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# Critical Interactionism

## An Upstream-Downstream Approach to Health Care Reform

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Currently, per capita health care expenditures in the United States are more than 20% higher than any other country in the world and more than twice the average expenditure for European countries, yet the United States ranks 37th in life expectancy. Clearly, the health care system is not succeeding in improving the health of the US population with its focus on illness care for individuals. A new theoretical approach, critical interactionism, combines symbolic interactionism and critical social theory to provide a guide for addressing health care problems from both an upstream and downstream approach. Concepts of meaning from symbolic interactionism and emancipation from critical perspective move across system levels to inform and reform health care for individuals, organizations, and societies. This provides a powerful approach for health care reform, moving back and forth between the micro and macro levels. Areas of application to nursing practice with several examples (patients with obesity; patients who are lesbian, gay, bisexual, and transgender; workplace bullying and errors), nursing education, and research are also discussed. **Key words:** *critical interactionism*, *critical social theory*, *health care reform*, *symbolic interactionism.*

"... there I am standing by the shore of a swiftly flowing river and hear the cry of a drowning man. So I jump into the river, put my arms around him, pull him to shore, and apply artificial respiration. Just as he begins to breathe, there is another cry for help. So I jump into the river, reach him, pull him to shore, apply artificial respiration, and then just as he begins to breathe, another cry for help. So back into the river again, reaching, pulling, applying, breathing, and then another yell. Again and again, without end goes the sequence. You know, I am so busy jumping in, pulling them to shore, applying artificial respiration, that I have no time to see who the hell is upstream pushing them all in."[1(pp484-485)]

THIS classic story, recounted by McKinlay[1] and later Butterfield[2] and many others, illustrates the dire situation of the current health care system. As the population ages, more and more people are in need of rescuing at the bottom of the river. Currently, per capita health care expenditures in the United States are more than 20% higher than any other country in the world and more than twice the average expenditure for European countries,[3] yet the United States ranks 37th in life expectancy, a key population health index.[4] Continuing to focus only downstream perpetuates the problem and fosters excessive increases in health care costs without improvement in general health of the population. One can see from this story that both upstream and downstream approaches are needed to address these complex health problems If one focuses upstream to stop people from being pushed into the river, people already downstream in the river drown. Staying downstream and pulling people out of the river and reviving them is essential for their survival; however, it does nothing to stop the problem from continuing to occur. A simultaneous, dual approach is necessary, moving between both upstream

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and downstream levels, addressing both the larger sociopolitical and the individual levels.

There are several national organizations calling for health care reform that include this dual approach incorporating both an individual/downstream and system level/upstream foci for improving health outcomes. The national agencies and initiatives encouraging this dual approach include the Institute of Medicine, the Patient Protection and Affordable Care Act of 2010, American Nurses Association, American Association of Colleges of Nursing (AACN), the Department of Veterans Affairs, and The Joint Commission. The Institute of Medicine[5] report "The Future of Nursing, Leading Change, Advancing Health" calls on nurses to transform the health care system. The changes necessary to accomplish this include improving the educational level of nurses so that they can be effective leaders from the individual patient's bedside to the organizational level, working together with other professionals, health care organizations, the government, and insurance industry. This will require a framework to understand both individual strategies as well as structural level strategies for improved patient outcomes.

The US Department of Health and Human Services' Affordable Care Act of 2010[6] also requires nurses and other health care professionals to create a health care system that shifts the focus away from acute care and specialization to primary care, coordination of care transitions across systems, prevention and wellness, and prevention of adverse events particularly with chronic illness and the older adult population. This shift in focus will move some of the acute and specialty care that is individually focused and downstream to more dual micro and macro level prevention and wellness efforts.

The ANA encourages nurses to consider both the individual and organizational levels in their standards for hospitals aspiring for magnet status. In their Essentials documents for baccalaureate,[7] masters,[8] and doctor of nursing practice[9] education, the AACN includes foci across system levels as imperative for graduates of all 3 types of programs. The Department of Veterans Affairs and The Joint Commission, in their standards on safety issues and errors, both emphasize crossing levels from the individual to organizational and larger system levels to understand safety issues and intervene to prevent errors.

The purpose of this article is to describe a new theoretical perspective, critical interactionism, that combines symbolic interactionism (SI) and critical social theory into a new approach that focuses attention both upstream and downstream. Critical interactionism provides a theoretical foundation for interventions at both of these levels, applying both micro and macro approaches to improve health, reform policies, and transform manufacturers of illness in society. Following a brief discussion of SI and critical social theory, critical interactionism will be described. Examples including patient care and nursing practice issues will be discussed as well as implications for nursing education and research.

