the aesthetics, those art-acts[2] of psychiatric-mental health nurses who utilize participation and collaboration in their daily practice of developing interpersonal relationships with individuals, groups, families, and communities.

I believe that the investigator who is considering the use of PR must first be able to answer and defend the following philosophical question: What constitutes research and knowledge development in nursing? Once this process has ensued and the investigator

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has a sense of his or her own philosophical beliefs regarding knowledge development, he or she then has the option of selecting a wide variety of qualitative methodologies and methods. PR has several philosophical approaches as well, which then subsequently guide its methodologies and methods.[3–7] Each approach to PR is unique and relies heavily on which particular frame of reference, values, and/or philosophical beliefs the researcher or facilitator aspires to and utilizes to generate knowledge, thus answering the initial question and following through with the corresponding methodology and methods.

PR is not a new methodological approach or process of inquiry. It has been used for several decades in the social sciences and in feminist research.[1] In its early development and throughout its evolution, PR has maintained a "collaborative" approach. Hall[8] relates that participatory or collaborative research is a methodology by that the people studied actually *make the decisions with the investigator* about the study format and the data analysis. I believe that this idea of collaboration in PR fundamentally seeks to narrow the distance between the researcher and the researched as well as to use strategies that strive for self-observation, reflection, and the potential for transformation in the research process and setting.

Interactionality is a series of new, innovative methodological techniques grounded in PR and philosophically guided by a critical social science. Interactionality is ideologically opposed to traditional scientific approaches that seek to control, predict, or explain human behaviors or suffering. Interactionality also moves beyond hermeneutics, a branch of European philosophy that seeks human understanding and interpretation of texts and is instead ideologically guided by critical theories, those that seek to not only understand and interpret human behavior and/or suffering but also endeavor to extend knowledge development using social and political attentiveness and the potential for social and political action. Inherent in its methodology and methods, Interactionality therefore seeks to understand the intentions and desires of its participants with the view of cocreating knowledge that is useful to both the researcher and the researched.

Interactionality does differ from many of the established forms of PR that have been developed and used in the social sciences as it was developed within the discipline of nursing and sought to willfully extend the boundaries of PR by blending the philosophical notions of poststructural feminisms and a critical social science with the skills and practice of an advanced practice registered nurse (APRN) in psychiatric-mental health. To this end, it then sought to challenge the concepts of somatization that are used to describe a particular form of psychiatric illness in healthcare, nursing, and medicine today.[9]

The purpose of this article is to present and discuss "Interactionality" as a unique and innovative methodological approach to be used in nursing and healthcare. An introduction to the study that cocreated Interactionality will be briefly presented, including a description of the concept of somatization and how it interfaces with nursing in generally and psychiatric-mental health nursing specifically. This will be followed by a brief argument and the significance for an alternative method of inquiry as well as a description and discussion of some of the philosophical questions, assumptions, and concepts that helped to guide the interactive dynamics of Interactionality. The final section will introduce some of the challenges inherent in PR approaches: how one communicates the participant's lived sufferings; how one enacts, explores, and explicates the notions of resistance and, finally, how one documents the techniques that free individuals to be able to engage in the complexities of the critical research process.

BACKGROUND TO THE STUDY

Interactionality was initiated and developed in Australia as part of a doctoral

study within the Discipline of Nursing, and specifically within the practice of psychiatric-mental health nursing. As the primary investigator and cocreator of this study, I consciously and deliberately drew from the philosophical tenets of poststructuralism, postfeminisms, and a critical social science.[9] The study included the conversations and dialogue of 4 women and 4 nurses who met in participatory groups of 2 or more over a period of 6 to 8 months in the final decade of the 20th century. The "women" participants were invited to join the study from the referrals of several healthcare providers in the healthcare community who were able to identify and refer women who were labeled with the psychiatric and medical diagnosis of "somatization," also known as "somatoform disorders" in the *DSM-IV-TR*.[10] The "nurse" participants were invited to join the study out of an interest in the development of this study from within a university-hospital setting in Australia where I taught and also presented the ideas for this research.

