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Autoethnography as a Strategy for Engaging in Reflexivity

Wilma J. Koopman[1], Christopher J. Watling[1], and Kori A. LaDonna[2]

Abstract

Reflexivity is a key feature in qualitative research, essential for ensuring rigor. As a nurse practitioner with decades of experience with individuals who have chronic diseases, now embarking on a PhD, I am confronted with the question "how will my clinical experiences shape my research?" Since there are few guidelines to help researchers engage in reflexivity in a robust way, deeply buried aspects that may affect the research may be overlooked. The purpose of this paper is to consider the affordances of combining autoethnography (AE) with visual methods to facilitate richer reflexivity. Reflexive activities such as free writing of an autobiographical narrative, drawings of clinical vignettes, and interviews conducted by an experienced qualitative researcher were analyzed to probe and make visible perspectives that may impact knowledge production. Two key themes reflecting my values—fostering advocacy and favoring independence and autonomy were uncovered with this strategy.

Keywords

reflexivity, autoethnography visual methods, nursing, chronic illness

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Reflexivity is a key feature of rigor in qualitative research (Berger, 2013; Guillemin & Gillam, 2004). Life experiences and personal characteristics such as gender, race, ethnicity, social class and professional status draw us to our research questions, inform what we ask in interviews, focus what we pay attention to, and shape what we do not consider during the research process (Denzin & Lincoln, 2013; Finlay, 2016). Often confused with reflection, which occurs after the fact, reflexivity is an 'in-the-moment' and ongoing self-scrutiny (Finlay, 2016). Although reflexivity is variably defined (Gabriel, 2015), it is often described as the process of a continual internal dialogue and critical self-evaluation of researchers' positionality (Berger, 2013). Importantly, the researcher is 'having an ongoing conversation about the experience while simultaneously living in the moment' (Hertz, 1997, p. v111). Reflexivity compels us to confront the choices we make regarding the research question, the people we involve in the research process, and the multiple identities that we bring and create in the research setting (Alcoff & Potter, 1993; Lincoln et al., 2013; Reinharz, 1997). The ideal for reflexivity is that this self-appraisal be actively acknowledged and openly recognizable in the research process and product (Pillow, 2003).

But other than being philosophically embraced as a necessary element of rigor in qualitative research, the specifics of how to engage meaningfully in reflexivity are not well defined. Traditional approaches, such as sitting down and writing a reflexive paragraph or two about your positioning, having a conversation about your positioning with your research team, or addressing it post-hoc when writing a manuscript, may result in a superficial impression that misses hidden elements of one's perspectives (Berry & Clair, 2011). Such a cursory overview may fail to reveal implicit knowledge and experiences that may impact research rigor. This is a particular risk for researchers who are also insiders in the research setting they are exploring. That is, researchers who are insiders "possess a priori intimate knowledge of the community and its members" (Hellawell, 2006, p. 484) and therefore may face greater reflexivity challenges (Greene, 2014). For instance, as an experienced nurse practitioner who works in a chronic disease setting, I am now embarking on a PhD, using constructivist grounded theory to understand how patients' stories inform health professionals' knowledge and patient-centered practice. Therefore, I am confronted

[1]Western University, London, ON, Canada
[2]University of Ottawa, ON, Canada

Corresponding Author:
Wilma J. Koopman, Department of Health and Rehabilitation Sciences, Western University, 1151 Richmond Street, London, ON N6A 3K7, Canada.
Email: wkoopma@uwo.ca

with questions like 'how will my personal and clinical experiences influence my research?' and 'can innovations to advance reflexivity be drawn from existing practices?' Autoethnographies embrace the use of personal experiences to examine and/or critique cultural experience (Adams et al., 2015) offering a novel avenue to engage in reflexivity. Robust qualitative research relies on researchers having innovative tools to facilitate engagement in deep reflexivity. Autoethnography (AE) may be one possible avenue.