## DEVELOPMENT OF CRITICAL INTERACTIONISM

To date, most of the theoretical perspectives and approaches used in nursing and health care are focused downstream, on rescuing individuals. Symbolic interactionism has been used in nursing at the individual level to understand meanings and definitions of situations primarily among patients and families at the micro level. Critical social theory is the theoretical perspective that has been utilized most frequently to address upstream issues at the macro level and provide a framework for analysis and interventions at this level. A new theoretical approach is needed to provide a guide for examining health care problems from both upstream and downstream perspectives. Critical interactionism combines SI and critical social theory to provide this framework.[10]

Symbolic interactionism and critical social theory have each been used in nursing and health care to address issues at the individual level (symbolic interaction) and to understand

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power imbalances that occur at the larger system level (critical social theory). Symbolic interactionism has been used in nursing most often as the theoretical basis for grounded theory and as a framework for understanding patients' and nurses' perceptions and interactions. Habermas[11] and Waitzkin[12] have applied critical social theory to understand power inequities and oppression at the individual level, while suggesting refocusing on larger system issues to rebalance the inequities. A brief summary of each individual theoretical perspective follows.

### Symbolic interactionism

Symbolic interactionism views human beings as social beings. Individuals and society are inseparable with each being created through social interaction and understood in terms of the other. Behavior is determined not by forces within human beings such as instincts or drives or by forces from the external environment, but rather by a reflective, socially derived interpretation of the internal and external stimuli that are present.[13]

Human beings are thinking beings and do not simply respond directly to events and situations, but give meaning to these. A person's actions are then based on the meanings the situations have for him or her rather than in direct response to the event or situation. Human action is caused by interaction among individuals, as well as by interaction within the individual. The continuous active ongoing process of thinking, conversing with one's self during interaction with others, is key to understanding action.[14]

According to Blumer,[15] meanings are learned by human beings in the process of social interaction. Meaning emerges out of the ways in which other people act toward the person in relation to the thing for which meaning is being developed. These actions of other people serve to define the things for the person. Within the symbolic interactionist perspective, the self is dynamic and a result of continuous social interaction throughout life.[16] One of the characteristics of the self is that the individual is able to view the self as object, to step outside and imagine viewing one's self as others would. Cooley called this the "looking glass self."[17]

People do not sense their environment directly, but instead define the situations they are in. An environment may actually exist, but it is the definition of it that is important.[13] A definition of the situation emerges through interaction where an individual has taken the role of the other or has adopted a group standpoint.[18]

Symbols, especially words, are a central concept of the symbolic interactionist perspective. They are social objects, are meaningful, are used to represent and to communicate, and are used intentionally. Interaction occurs through the use of symbols. The processes of symbolic interaction begins with interaction with one's self and others in one's reference group. This results in the formation of a perspective or point of view that guides the person in defining the situation at hand. The person then bases his or her action on this perspective and definition of the situation. After the action is completed, the effects of this action are interpreted or given meaning, and then alter the person's perspective and definition of the situation. This changed perspective and definition of the situation then influences future actions of the individual.[14]

Symbolic interactionism is concerned with examining the interaction between the different role players in the health and illness situation. The focus is often on how the subjective experience of illness is constructed through the health care professional—patient exchange. The argument here is that illness is a social accomplishment among actors rather than just a matter of physiological malfunction.[19] In nursing, SI has been widely used as a theoretical foundation for grounded theory or dramaturgical interviewing methods as well as a framework for diverse works including conceptualization of care with families,[20] describing the nurses role in perinatal safety,[21] the effects of nurses' use of traditional Chinese medicine on

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professional identity,[22] and to study nurse-mother communication in the neonatal ICU.[23]

### Critical social theory

Critical social theory uses societal level awareness to expose social inequities. This theoretical perspective is derived from the belief that social meanings structure life through social domination.[24] Domination refers to the power influenced over another while oppression refers to the unjust or cruel exercise of authority or power. According to Marx, social class emphasizes the relations of capitalist economic production.[24] Emancipation describes the effort to be set free or obtain social justice and is the goal of critical perspective, where a society is transformed by personal and collective power.