CLARIFYING AND CHALLENGING THE CONCEPT OF SOMATIZATION: A PSYCHIATRIC-MENTAL HEALTH TERM INHERENT TO ALL DOMAINS OF NURSING

Somatization has many tiers of stratification and meaning in healthcare, nursing, and medicine. Most nurses can identify at least one story of an individual whom they have cared for in their practice and who presented with a symptom or with many symptoms that, through testing and invasive procedures, were proved to be "unfounded" or to be of "unknown origin." Thus, the outcome of the assessment of this individual by the healthcare providers may be to surmise that his or her symptoms were then "atypical," or worse, "all in their head," "imaginary," and/or "being made up." This individual labeled or diagnosed as atypical, "somatic," "psychosomatic," or even suffering from "hysteria" then leaves the clinic or the hospital. At some later time, this individual represents to healthcare providers with another "pattern of frequent, unexplained or functional (physical) symptoms that prompt help seeking and cause disability" as well as sustained treatment, medication or further testing.[11(p1)] It is this particular behavior and action that has been coined and defined as somatization.

The concept of somatization became known to me as soon as I began to practice nursing as a generalist, noting that patients were given diagnoses such as atypical, somatic and/or "neurotic." I then became much more involved in understanding this concept when I began my career as an APRN in psychiatric-mental health in the mid-1980s, working in a large inner-city community mental health center attached to a large medical center and medical school. Patients diagnosed with somatization were being referred to me because I was one of two advanced practice nurses working in the mood disorders outpatient clinic. It was acknowledged that I had the skills and knowledge to manage these "challenging patients," their symptoms, and their medications, and so I agreed to develop a subspecialty of working primarily with women who were labeled with somatization. However, the real challenge for me was not working with the women. The real challenge came when I sought help from the professional literature as well as other colleagues. I was dismayed by the lack of useful information and direction, and felt angry by the insinuation that women like this were acting "hysterical," "histrionic" and that their cries for help were only "attention-seeking." I was initially told to "limit my time with them" as well as to provide only "supportive therapy and medication management" because of their demanding ways and neediness for care. I returned to the literature with the hope that I might find clarification of the many layers of meaning, asking questions and getting some surprising answers.

WHAT EXACTLY IS SOMATIZATION? CLARIFYING THE CONFLICTS AND CONTRADICTIONS BETWEEN THEORY AND PRACTICE

The concept of somatization is documented in the psychiatric and psychosocial literature as a symptom or a disorder.[11] When it is described as one distinct symptom, somatization usually then affects only one area of an individual's body as happens in loss of vision (blindness), loss of mobility (paralysis), and/or loss of consciousness (seizures). In addition, the single symptom can be expressed as "pain." When an individual is expressing "somatoform pain," a diagnosis is made because there is no organic pathology to account for the level of distress that the individual is reporting or reflecting. The pain is grossly in excess of what would be expected from the physical findings of the history and physical examination.[10]

When somatization is described as a disorder, it usually then affects several areas of the individual's body, with reports of multiple, chronic symptoms. Somatization has been described in the medical and nursing literature during the last decade to affect women 10 times as frequently as it does men, with the lifetime prevalence estimated at between 0.5% and 2%, which is believed to be an "underestimation."[12] Somatization is also documented as commencing before the age of 30, leading to the incessant seeking of help, use of over-the-counter and prescription medications, long-term disability, and iatrogenic illness.[10,13] At least 30% of individuals who present with these multiple symptoms are found to have "no bona fide" medical condition that is the cause of the complaints.[14]

The vast range of information in the medical and nursing literature over the last 2 decades also highlights the nature and course of somatization as well as the possibilities for its presentation and challenging management in the healthcare industry.[11,13,15,16] After an exhaustive literature search, what appeared to be missing from this literature was the participation and collaboration of those individuals who suffer from these symptoms and syndromes called somatization. All of the known research was generated in the empirical-analytic paradigm of knowledge development using description, prediction, and control of the "subjects" as its focus. There was no known literature developing knowledge from the perspective or collaboration of the sufferers, those who live with the disorder and syndrome even though these sufferers were consistently portrayed as "hopeless" and "untreatable."

Subsequently, it was this particular issue of the unfounded, imaginary symptoms that seemed to keep resurfacing as a conflict and contradiction in my practice as a nurse-psychotherapist (both in the United States and in Australia) over the next 15 years. The contraction between theory and practice was looming over me nearly every time I met with and worked with a woman labeled with some concept of somatization. Despite the findings in the literature (theories, case studies, and descriptive reports), the women related to me that they were not feigning their symptoms, were not malingering for attention and/or disability, and were not merely "acting" hysterical. They, instead, shared with me that they were deeply distressed, depressed, confused, often abused, and/or merely trying to survive. The women shared that their reasons for seeking the help of healthcare providers was to understand what was happening to them—in their bodies, in their minds, and within their spirit. It was the implication and inference of their "imagined sufferings" by healthcare providers that actually instilled a sense of hopelessness, oppression, and disempowerment within this particular population of women and at times "worsened their symptoms and even their overall well-being." Trying to understand their bodies, the symptoms and distress it was communicating to them, was not imaginary, or "made up," but was rather very real and very debilitating.

