Introduction
Reflexivity is an invaluable skill for nurses and researchers, as it assists in closing the gap between research and practice and improves nursing practice (Freshwater and Rolfe 2001). Reflexive research can bring the academic researcher and the practising nurse closer together, as nurse researchers with higher degrees have reflexive and critical thinking skills that can benefit their clinical practice (Ramsden 2000, Peerson and Yong 2003).
The question posed in qualitative research is no longer whether to be reflexive, but how to go about ‘doing’ or practising reflexivity (Finlay and Gough 2003). However, although there is agreement about the importance of being reflexive (Etherington 2004, Dowling 2006), it is sometimes difficult to determine what ‘being reflexive’ means or how to demonstrate reflexivity in research (Doyle 2013, Engward and Davis 2015).

Reflexivity has been discussed since Lincoln and Guba (1985) as being necessary for developing rigour in qualitative research. It encourages researchers to monitor their beliefs and personal experiences and the effects of these on research, while enhancing congruency and trustworthiness throughout the research process (Berger 2013, Attia and Edge 2017). Being reflexive is also important in understanding how to situate one’s biography in the context of the research (Hellawell 2006, Davis 2020).

Reflexivity is a component of nursing praxis and assists in building clinical knowledge and improving practice (Timmins 2006, Newman et al 2008). However, reflexivity may be conflated with reflective practice in day-to-day nursing and be poorly understood (Peerson and Yong 2003). Practical examples of reflexivity in nursing literature could assist in differentiating reflexivity from reflective practice, as well as highlight the benefits of reflexivity to nurses and patient care.

Academics and clinicians support closing the gap to bring research and nursing practice closer together (Freshwater and Rolfe 2001, Leach and Tucker 2018). One way to do this is to consider reflexivity in the context of the skills needed to ‘do’ research and articulate the effects for nursing practice. As there is little written about applying reflexivity in research or nursing, the aim of this article is to provide an example of reflexivity in research to demonstrate that knowledge and experiences are transferable to nursing practice.

**Reflexivity and reflecting in research**

‘Reflexivity’ means applying constructive self-scrutiny to recognise and take responsibility for one’s own situatedness in a study (Finlay and Gough 2003). By doing this, researchers can recognise and take responsibility for their own positioning in the research through a type of self-monitoring. This means reflexivity is an active process that challenges the status quo, in which researchers examine their assumptions, decisions, interactions and the potential effects the research may have on others (Berger 2013, Barrett et al 2020).

Reflexivity still has uncertainty associated with it and there is no agreed specific process to follow. Researchers have to develop their own ways of being reflexive (Dowling 2006, Braun and Clarke 2022). Nevertheless, reflexivity appears to consist of three components (Schön 1983, Barrett et al 2020):

1. Reflecting on a situation using ‘reflection-in-action’ (reflecting while practising) and ‘reflection-on-action’ (retrospective reviewing of practice).
2. Creating an outcome or action from the reflection.
3. Considering the outcome or action in the context of the study.

Therefore, reflexivity requires reflection but is different to reflection: reflection is intended to provide insight by looking at an action before or after it took place; reflexivity involves a more dynamic application of the reflected insight to new knowledge and understandings (Finlay and Gough 2003, Davis 2020).

**Reflecting and reflexivity in nursing**

Reflection and reflective practice are built into professional competencies (Nursing Council of New Zealand 2007, Nursing and Midwifery Board of Australia 2021, RCN 2021) as a recognised way to access the knowledge embedded in practical experience (Stein-Parbury 2018). Reflection encourages nurses to think about their actions and interactions in clinical practice and how practice may improve (Taylor 2010, Johns 2017). Nurses tend to reflect...
on their clinical experiences with other nurses informally and this type of reflection may not always be critical, which makes it less likely to result in the development of new knowledge or improved nursing practices (Fowler and McGarry 2011).

Being reflexive requires nurses to go beyond the superficial level of reflecting on incidents to deeper levels of reflection in which they interrogate their own values and understandings (Nairn et al 2012, Jenkins et al 2019). However, it is doubtful that nurses undertake this level of reflective depth, perhaps due to unconsciously holding opposing values at the same time (for example, holistic care and ‘victim blaming’) and lacking the time or supervision to undertake being reflexive in practice (Nairn et al 2012). Yet the literature articulates reflexivity as being a component of nursing knowledge development (Rolfe 2006, Timmins 2006, Reed and Shearer 2011).

One approach to reflexivity is to examine the biases, assumptions and values underpinning nursing practice (Peerson and Yong 2003). Another approach is to have nurses reflect on clinical situations, consider outcomes and act on the resulting outcomes, with these actions contributing to nursing knowledge (Fowler and McGarry 2011, Barrett et al 2020).

As such, reflexivity can enhance nursing practice and can ease what Benner (1982) saw as a tension between theory and the complex realities of clinical practice (Peerson and Yong 2003, Timmins 2006).