A critical social theoretical perspective "can be used to understand the linkages between the health care system and the broader political, economic, and social systems of society."[25(p5)] According to Navarro,[26] the health care system mirrors the class structure of the broader society. Critical social theoretical perspective is informed by the following values and assumptions:

1. The problems and inequalities of health and health care are connected to the particular historically located social arrangements and the cultural values of society.
2. Health care should be oriented toward the prevention of disease and illness.
3. The priorities of any health care system should be based on the needs of the clients/population and not the health care providers.
4. Ultimately, society itself must be changed for health and medical care to improve.[27(p45)]

Habermas' theory of communicative action emerged from the broader critical social theory.[11] The concept of communication or communicative action has been central to Habermas since he opposed the reductionist view in the natural sciences as well as the instrumental action in Marxism as a form of generating human knowledge.[28] Ideology is the interlocking set of ideas and doctrines as seen from the perspective of a social group. Ideological hegemony is the permeation of a certain dominant set of ideas within a society. This thinking is then used to guide what is right and not right about the social world around us.[11,29] Through ideas and doctrines, individuals form relationships to the real conditions of their existence. The dominant ideology of society permeates the face-to-face interactions of individuals. This ideology is present in interpersonal interactions where elements of ideology appear in every communication. The interactions between client and health care provider reinforce broader social structures and have been described as medical discourse.[12,30] Waitzkin[12,30] suggested that clarifying this pattern in health care sheds light on professional-client discourse in exploring connections between personal and social issues and the social context of medicine. Studies have analyzed interactions between client and health care provider in health care encounters or medical discourse.[12,30] Critical social theory in nursing augments understanding of how dominant ideology impacts the nursing profession, the health care delivery system and patient care.[31] Thompson[32] introduced the concept of critical scholarship in nursing and Campbell and Bunting[33] explored critical theory in nursing to expand nursing philosophy and research in practice.

## COMBINING SYMBOLIC INTERACTIONISM AND CRITICAL SOCIAL THEORY

A few authors have used the perspectives of SI and critical social theory together in theoretical discussions and in research studies. The term "critical interactionism" was suggested by Sandstrom and Fine[34] to describe a convergence of the 2 perspectives. They discussed Hall's work[35] in developing a framework for critical interactionist's analysis of power, politics, and policy formation and Schwalbe's[36] synthesis of Marx's and Mead's

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theories, making linkages between local actions and extralocal inequalities. Interactionists have also contributed to analyses of concerns such as ideology.[37] Denzin[38] called for an emancipatory critical interpretive interactionism with attention to language and behavior that considered gender, biography, and class. Reynolds also blended critical theory with an interactionist perspective stating that "A skillful welding of the radical sociology of Karl Marx with the liberal social psychology of George Herbert Mead is where to start; it holds the key to a viable future for our discipline."[39(p35)]

Nurse researchers Sundin and Fahy[40] critiqued Denzin's interpretive interactionism in light of critical and postmodern thought and arrived at a new methodology that they called critical, poststructural, interpretive interactionism. They identified areas of divergence between SI and critical perspective and then modify the symbolic interactionist premises to include critical perspective. The resulting method was used to study end-of-life decision making in the critical care unit. A new step, change, was added to the research as they incorporated the "imperative that critical research is designed to bring about change in the social world."[41(p20)]

Burbank and Martins[10] examined SI and critical social theory for areas of divergence and synergism. They suggested combining them into a new theoretical perspective called critical interactionism that directed the focus of health care both upstream and downstream simultaneously. Only by using such an approach could complex health care problems be resolved.

Combining SI and critical perspective into a single theoretical perspective raises several questions. The 2 have traditionally been thought of as divergent theoretical perspectives, extending even to their disciplinary focus. Symbolic interactionism is generally considered to be a social psychological perspective while critical perspective sits solidly within the discipline of sociology. Their underlying philosophies of science are different as is their level of focus with SI traditionally associated with a micro/ individual perspective and critical perspective using a macro/ societal perspective. This micro/macro difference is reflected in the divergence of some of their major concepts and basic tenets as well as their primary goals and concerns. Each of these areas will be explored further here.

Critical social theory is generally thought of as based on a critical realist ontology, which holds that there is a reality "out there" but that it may not ever be completely known or understood. Evidence of a critical realist position lies in the goal of critical theory of liberation of people who are oppressed, including their movement from "false consciousness" to "true consciousness."[41] Epistemologically, according to Guba,[41] critical theorists espouse a subjectivist view based on their belief that objective observation is impossible. The process of inquiry is always colored by the values of the observer.