It was this conflict and contradiction that gave me the impetus to begin this process of

uncovering, identifying, and challenging the meanings and language buried beneath this syndrome. Rather than revisit the literature for answers, I sought to ask questions of myself, and of those who suffered from somatization as well as other nurses who may take care of individuals with this type of suffering.

THE PHILOSOPHICAL UNDERPINNINGS: WHAT ARE THE QUESTIONS?

If a theory is expected to benefit practice, it must be developed cooperatively with people who practice nursing.[2]

The whole point of a critical theory is to redress a situation in which a group is experiencing deep but remedial suffering as a result of the way their lives are arranged. Its aim is to overturn these arrangements and to put into place another set in which people can relate and act in fuller, more satisfying ways.[17(p29)]

Therefore, if a theory is expected to benefit individual suffering, it must be developed cooperatively with people who suffer.

To initiate a study exploring the contradictions of meaning between what was written in the medical and nursing literature and what was being experienced by those who had suffered, I acknowledged that I first needed to consider many questions. I also needed to put my own beliefs, biases, and values on the table, so to speak, to proceed in designing a process of developing new knowledge. I then asked the following questions of myself:

What constitutes knowledge?
What constitutes the knowledge about pain, discomfort and bodily symptoms that surface?
Where does the meaning of somatization come from as well as the meaning of pain?
How do nurses know about somatization? (How do I know about somatization?)
How do nurses know how to care for individuals who are diagnosed with somatization? (How did I know how to care for them?).[9]

Beginning with these questions, I also acknowledged that I needed to consider more specific questions that were relevant to women diagnosed with somatization. And it was this next particular set of questions that then assisted me to begin to lay the philosophical foundation for Interactionality.

Who are the potential participants (women diagnosed with somatization) and from where do they come? How do they see themselves beyond their defined labels?
What are some of the events that they see as important in their lives?
What do they see as the influences that played a part in their lives, their suffering, and/or their oppression?
What do they think will help them? What do they think will help their suffering cease?[9]

It was at this stage that I became enlightened to the notion that not only did I want to include women diagnosed with somatization (and nurses who cared for women like them) as the participants in the study, I also wanted to be able to utilize a methodological approach that was practice based and collaborative in nature, one that sought to narrow the distance between the researcher and the researched, and one that would address the conflict and contradiction between theory and practice. This, in essence, shared an affinity with my own beliefs about the politics of knowledge development and, more specifically, how nurses can (and do) develop knowing and knowledge in nursing through the therapeutic, interpersonal relationships that are present as they practice nursing.

The research process then grew and I began to utilize some of the beliefs, values, and advanced techniques and skills that I had developed as an APRN in psychiatric-mental health nursing to consider a methodology. I subsequently documented my observations and reflections in a journal of "field notes," leading me to the notion of participatory inquiry, and its philosophical tenets, which indeed encouraged collaboration, interaction,

dialogue, and discussion as a means for developing knowledge.

FROM PHILOSOPHICAL QUESTIONS TO PHILOSOPHICAL ASSUMPTIONS: UNCOVERING CENTURIES OF MEANING ABOUT SOMATIZATION

Through this process of asking questions, several philosophical assumptions unfolded and led onto the methodology and methods of Interactionality with the goal of uncovering the multiple meanings about somatization in nursing and healthcare today. There are 3 basic assumptions underpinning the foundation of Interactionality. Each will be presented and briefly discussed with examples of how each assumption relates to the concepts of somatization. They are

Knowledge is historical, value laden, and is influenced by dominant discourses over time and space, translating into language and action;

Knowledge is power and therefore can be used to control, coerce, and manipulate individuals; and

Knowledge (therefore) needs to be critiqued, challenged, chosen and with the potential for change to guide the participants in research toward self-understandings and meaning that is relevant to them rather than only meaningful to the researcher and/or the dominant discourse at the time.[9]

Knowledge is historical, value laden, and is influenced by dominant discourses over time and space, translating into language and action

All thought is fundamentally mediated by power relations that are socially and historically constituted.[3(p139)]

The first philosophical assumption asserts the notion that knowing and knowledge transcend time and space, and that knowing and knowledge are also profoundly influenced by dominant institutions, agencies, and/or discourse that have personal, social, and political power and authority over individuals, groups, and families.[18,19] This knowledge then has (a history of) power and authority, which subsequently translates into language and a series of actions that are unwittingly and unknowingly accepted and rendered as "what must be" by vast numbers of individuals, institutions, and agencies within a society or culture.