Finding the interface

The term ‘gap’ – as in closing the gap between research and practice – is interesting as it refers to a space between research findings and everyday clinical practice. The gap refers to the long-known challenge of engaging clinicians in research findings and applying them to practice (Rolfe 1993, Seymour et al 2003). Reasons for this include nurses being time-poor and overworked, succumbing to the influence of custom and tradition on nursing rituals, and being unaware that knowledge has changed (Leach and Tucker 2018).

Nurse researchers are well positioned to consider an interface, rather than a gap, between the domains of research and clinical practice (Wendler et al 2011). Conceptually, an interface is a meeting point. Finding this interface requires seeing things from a different viewpoint and being reflexive. Reflexivity requires taking a ‘meta-reflective’ stance, which is like the view from a hot air balloon over the domains of research and nursing practice. This balloon ride provides a panorama above the distractions of daily clinical life, which makes it easier to identify the interface between research and practice and make insights about both domains.

An example

The following is an example of exploring the research-practice interface using reflexivity, drawn from the lead author’s experience of working as a palliative care nurse while undertaking a PhD. The process involved three reflexive activities investigating a change in clinical interactions that she had noticed while also conducting research. The first activity involved noticing the change in the reactions of patients and families and identifying the role of research in this change (Box 1); the second related to the change in outcomes, with these actions contributing to research findings and applications to practice (Rolfe 1993, Seymour et al 2003). Reasons for this include nurses being time-poor and overworked, succumbing to the influence of custom and tradition on nursing rituals, and being unaware that knowledge has changed (Leach and Tucker 2018).

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Key points

- Reflexivity is important in research and nursing practice, although there is some doubt about the implementation of reflexive practice.
- Being reflexive generates knowledge about research skills and filtering across the interface between a research project and clinical practice.
- Being reflexive as a researcher and nurse has a transformational influence on improving patient interactions.
- Reflexivity encourages critical, flexible, lateral thinking and innovation.

Box 1. Noticing a change in practice and exploring the reason

I began noticing a change in my nursing interactions visiting palliative patients and families at home. I found myself thinking, ‘That’s interesting. That is the third time recently a patient has given me that kind of feedback.’

The change in my patient interactions was confusing, as for the first time in my years as a nurse, I was getting unsolicited verbal feedback from patients about the benefits to them from our first meeting. Something had changed or transformed in how I related with patients and families – they really wanted to tell me what they experienced in our interactions.

What became obvious when I began investigating this further was that the changes in my communication happened in parallel with my research experiences. I was researching full-time, with one day a week as a nurse in community palliative care. This meant I was interviewing participants and analysing data as a researcher at the same time as meeting patients and their families at home as a nurse. As a nurse researcher, I asked myself, ‘How is this change in my communication affecting my nursing communication practice?’

I adopted a meta-reflective position of reflecting on my reflections to determine what had changed in my communication (Freshwater and Rolfe 2001, Verdonk 2015), and to view how my thinking was influencing my nursing. I considered the research activities of interviewing, transcribing and analysis as potential influences on my thinking and behaviour in clinical practice. Table 1 outlines reflexive journal notes how each of these research activities developed qualities in my communication practice.
to the communication skills developed and enhanced by using research skills (Table 1); and the third examined an example of how the insights gained during a home visit were integrated into practice (Box 2).

**Discussion**

In the example above, being reflexive assisted in generating knowledge about research skills filtering across the interface between a research project and clinical practice. The most difficult part of the process was teasing out what research skills were involved and what was different in the interactions with patients. On the other hand, when these skills and behaviours were identified, the concept of an interface made it easier to think about the transferability of skills and knowledge from one domain to another. Reflexive journaling also provided clues and helped make sense of the changes and insights gained. Being reflexive as a researcher prompted being reflexive about nursing.

One view of reflexivity is that it can result in ‘communication into the deeper domains of human experience’ (Freshwater and Rolfe 2001). The qualities of listening to understand and finding meaning that the lead author developed during her research transferred into practice, creating a sense of really being with the person. ‘Being with’ patients demands that health professionals be comfortable with their own feelings, thoughts and reactions, and manage these appropriately (West 2015). Reflexivity is one way to for nurses to become more comfortable with themselves and, as a result, with the patients and families with which they interact.

Just as who we are and what we bring to research shapes and informs research (Braun and Clarke 2022), the same is true for nursing – who we are as individuals, what we believe, our values, our social identities, our training and our experiences shape and inform our nursing practice. When adopting a reflexive approach to nursing, the first step is to decide to ‘be reflexive’ and to take an active reflective approach, starting with ourselves. Taking an inventory of ourselves to explore the taken-for-granted aspects of social position, education, gender, culture and political