Symbolic interactionism emerged out of the American philosophy of pragmatism originally attributed to William James and Charles Peirce.[42] Mead believed that the scientific method could be extended to all areas of intellectual inquiry. In Mead's view, the world, as conceived by science, is located within the wider world that is experienced and is composed of that which is common to and true for various observers. The experienced world is thought of as natural events sensed by observers, events that are a property of the observer as much as they are a property of the things observed. This, Morris wrote is an "objective relativism" where "qualities of the object may yet be relative to a conditioning organism. A certain portion of the world, as experienced, is private; but a portion is social or common, as science formulates it."[43(pxix)]

A second major area of divergence is in the level of focus and the concepts, premises, and goals of the perspective relative to that focus. Symbolic interactionism holds a micro perspective, most often focusing at the individual level. Major concepts and premises of SI involve the self, meaning making through interaction, use of symbols, and individual

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behavior. Society is considered, but usually only as it relates to the development of meaning and as it helps to form individual's definitions of situations. The goal is to understand and explain behavior, the creation of meaning, and the self through interaction.

Symbolic interactionism has been criticized because of lack of ability to address issues of power.[44] Dennis and Martin[45] refuted this, arguing that the interactionist tradition does show a fundamental concern with power. They cited examples in the fields of deviance and education in the study of the social processes through which power is enacted and institutionalized in real situations.

With critical social theory, the main focus is at the macro level, looking first to the society to understand power structures within social systems. Major concepts include social class, ideology, power, oppression, and with the goal to equalize power relationships through emancipation. Habermas, in his theory of communicative action, brought critical social theory to the individual level and asserted that all the power inequities that can be seen in society at large can be found in individual interactions between people as well. Other than Habermas and Waitzkin, however, critical social theory generally maintains a macro perspective.

## A NOVEL APPROACH: CRITICAL INTERACTIONISM

Despite their areas of divergence, SI, and critical social theory can be combined into a broad new theoretical perspective capable of providing theoretical bases for upstream-downstream thinking. Symbolic interactionism and critical social theory are diverse perspectives that maintain their own similarities and differences; indeed, these differences are necessary to apply critical interactionism to both upstream and downstream problems. It is believed that only by addressing both of these levels simultaneously can complex health problems be resolved.

While the underlying philosophies, major foci, concepts, premises, and goals of the 2 perspectives are divergent, there are areas within each perspective that may be seen as complementary. The underlying philosophies provide 2 different views of reality and knowledge development; however, they are not necessarily contradictory. Critical realists are not usually thought of as subjectivists. This ontology/epistemology combination leads to the idea that there is a reality out there; however, it is unable to be truly known because the value lenses through which people view their world prohibit making any "accurate" observations. Pragmatists sidestep the question about whether or not there really is a reality "out there" and instead look for knowledge that is useful for solving problems. Mead believed that qualities of objects were relative to those who observed them; events were a combination of the properties of the events along with the properties of those who observed them.[43] The effect of this relativist position on knowledge development is similar to the subjectivist position of critical perspective without the added attribution of subjectivity specifically to value-laden observation. A pragmatist philosophical position for critical interactionism focuses on solving problems both upstream and downstream with a "whatever works" approach.

The goal in critical interactionism is to understand and intervene at both downstream and upstream levels through understanding value-laden meanings at the individual/group level and repressive structures at the organizational and societal levels. One of the premises of definition of the situation in SI indicates that situations may be redefined though interaction with others. It is possible that a group of people with little power may organize, redefining the situation for themselves and others in power, and thus increase their own power base within the social structure. A grass roots movement in an underserved community may gain power and voice by redefining the situation for those in power and be successful in getting the resources they need to increase their power base.

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The concepts of reference groups and looking glass self within SI and ideological hegemony within critical social theory can be seen as complementary also. Shibutani described a *perspective* as "an ordered view of one's world—what is taken for granted about the attributes of various objects, events, and human nature."[46(p564)] Reference groups are the groups with whom the individual communicates and whose perspective is used to see reality. They can be any groups the individual belongs to including social class, ethnic groups, community, or society. Critical perspective purports that the dominant ideology is transmitted within a society so that all social classes, the entire society, reflect the ideology of the ruling classes. The concept of reference groups may explain this transmission mechanism. This dominant ideology may also be communicated through the concept of the looking glass self where a person can step outside themselves and imagine seeing themselves as others see them. The Table summarizes parameters across the 3 theoretical perspectives: SI, critical theory, and critical interactionism.