In terms of this particular study of women and the concept of somatization, the actions become how "she ought to be," or how she "should behave," rather than how she actually is or what influences may be rendering how she expresses her health and illness. This knowledge, which is grounded in dominant discourse and power relations, translates knowledge from one generation to the next, one culture to the next, now embedding itself into the medical and nursing language and actions unbeknownst to these sufferers of somatization.

An example of this particular assumption in relation to the concept of somatization is depicted historically as far back as ancient times when Egyptian and Greek physicians inferred that women's gender characteristics and behaviors were linked to her uterus ("hystera" in Greek). Therefore, they concluded, a woman's poor health (and unfounded physical and emotional symptoms), were directly related to her "discontented and displaced uterus."[20,21] In other words, when women became ill in ancient Egypt and Greece, the male physicians surmised that it was related to some disordered sexual activity and specifically to her uterus and its position within her body. Treatments included "feeding the uterus" or "luring it back to its place in her body" as it had "wandered away" from its rightful position. Of course, this was all speculation with the knowledge grounded in patriarchy mythology and the power of the male deities or gods. Male physicians who could not understand why a woman would "ache in the sockets of her eyes and take to her bed" would conclude, as documented in the Egyptian papyrus, that she would require some

form of treatment to lure or repel the uterus back to its rightful place.[22]

In many cases, sexual intercourse was recommended for women with the implication that women suffering from these symptoms were "lacking" or in need of male "bits or pieces." Ointments were made from the urine and sperm of men and then combined with beer, and then were rubbed on a woman's fingers, limbs, and in her "diseased place" (uterus) as an example of women's "lacking" and therefore "needing" of the excrements of men to make their bodies "right."[20–22]

This interesting piece of history seems to exist even today as many women's healthcare practitioners criticize the healthcare literature, education, and practice that focus primarily on a woman's uterus or her reproductive organs as a reason for her "woes," symptoms of distress, and/or pain. "Since the 1960s, hysterectomy has been one of the most frequently performed inpatient surgical procedures in the United States, with an estimated 33% of women undergoing a hysterectomy by 60 years of age."[23(p17)] This very idea of the uterus being "diseased," lacking, and/or perhaps "wandering from its rightful place" is currently present in the assessment and treatment of women, when women presented to healthcare providers with multiple physical and emotional symptoms that could only be "traced," understood, and assumed to be in relation to her "discontented and diseased" uterus. Today, however, it is removed as a means for curing a woman's woes.

Knowledge is power and therefore can be used to control, coerce, and manipulate

It is much safer for the patriarchal order to encourage and allow discontented women to express their wrongs through psychosomatic illness, than to have them agitating for economic and legal rights.[24(p44)]

The second philosophical assumption recognizes and asserts that knowing and knowledge is power.[2,18] How society determines how one generates and/or obtains knowing and knowledge is the crucial piece of this assumption. If knowledge about somatization descends exclusively from the observations and insights of those in power (rather than those who experience somatization), then this type of knowledge is prejudiced and/or biased, as it excludes those who suffer from it. On the other hand, if healthcare providers design research focusing on *understanding and uncovering the meanings* of what women report as somatization, it would be assumed that this is also knowledge: the woman's knowledge of her body.

However, traditional scientific methods of knowledge development do not include the observations and insights of those who suffer from somatization. Therefore, knowledge is power and can be used directly or indirectly to control, coerce, and manipulate individuals, groups, and families within a given community. In this study, the knowing, knowledge, and power of the medical and nursing literature and subsequent discourse and language about somatization have influenced those suffering from somatization that they are abnormal, impaired, or lacking something if their bodily symptoms cannot be explained through medical assessment, testing, and intervention.

As Fay[25] relates, these behaviors and actions not only descend from those "in power," they also function as ways that individuals use to cope with their situations, even if the contradictory or inadequate behaviors and actions seem to be false or in conflict with their real needs. In other words, the behaviors are in some ways supporting the social order of things, even though the women may realize that it doesn't make sense. If this "order of things" transcends time and space (thus being historical), and translates into language and actions that may be unbeknownst to the general populace, it can then be used to serve the needs of the "establishment" or culture, rather than to serve those individuals it controls, coerces, and oppresses. It is this language and the actions inherent in its meanings that I believe have power and authority over others and women, in particular, in regard to somatization.