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<th>Table 1. Communication qualities developed by research activities</th>
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<td><strong>Research activity</strong></td>
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| **Interviewing** | As a researcher, I attune to the participants’ verbal and non-verbal responses during interviewing. I often explore the responses participants gave and ask for more information with phrases such as ‘That is interesting. Tell me more about that.’ Taking this approach of ‘exploring’ into clinical practice has been like opening a door for people to talk about their experiences more freely. This works well when I am listening deeply | » Exploring and curiosity  
» Deep listening |
| **Transcribing** | Transcription provides opportunities for practising reflexivity as a researcher. By listening to the recorded interviews verbal (all utterances) and nonverbal (silences, pauses, volume, tone of voice and laughter, breathing and so on), I could recall more details of the participant’s body language. I learned about myself and my rapport-building style by listening to my questions and comments as the researcher. I heard my quickness to fill the void and hurry things along at times. Transcription of the spoken word can pick up a pause or the moment a hidden thing is being spoken of. I can hear and see a turning point in the dialogue. As a result, I have expanded my listening abilities beyond hearing just the words spoken | » Holistic listening  
» Self-critique of interviewing and rapport-building |
| **Analysis** | I am building experience with analysis of data and constructing meaning, which sees many ideas and codes come and go as Post-it notes on my noticeboard. This is an exercise on being fluid and flexible in my thinking, which is different to many clinical problem-solving situations. Bringing this sense of flexibility to clinical interactions relieves me of the self-expectation of having to solve all the problems presented by patients and allows deeper listening to the meaning of what is being said. Researching encourages listening to understand | » Flexibility of thinking and expectations  
» Finding meaning  
» Listening to understand |
influences is the essential beginning of becoming a reflexive researcher (Braun and Clarke 2022), and could be argued to be equally essential for nursing professionals interacting with any patients and families. Reflexive journaling is a recommended way to capture thinking, feelings and changes in approaches in or about clinical situations (Etherington 2004). As well as learning about ourselves in relation to others from the notes and memos in journals, these can also become the basis of research projects, discussions and teaching.

As reflexivity encourages not only critical thinking but also flexible, lateral thinking and innovation, it is well placed as a practice that can develop the critical and creative thinking needed by researchers and nurses to transfer knowledge into person-centred nursing care (Persson and Yong 2003, Seymour et al 2003). Taking the plunge into a more reflexive practice will likely be rewarding to practitioners and their patients.

## Conclusion

Reflexivity is important in research and nursing practice, although there is some doubt how well reflexivity is implemented in nursing. This article provides an example of being reflexive that helps generate knowledge about research skills filtering across the interface between a research project and clinical practice. Being reflexive as a researcher and a nurse can have a transformational influence on improving nurse-patient interactions.

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**Box 2. Distilling reflection into practice**

After reflecting on recent clinical encounters with patients, I could see how each of the research activities of interviewing, transcribing and analysis influenced my communication practice with patients and families. The following is an example of a patient and family encounter where I identified two of the qualities developed during researching: listening to understand and finding meaning (Table 1).

### Example

The conversation occurred with a dying woman and her partner who was experiencing great conflict as ‘the carer’. I met them in their home for an initial visit and we had a complex conversation about the disruption the patient’s dying caused to their lives and their relationship. During the conversation I was aware of a ‘shift’ in both the patient and her partner. It was in later interactions that each person independently spoke to me of the benefits to them of that first conversation:

> You know that first visit to our house! I told you things I had not spoken before. I saw myself differently after that. It has helped me accept things as they are a bit more. (Patient)

> That first time you came and talked with both of us... was when I felt really listened to and seen. It changed things for me. I could see I needed to get more help for myself. (Partner)

During our initial meeting, I felt I had rapport with them both and a sense of trust established. I provided a space for an intimate conversation, giving each of them time to talk and be listened to. That seemed to help them to make realisations about themselves and the difficult situation they were in. We had many other conversations together, but it was that first in-depth encounter that allowed some sort of healing to occur for them both (as reported by them to me).

I reflected at the time that ‘something happened’ but I was not quite sure what, alerting myself to reflect more deeply on this later. I have no sense of saying anything clever or profound. In fact, the moment I perceived that ‘something happened’ was in a pause between the three of us – a silence. It seems that my listening with the intention of meeting them as people and understanding how things were for them was enough to allow some sort of healing to occur for them both (as reported by them to me).

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Reflexivity helped me to identify that the skills I developed in researching had moved seamlessly into my practice:

**Listening to understand**

In the reflective memo after this visit, I wrote that I was not doing or saying anything ‘clever’ or giving advice. This is an insight for me as a nurse, as I can have a lot of important things ready to tell people! Before, I may have been superficially hearing and composing the next question or answer, whereas now, I relax my position of being a problem-solver to one of listening better to tell people! Before, I may have been superficially hearing and composing the next question or answer, whereas now, I relax my position of being a problem-solver to one of listening better to tell people! Before, I may have been superficially hearing and composing the next question or answer, whereas now, I relax my position of being a problem-solver to one of listening better to understand the moment I perceived that ‘something happened’ was in a pause between the three of us – a silence. It seems that my listening with the intention of meeting them as people and understanding how things were for them was enough to allow some sort of meaning-making for them.

**Finding meaning**

One of the most impactful changes I now observe is when patients and families find their own meaning in these interactions, evidenced by the feedback they give to me. This feedback seems important for them to give and adds meaningfulness to my nursing practice.

Learning research skills and being reflexive as a researcher has had a transformational influence on my relational practice as a nurse. The changes are sustained and integrated into my nursing practice.

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