In critical interactionism, the richness of each individual perspective of SI and critical social theory is maintained while strengthening their areas of mutuality. Concepts of meaning from SI and emancipation from critical social theory move across system levels to inform and reform health care for individuals, organizations, and societies. This provides a powerful theoretical basis for health care reform, moving back and forth between the downstream and upstream. Critical interactionism allows for movement between not only upstream and downstream but micro and macro levels as well. Figure 1 depicts SI and critical perspective as they converge into critical interactionism. Critical interactionism is represented by the entire figure (Figure 2), including all of SI and all of critical social theory and the overlapping diamond in the center, rather than merely the overlapping central segment. It is believed that both perspectives in their entirety need to be applied in a fluid motion, moving back and forth among levels. In this way, nurses can transform health care at the individual and larger system levels making positive and enduring changes.

## APPLICATION OF THE CRITICAL INTERACTIONIST PERSPECTIVE

### Nursing practice

Nurses are in key positions to transform health care to be safer, more cost-effective, and higher quality. Change is needed in the health care system from the clinical micro systems to the macro systems.[47] In addition to the concern over health care outcomes, nurses in patient care settings should be provided with the tools to review patient histories/initial assessments with a lens that helps with upstream interpretations. So often the assessment tools used on admission focus on patient history as it relates to individual health behaviors and lifestyle. These are important components with critical interactionism but these tools also need to include assessment of upstream factors such as work, exposure histories, hunger, poverty, and other factors related to socioeconomic status, oppression, or marginalization. Assessment of organizations and larger systems is also needed and tools must be made available for systematic assessments.

It is suggested here that every patient care situation and all of nursing practice can benefit from application of a critical interactionist perspective. Moving downstream and upstream, from the individual to larger system perspective and back, is essential to resolving problems in both of these areas. Critical interactionism provides a theoretical base for the dual upstream/downstream and macro/micro approach so necessary for reforming health care. Several examples are described here including care for patients with problems of obesity and lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQQ) patients. Nursing practice issues of workplace bullying and errors are also discussed. In addition, implications of critical interactionism for nursing education and research are described.

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**Table.** Summary of Symbolic Interactionism, Critical Social Theory, and Critical Interactionism

| | Symbolic Interactionism | Critical Social Theory | Critical Interactionism |
|---|---|---|---|
| Discipline | Social psychology | Sociology | Cross-disciplinary |
| Level of focus | Downstream and micro | Upstream and macro | Upstream and downstream, macro and micro |
| Ontology | Pragmatism (originally), Relativism | Critical realism | Pragmatism |
| Epistemology | Subjective, relative to those who observe them (Mead)<br>Reality is socially constructed (interpretivism)<br>Objective relativism (Morris) | Subjectivism<br>Value-laden observation | Subjectivism<br>Interpretivism |
| Goal | Understand human actions based on definitions and meanings they have of world around them | Emancipation, interventions to promote egalitarian balance of power | Understanding and intervening at both downstream and upstream levels examining both meanings and organizational and societal repressive structures |
| Major concepts | Meaning, self, interaction, symbols, acts, perspectives | Power, social class, ideology, oppression, emancipation | Meaning and power<br>Upstream—social class, ideology, oppression, emancipation<br>Downstream—self, interaction, symbols, acts, perspectives |
| Perspectives | Derived from reference groups and orientational others<br>Looking glass self—viewing ourselves as others see us | Ideological hegemony—pervasive dominant thinking that permeates society at all levels | Derived from reference groups and orientational others who perpetuate pervasive dominant thinking |
| View of human beings | I and me, socially constructed, free to make meaning of social world and to choose responses | Socially constructed, limited freedom to choose response, and result of power relations that constrain their responses | I and me, socially constructed, with varying degrees of socially constrained freedom to make meaning of their worlds and choose responses |
| Health | Focuses on individual's experiences of health, illness, and health care and the meanings surrounding them | Focuses on power inequities that manufacture and perpetuate illness and its treatments | Focuses jointly on the individual's and society's contributions to and responsibility for health and illness |
| Actions/ interventions | Defining and reinterpreting situations for more healthy outcomes, individual behavior change | Balancing power inequities, restructure manufacturers of illness to promote health | Changing societal constraints on redefining situations and supporting positive individual behavior change while working to change manufacturers of illness |

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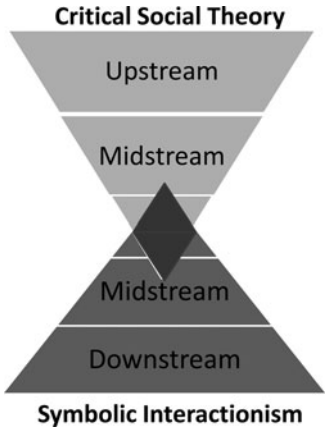