This study has shown that the beliefs, values, and meanings used in the culture and language of "health and illness care" have, for centuries, been defined by patriarchy, religion, and then traditional sciences, obscurely defining how women should behave, communicate, and express their health and illness, leading them to believe (from one generation to the next) that what they feel, think, and experience must be maintained even if it doesn't make sense.[9] Therefore, women who do not present and behave in a way that is determined "normal" by those in power (medicine, nursing, and healthcare) are therefore abnormal and, in many cases, labeled with the diagnosis of somatization. These ideas have thus "cemented" specific boundaries for how women should behave as well as consequences if the boundaries are violated. What happens to women who dare to defy these boundaries?

Again, history supplies some of the answers. The illustrations, depictions, and documentation of those who defy the cemented boundaries of what "she ought to be" uncover that there were severe consequences for women who did not conform to a particular society's ideals and order. These consequences include women being alienated, marginalized, persecuted, and sometimes even tortured and murdered throughout history. This is best documented and illustrated in the historical accounts of the European witch-hunts and burnings from the 14th century onward. Women were hunted down and burned at the stake for the "odd and usual ways in which they behaved" as illness and disease during that time were associated with evil and "bewitchment."[21,26,27] Hysteria, hence somatization, ceased being a "disease" of women (and their uteri) and became a bewitchment of women. During this period in time, the symptoms of hysteria were believed to be the product of the devil and to be feared by men and others in the communities. Women who suffered from paralysis, unfounded pain, and/or mood fluctuations were tried and judged as being possessed by demons, inferring that their symptoms were related to their relationship or pact with the devil.[21]

Exorcisms were the first line of treatment but torture or death were seen to be simpler and believed to relieve the sufferer and society.[26,27] It has been asserted from the records of civil authorities from 1600 onward that 200,000 to 9 million women were murdered, and in Germany alone, the number of women burned as "witches" reached 100,000[26,28] until the last burning took place in 1775. Women suffered at the hands of a society that feared the unknown, and thus controlled, coerced, and manipulated both the sufferer and the society into believing that they must be removed, put away, or hidden as a means for elimination and silence. If a woman did not conform and/or "behave" as dictated by dominant agencies and discourse, she was then silenced, through her illness or her death.

Knowledge needs to be critiqued and challenged, and have the possibility of choice and the potential for change

Silence: silence is the mark of hysteria. The great hysterics have lost speech . . . their tongues are cut off and what talks isn't heard because it's the body that talks and man doesn't hear the body.[24(p49)]

Silence is one "mark" of hysteria and/or somatization. To reclaim the words and the language of the women who were/are silenced over time and space, one must be able to listen as well as to find ways of "giving them back their tongues." This is one of the essentials of using a critical social science to guide the methodology. To do this and actually "hear" the body, as Cixious so aptly states, I recognized that this generation of knowing and knowledge would need to be developed using a methodology and methods that would uncover, deconstruct, identify, understand, and potentially transform this particular language of women suffering from somatization into a (heard) meaning and into acts or actions that would be empowering to them.

From this point, I was able to create specific methodological strategies, guided by

the philosophical tenets of poststructuralism, postfeminisms, and a critical social science endeavoring to critique, challenge, promote choice and the potential for change in the powerfully "constructed" language that has for so long dominated women labeled with somatization. This research process then facilitated women to be able to consider, invent, reclaim, and/or choose a language and actions that were meaningful and familiar to them. These strategies, guided by philosophical tenets, bore 4 conceptual assumptions.

Critique
Challenge
Choice
Change

Each conceptual assumption builds on the previous philosophical assumption and will be presented, described, and discussed in regard to the deconstruction of the concept of somatization.

Critique

The conceptual assumption of critique specifically focuses on the notion that previous knowledge and language about somatization has not been "critiqued" and/or examined in a critical manner. The idea that women who present to healthcare professionals with physical and/or emotional symptoms that are unfounded has been accepted as the "truth," based on knowing and knowledge dating back to the ancient Egyptians. Therefore, the conceptual assumption of critique draws its ideology from a critical social science and the belief that there are 2 distinct perspectives leading to the development of knowledge: scientific and critical.[29] Those who aspire to a critical perspective assert that the scientific perspective aims to develop knowledge by manipulating the external world, by insisting that the researchers distance themselves from the subjects being studied by observing, controlling, and making predictions about the subjects being studied. Therefore, the scientific perspective is in the power position, assuming that only "they" have the ability to find the answers or outcomes to the research question.

The critical perspective of knowledge development, on the other hand, makes itself a part of the object that it seeks to define and also narrows the space between the knower and the known, the researcher and the researched. The critical perspective respects the relationship between the researcher and the researched and encourages the many "possibilities" and/or the many "potential" outcomes, rather than to seek to predict or control them. One of the failures intrinsic to the scientific methodologies is its inability to free practice-based knowledge into an emancipatory social theory, thus promoting the intersection between the self-understandings of the participants and the potential for change and/or transformation.[30]

I believe that this is one of the fundamental features of nursing practice: our respect for and acknowledgement of the many diverse expressions of health and illness in individuals, groups, and families, with an endless number of outcomes that can occur as we practice nursing care. The whole idea of knowing and accepting that no two individuals, groups, and/or families will experience pain, loss, and/or trauma alike is akin to this conceptual assumption. Yet, we allow scientific theories to tell us otherwise.

In regard to somatization, nurses and nursing have borrowed knowing and knowledge from the scientific perspective of medicine, discouraging the very things that we hold basic and intrinsic to our practice: interpersonal, caring, and therapeutic relationships and the idea that no two individuals are alike or will require the same kind of nursing care. Trying to apply generalizations from the scientific perspective of medicine to nursing practice, thus merely distancing ourselves from those with whom we care for, has always seemed to enforce and instill a hierarchy of power, of knowing and knowledge that I believe does not gather reliable or credible information, in nursing practice or research.

In this study, the conceptual assumption of critique was extended to uncover the many meanings of somatization and was able to illuminate these contradictions between the knower and the known: nursing practice and the scientific perspectives of medicine and the women suffering from somatization.

Challenge

The conceptual assumption of challenge builds on the concept of critique and the notion that language and knowledge is historical, value laden, and culturally biased. Challenging these processes requires that one uses a specific method to be able to identify, illuminate, and uncover what may be hidden or unknown. Drawing from the tenets of action research, the action research spiral was adapted as a strategy to uncover and identify the many meanings and coercive actions that were impacting upon the participants in this study. Action research asserts the idea that social action is unpredictable and risky, with effects and constraints that are unforeseen and unrecognized. Thus, action research requires collaboration and dialogue to enact potential change among its participants.[31]

In this study, the conceptual assumption of challenge uses 4 aims to engage participants in the process of the action research spiral:

To develop a plan of critically informed action to improve what is already happening;
To act to implement the plan;
To observe the effects of the critically informed action in the context in which it occurs;
To reflect on these effects as a basis for further planning, subsequent critically informed action . . . through a succession of cycles.[32]

It is the succession of cycling and recycling information, knowing, and knowledge within the action research spiral that forms the basis for trustworthiness, essential to the credibility of qualitative research and hence to this study. The participants were encouraged to read the transcribed verbatim, make changes, or delete what information they didn't think or feel represented what they were trying to communicate, understand, or challenge. They were also given the opportunity to add ideas, thoughts, and feelings to the data. It was through this action research process that the participants were able to challenge the many meanings of somatization.

Choice

The conceptual assumption of choice focuses on the belief that culture has a significant role in the shaping and influencing of an individual, rather than the individual shaping and influencing culture. The concept of choice was utilized and descended from the ideology of resistance, a term developed in Neo-Marxist sociology[19] and Liberatory education[30] reflecting the "struggles" of individuals and the actions of dissonance that surface when contradiction and conflict occur within the critical research process. In other words, the assumption of choice developed and used in this study rejected the notion of free will. Free will traditionally asserts an ideology that individuals are able to decide and are able to conceive their self as being able to make decisions and initiate action. Free will also implies that individuals have the power to determine their choice of action independent of causation.[33]

In this study, the women labeled with somatization and the nurses who cared for them did not have "free will," hence, they could not make choices or decide which course of action to take, independent of causation. Instead, the women sought the care of healthcare providers to no avail and the nurses followed the knowing and knowledge of medicine and centuries of traditional wisdom procuring an impossible outcome, a controlled and coerced existence, rather than to procure and consider the endless possibilities in the lived sufferings of those with somatization and those who cared for them.