**Figure 1**. Convergence of critical social theory and symbolic interactionism.

### Patient care issues: Patients diagnosed with obesity

According to the Centers for Disease Control and Prevention,[48] research has shown that as weight increases to reach the levels referred to as "overweight" and "obese," the risks for the following conditions also increase: coronary heart disease, type 2 diabetes, cancers (endometrial, breast, and colon), hypertension, dyslipidemia, stroke, liver and gallbladder disease, sleep apnea and respiratory problems, osteoarthritis, and gynecological problems (abnormal menses, infertility). Individual behavior change models have been used extensively for weight loss to reduce the risk of diseases associated with obesity. This individual focus requires lifestyle and behavior change including nutritional and exercise programs along with emotional support. For more immediate results, the health care system has taken a clearly downstream approach in treating obesity with bariatric surgery. It is deemed more cost-effective than treating patients with chronic illnesses associated with morbid obesity. Individual counseling and preparation for bariatric surgery are increasingly used as strategies for morbid obesity that may be more successful than "diets." According to the American Society for Metabolic and Bariatric Surgery.

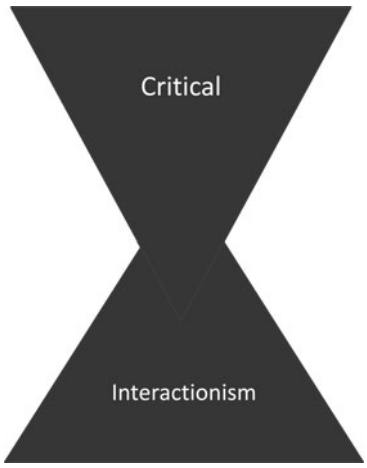


**Figure 2**. Critical interactionism including all of critical social theory and symbolic interactionism.

> "bariatric surgery is known to be the most effective and long lasting treatment for morbid obesity and many related conditions, but now mounting evidence suggests it may be among the most effective treatments for metabolic diseases and conditions . . . . Surgery for severe obesity goes way beyond weight loss. This surgery results in the complete remission or significant improvement of type 2 diabetes and other life-threatening diseases in most patients. . . . People generally don't think of surgery as a treatment for diabetes or high blood pressure, but it is, and we expect metabolic surgery to play an ever increasing role in managing these diseases."[49(p2)]

The focus on a surgical intervention to reduce obesity and chronic illness is a downstream strategy and at the heart of the dominant ideology of biomedical individualism as described by Krieger.[50] It does not address structural factors that contribute to ill health. The upstream preventive strategies defined by McKinlay[1] and Butterfield[2] that address the societal level/political economy of illness is missing. A critical interactionist perspective includes individual strategies focused on treating the immediate problems of morbid obesity such as weight loss and bariatric surgery, while working to prevent the chronic health issues at both the individual and structural level. This would be done by using lifestyle strategies along with system level strategies to target the industries that

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benefit from food products that contribute to poor health. Upstream social marketing factors often work against downstream individual level prevention and treatment strategies. Critical interactionism would move across system levels addressing prevention and treatment downstream and upstream through analysis and interventions with the structural/political/economic factors that contribute to obesity.

### Patient care issues: Patients who are lesbian, gay, bisexual, transgender, queer, and questioning

Lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQQ) populations in the health care system often experience discrimination, stereotyping, and bias from the individual to the system level. They may hide their identities and "pass" to avoid discrimination and even potential abuse from an LGBTQQ-unfriendly health care system. Interventions either at the individual level or the larger system level are not sufficient but must be used together. A critical interactionist approach would recognize the need for changes needed in knowledge, skills, and attitudes with individual health care providers. It would explore the meaning of the situation for the LGBTQQ person experiencing the health care system as well as the changes needed in the system's culture and structure. Nursing strategies with this perspective would include implementing recommendations made by Healthy People 2020[51] that states that LGBT health starts not at the individual level but with the history of oppression and domination.