The notion of resistance interfaced with the assumption of choice in this study, presenting and examining the idea of a false consciousness, "the denial of how our commonsense ways of looking at the world are permeated by meanings that sustain our disempowerment."[30] In other words, what one believes about his or herself and his or her life is essentially a product of the environment/society where he or she socializes, a product of how history has defined his or her life, and is governed by the values of those who have been in power. The theories of traditional science (scientific perspective) have historically guided the way that knowledge is/was valued and understood and has had a powerful control over society. "Scientism means science's belief in itself: that is, the conviction that we can no longer understand science as one form of possible knowledge, but rather must identify knowledge with science."[34] In this statement, Habermas is speaking of dominant discourse, the power that science (and the scientific perspective) has had over knowledge and knowledge development: that there is only one truth, one form of possible knowledge.

Change

The conceptual assumption of change focuses on the whole embodiment of the infinite, endless possibilities and the invisible, unspoken ways of knowing and knowledge development and meaning that have been oppressed, coerced, and manipulated by those in power. Inherent in this assumption is the notion that there are many forms of knowing and knowledge development rather than one (scientific) perspective. The conceptual assumption of change rejects the predictive, controlling, and manipulative manner inherent in the scientific perspective and instead relishes the potential of the critical perspective that openly sanctions and, thus, promotes the once-feared invisible, unknown, and artful ways of knowing, knowledge development, and being human.

By blending the principles of nursing with the critical perspective, nurses can participate in and encourage "other" innovative approaches to knowledge development, those approaches that can benefit those who suffer rather than just those interested in the suffering.

The critical perspective and "critical theory spring from the assumption that we live amid a world of pain, that much can be done to alleviate that pain and that theory has a critical role to play in that process."[35] Therefore, the conceptual assumption of change can assemble and integrate its meaning from the aesthetics of nursing, the transformative art-act, the synchronistic narrative and movement used by nurses in their interactions with their patients.[2,36]

Nursing is an art and a science. As a developing "art," nurses have the ability to grasp meaning that occurs within and between the complex nursing interactions that they share with individuals, groups, and families in their practice. This art-act of "grasping the meaning" becomes the-knowing-in-the-moment-of-creating that takes form and is akin to creativity.[2] This creativity is the act and actions that we repeat time after time with those in our care, yet it is not always spoken or documented as valid knowing and knowledge.

Therefore, the conceptual assumption of change promotes this creative blending of grasping meaning, encouraging "stunning" interactive connections and dialogue that then stimulates, sustains, and maintains the process of Interactionality and creates endless possibilities for transformation to occur as part of the research process.

In summary, the 4 women diagnosed with somatization and the 4 nurses who participated in this study used these conceptual "tools" of Interactionality and, thus, grasped meaning, made intrapersonal and interpersonal connections, as well as considered a familiar and/or forgotten language, knowing, and knowledge lost or perhaps buried under centuries of history, culture, and power toward a deeper meaning and understanding of somatization.

INTERACTIONALITY IN ACTION: CAPTURING AND COMPLETING THE CIRCLE (CYCLE) OF COMMUNICATION THROUGH ANALYSIS, DISCUSSION, AND DOCUMENTATION OF THE FINDINGS

In one utterance, two consciousnesses could coexist.[37]

Interactionality has been presented as an innovative, evolving, and transcending process that occurs over time and space. Capturing the knowing-in-the-moment art-acts and actions of the participants is another important piece of the emancipatory process that needs to be communicated within the discipline of nursing and the healthcare system. To this end, new knowledge about somatization can be shared and understood, completing the circle of communication of the research process. Analyzing, discussing, and documenting data in qualitative research have been challenging for nurses, and it is particularly challenging as one attempts to analyze and discuss a critical research process such as that which is inherent within Interactionality. This section briefly focuses on this endeavor with an example of the methodological trail that was used to maintain trustworthiness in the analysis, discussion, and documentation of the participant's meanings of somatization through the critical research process.

When analyzing, discussing, and documenting a critical theory, it is essential to assert and preserve each participant's interpretation and understanding.[17,30] The interpretation and self-understandings can also be agreed upon through group discussion and consensus, thus alluding to the notions of individual and collective meaning within participatory groups. This, however, is a challenge when attempting to analyze, discuss, and document this information for research purposes and, in particular, to an audience that is more familiar with validity and reliability associated with statistical outcomes.