Examples of specific critical interactionist interventions, at the micro level, are assessment of individuals' needs using definition of the situation to ascertain the meaning assigned to the situation. Habermas' analysis of communication would also be applied, recognizing that all power imbalances are reflected in face-to-face interactions. Behavior can be changed through redefining situations and self-image can be improved through positive interaction with reference groups. At the macro level, the concept of looking glass self expanded to population level often results in homophobia, which is then internalized by LGBTQQ individuals and others; hegemonic forces perpetuate a view of LGBTQQ people as less valuable. At the organizational level, staff education and consciousness raising must occur to counter the hegemonic forces of discrimination. The pervasive assumption of heterosexuality in all encounters must be changed. Emancipation of LGBTQQ people can occur through redefinition of the situation from individual to societal levels and through structural changes of societal barriers and empowerment of the LGBTQQ population themselves. Specific examples of interventions across systems levels are creating welcoming environments with LGBT friendly signs; changing assessment tools to include options for describing partnerships; getting buy-in from administrators, individually and collectively; and changing advertising and Public service announcements to be inclusive.

A critical interactionist perspective would also include addressing strategies that look at the social determinants of health with the LGBTQQ population. These strategies would include developing antibullying policies in schools, reducing legal discrimination related to housing, marriage, health insurance, and retirement, and caring for LGBTQQ elders. Structural changes could also include adding LGBTQQ individuals to the health organizations board of directors and providing symbols of LGBTQQ cultural acceptance with flags and posters.

### Nursing practice issues: Workplace violence and bullying

Workplace bullying and incivility permeate the health care system and are common problems for nurses. This phenomenon is often identified as a "nursing problem." Strategies to address workplace bullying commonly focus on individual behaviors and professionalism. Many articles on the topic use a critical

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perspective and the idea of oppressed group behavior to understand the phenomenon; however, then they continue to identify strategies for individual nurses to change their behavior. Viewing workplace bullying as the nurse's problem places the focus downstream and stays downstream. Farrell,[52] however, used a micro/meso/macro lens to address workplace bullying and interpersonal conflict in nursing. He described the micro level as focused on individual level interaction between persons or on the person/environment duet. Organizational structures and workplace practices were addressed at the meso level. Health care providers focusing at the macro level experience conflict that can be explained by domination and control. A critical interactionist perspective would educate and empower individual nurses to address the problem while move midstream to assess the organizational structure and climate that fosters the issue, and look even further upstream at the oppression of women in society and nurses as a professional group in the workplace.

## Nursing practice issues: Workplace errors

Medication errors are among the most common errors in health care organizations. In the ensuing investigation, traditionally, the focus was only at the individual level with the blame often placed on the individual nurse.[53] Inquiries are misguided because often analysis stays at the individual level (eg, misreading a label) and seldom look at system level factors. Root cause analysis is a widely accepted process promoted by The Joint Commission and others for addressing errors and adverse incidents that occur in the health care system. Its purpose is to find out what happened, why it happened, and what to do to prevent it from happening again. To be thorough, a root cause analysis of errors must use the upstream-downstream approach of a critical interactionist perspective. The analysis includes human interaction factors but it must also include analysis of underlying causes at the organizational level, and identification of potential areas for improvement from the individual to the system level.[54] Through a critical interactionist approach, individual factors including cognitive processes would be addressed along with a systems level of analysis including hospital policy, staffing patterns, orientation programs, organizational communication patterns, quality versus quantity patient care initiatives and other workplace issues. The *Just Culture* model seeks to create an environment that encourages reporting of mistakes so that precursors to errors can be better understood to fix the system issues. Rather than being punitive,

> "a Just Culture recognizes that individual practitioners should not be held accountable for system failings over which they have no control . . . [M]any individual or "active" errors represent predictable interactions between human operators and the systems in which they work. However, in contrast to a culture that touts "no blame" as its governing principle, a Just Culture does not tolerate conscious disregard of clear risks to patients or gross misconduct . . . ."[55(p3)]

This exemplifies application of a critical interactionist framework by moving from the individual to larger system levels to search for the underlying factors responsible for the errors.

This critical interactionist dual approach combining micro level with macro level interventions may not be easily applied. It may create tension for nurses in at least 2 ways: (1) when the good of society (macro) conflicts with what may be good for the individual (micro) and (2) the practical conflict that arises with limited time to deliver quality care at the individual level resulting in no time left for addressing macro issues upstream. An example of the first instance is a person's right to refuse influenza vaccine and getting the flu, thus increasing the spread of infection by exposing many others. Because individual rights and autonomy are protected, others may suffer. Nurses can help resolve this tension through individual education and larger system level interventions such as mass media campaigns to inform people of the

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consequences of their actions and to increase hand washing and protective measures. In the second instance, an increased awareness of interventions at the macro level is needed. Nurses must then make a commitment to address both micro and macro levels and work together to support upstream interventions. Only through an alliance of nurses working at different system levels and supporting each other as they care for individual patients as well will this dual approach be possible. Using this synthesized approach, nurses can care for patients with chronic illnesses related to long-term smoking, for example, while working to change smoking policy at the larger system level. Depression can be treated at the individual level while promoting positive attitudes toward people who are LGBTQQ wherever homophobic attitudes are noted.