In this study, capturing and communicating the participants' multiple and diversified meanings of somatization is just one example of the many challenges that I confronted as I sought and maintained trustworthiness in this portion of the study. Throughout the weeks and months of participatory meetings, the concept of somatization was transformed to mean different things to each participant in this study. The stratified layers of meaning were observed, reflected upon, and transformed through each participant's life story, through his or her voice and through the transcribed verbatim.

At times, meanings of somatization were described as pain for the women and the nurse participants. They described not only physical pain, but also emotional and spiritual pain. Somatization was also described in silence, as one participant had no words to communicate its meaning. She exemplified this during the research process as she cupped her hands together, relaying that the space inside (her hands) represented its meaning to her. As the women and the nurse participants identified and acknowledged the semantics of the concepts somatization and pain, they also began to uncover and discuss the many layers of meaning buried in dominant ideology and discourse. I realized that it was essential (and a challenge) to be able to communicate these "art-acts" and these "knowing-in-the-moment" aesthetics inherent in nursing,[2] as the expressed meanings not only represented the participant's reality and conscientization,[18] but also the nursing knowledge that transcended from this methodological process.

To be able to write the words, language, and meanings of the participants while also attempting to maintain the integrity of the philosophical assumptions underpinning the methodological approach was my quest. Like other critical researchers, I struggled with how to write the intense essence and realities of the participants. Writing words without the actualized meanings seemed to me like a watered down cup of coffee. I wanted instead to somehow try to fully express the richness, the aroma, and the flavors of the participant's words, language, and self-understandings. I pondered how I would be able to share these

pertinent and extraordinary meanings to others: to those who were not present in the meetings; to those who may be suffering from somatization; as well as to those who were interested in individuals labeled with somatization.

I believe that meaning stands philosophically outside of and beyond the elective and predictable path of structuralism, supporting the ever-transforming poststructuralisms present in our world today. Therefore, I knew that I also needed to be able to communicate these intricate patterns of communication: the notion that language is much more than words. I believed that I needed to be able to animate and infuse life into its text.[37–40]

It was then that I drew from the work of Mikhail Bakhtin (1895–1975) and the Bakhtin Circle, Pavel Medvedev (1891–1938), and Valentin Voloshinov (1884–1936), all Russian scholars of literature who met and discussed intellectual ideas during the postrevolutionary Russia in the early 20th century. Their creativity and intellectual pursuits were stymied by Stalin's reign of power in Russia and until recently versions translated into English were not available.

The overall premise in the texts written by "the Bakhtin circle" focused on the nature of discourse: how dialogue and communication conveyed its meanings.[38] Each essay asserted that within language, words have meaning, but that they were not being fully expressed in text. Therefore, language was seen to be as more than words in a dictionary, more than a possibility or a promise of meaning. Bakhtin posited that language and words also have actualized meanings used in specific utterances.[38] It is these utterances, or in the discipline of linguistics, a unit of language from a word to entire text, that Bakhtin[39] refers to in his work as the locus of one's encounter with their self-consciousness, their mind, and their reality with all of its sociohistorical nuances. Bakhtin's work is important because he views language usage as an eminently social and political act linked to the ways individuals define meaning and translate their relations to the world as an ongoing dialogue with others.

Meanings, to Bakhtin, therefore could become double voiced, with the idea that an author could take someone else's discourse and infuse it not only with the authorial intentions, but retain the original speaker's intention as well.[39] In one utterance, 2 consciousnesses could coexist. Bakhtin supported the notion that critical dialogue is a form of authorship since it provides the medium and gives meaning to the multiple voices that construct the "texts" essential to everyday life.[37]

Building upon his thinking and ideas, I believe that Interactionality can also be extended toward the notion of writing "double voiced," furthering the trustworthiness and credibility of its methodology and methods as well as endeavoring to maintain the philosophical assumptions related to being able to share and communicate the critical theories of the participants in this particular method of inquiry. This possibility of double-voiced discourse could be implemented without pilfering ownership of the data or robbing the participants of their true meanings. It is here that I now focus my thinking and work as I extend Interactionality in my practice, teaching, and research.

SUMMARY

Interactionality is a series of methodological strategies developed and used as part of the emancipatory theory in an advanced practice-based nursing study grounded in the tenets of poststructuralism, postfeminisms, and a critical social science. This article has focused on the philosophical and conceptual assumptions of Interactionality that then guided the critical research process and extended the boundaries of participatory inquiry within the discipline of nursing. The notion of a double-voiced discourse was introduced as a means for building upon in future research, practice, and teaching as communicating the findings in critical research remains both a challenge and an enigma.

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