As hospitals work to improve quality and move toward magnet status, increased input and autonomy of nurses is essential. As nurses' voices become stronger, the potential for a dual upstream-downstream approach increases and with it, the quality of health care may be transformed

## APPLICATION OF CRITICAL INTERACTIONISM TO NURSING EDUCATION AND RESEARCH

Organizational and system level leadership is needed for high quality patient care according to the AACN Essentials Document of Baccalaureate Education.[7] Leadership skills need to be taught that emphasize micro/individual components such as ethical decision making, effective working relationships, respectful communication, collaboration with interdisciplinary teams, and conflict resolution strategies. At the same time, AACN recommends that nursing leadership education include awareness of complex systems, the impact of power, politics, power, and regulatory systems. To be effective, baccalaureate graduates must be able to practice at the microsystem level within an ever-changing health care system. This practice requires creativity and effective leadership and communication skills to work productively within interprofessional teams in various health care settings.

Educators need to be able to move across levels from individual to societal in when teaching concepts and encouraging critical reasoning. The AACN Essentials of Baccalaureate Education[7] recommends not only health promotion and disease prevention at the individual level but at the population level as well. The Essentials expects the baccalaureate graduate to be prepared to explore the impact of sociocultural, economic, legal, and political factors influencing health care delivery and practice. It is suggested that environmental and population focused nursing education include population level nursing assessment as well.[50] The template for this is not provided but the essential outcomes of baccalaureate, masters, and doctor of nursing practice education include these upstream/structural factors.

Faculty need to guide nursing students to move from the individual to the system/structural level when discussing etiology of diseases, in health assessments, and in organizational analysis. The impact of the sociopolitical environment, system level variables, and health policy in planning health care strategies for individual patients must be incorporated. Educators must also look at new leadership initiatives needed for reforming health care systems that include micro and macro level analysis. Critical interactionism will help future nurses understand system level variables.

Critical interactionism in nursing scholarship and research can be applied in 2 ways to expand individual level analysis to include structural and hegemonic influences. First, nursing scholarship at the individual level, including conclusions drawn from evidence-based practice, can be examined using an upstream lens to look for sociostructural influences on the knowledge generated. One approach is through the use of critical scholarship incorporating an archeology of knowledge provided by Foucault.[56] Using critical interactionism, nursing scholarship can be

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scrutinized to discover issues of power. Foucault's central thesis in *The Order of Things*[56] is that in all periods of history, people have possessed specific underlying conditions of truth that constituted what could be expressed as discourse (including medicine and science).

Second, specific research methods that incorporate a dual approach can be used to generate new knowledge. One method of research that exemplifies a critical interactionist perspective is participatory action research or community action research. In participatory action research, the researcher is actually an interventionist and works closely with the community he/she is "studying" and simultaneously trying to assist. Participatory action research allows for critical inquiry and social justice and to question "expert" knowledge. Nursing scholarship needs expansion and inclusion of critical interactionism in questioning the status quo of traditional research designs.

## CONCLUSIONS

By using a critical interactionist approach, both micro and macro levels come into focus and downstream and upstream strategies for change across individual and societal levels can be developed and applied. Application of critical interactionism to patient care issues and nursing practice offers exciting new opportunities for transforming health care across system levels. It gives nurses added insight into patients' and families' problems at the micro level while giving them a lens to see and tools to apply to problems at the macro level in health care. Developing interventions using a critical interactionist perspective assists nurses to give high quality care downstream at the individual level while also working upstream to address the manufacturers of illness. In nursing education, the AACN Essentials of Baccalaureate, Masters, and Doctor of Nursing Practice guide educators to teach nursing students to assess and intervene across system levels to transform health care. This may be best guided by a critical interactionist perspective. The landscape is rich with new research questions emerging from this expanded theoretical perspective, new possibilities for continued theory development, a new approach to nursing practice and education, and the potential for new practice strategies that can address individual client and larger system problems through empowerment of clients and nurses. Perhaps health care reform can truly be achieved through a creative, persistent application of critical interactionism by dedicated nurses.

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