AE acts as a mirror to examine the researcher's subjective experiences in the cultural context, and it offers a unique lens to engage researchers both emotionally and cognitively to stimulate critical thinking (Peterson, 2015). While AE has the capacity to strengthen reflexivity practices, methodological divides and ethical concerns may hinder and limit personal writings (Wall, 2016). AE writings offer unique opportunities for readers to gain access to otherwise inaccessible private human experiences, such as family relations (Wyatt, 2005), death and dying (Ellis, 1995b), and childhood sexual abuse (Ronai, 1995). But methodological debates about whether AE should be evocative or analytical (Wall, 2016) are ongoing. Evocative AE, pioneered by Ellis (KEEP) favors an 'emotional self-reflexivity' approach to writing stories of intimate personal matters such as loss, or abortion (Ellis, 1995b; Minge, 2007), often aesthetically portrayed in poetry, music or drawings. Analytical AE brought to the fore by Anderson, (2006) extends the subjectivity of evocative AE to also include others, more in keeping with ethnographic research, using a more traditional reporting style. For example, a Chicano activist used experiences that formed his racial identity development and research on transformative teaching to promote social justice (Romo, 2004). As stories of self are intertwined with narratives from other lives, autoethnographic writings are limited by the necessary sensitivities to other people's contribution to the AE. Although permission from ethical institutions to engage in personal ethnographies is usually not required, the risk of having another person's identity revealed without proper consent may cause ethical dilemmas while writing up these stories (Chatham-Carpenter, 2010). Wall (2016) aptly advises researchers to link 'experiences to theory and literature" (p.7) thereby respecting themselves and others. While AE is fraught with legitimate concerns, the exploration of personal perspectives through the lens of culture and self-other interactions suggests a potential for the methodology to inform and improve the practice of reflexivity. Importantly, autoethnography lends itself to artful and aesthetic presentations adding a new dimension to qualitative researchers 'writing' lives.

Using AE before and during the research process promotes visibility of a researcher's perspectives (Darawsheh & Stanley, 2014; Huang, 2015; Spry, 2001). Since the life experiences of 'insiders' are likely to be more deeply intertwined with both their research questions and how they collect and analyze data, the purpose of this paper is to consider the affordances of using tenets of AE to facilitate deeper engagement in reflexivity, particularly for researchers with insider status in their research settings.

Positioning the Researcher

For decades, I have worked in health care as a nurse. My graduate research is centered on the interactions of health providers, patients and their families, a world I am deeply embedded in as an insider. Being so entrenched in a professional context makes it difficult to achieve the depth of introspection required for reflexivity. Introspection does not come easily to me; without a structured approach, my efforts at reflexivity risk lacking the necessary depth and richness required for rigorous qualitive research. While reflexivity in qualitative research is often perceived as an informal process (Cunningham & Carmichael, 2018), I explored the affordances of bringing the formal approaches of AE to bear on the process of reflexivity (Chang, 2008).

Methods

Before embarking on my PhD thesis work, I purposefully engaged in reflexivity to examine how my clinical background will influence my research. To scrutinize both my personal and professional experiences and how they might impact my research questions, methodology, data collection and analysis, I engaged in both narrative autobiographical writing and in drawings of clinical vignettes followed by interviews (Chang, 2008; Cristancho & Helmich, 2019; Ellis & Bochner, 2000). The following questions guided each stage of the methodological process: How do my personal and professional experiences influence my understandings of patients' stories? How might these new insights shape and guide my conduct and thinking as a researcher? My advisors and I created questions aimed at generating insight into experiences that might be similar to those of my patients. For example, how do you manage a family work life balance? What is being a caregiver for ill family members like? And other personal questions such as: What influenced you to become a nurse? What aspects of your clinical work are challenging or complex? Why did you choose to embark on doing a PhD?

To begin answering these questions, I first engaged in autobiographical writing to record aspects of my life experiences that may meaningfully influence my research. I was encouraged to write freely and to add stories of any life events to the autobiographical narrative as they came to the surface. These writings were shared with one of my co-authors (KAL), a colleague and friend who also has expertise in qualitative research and visual methods.

Next, I engaged in two rich picture interviews in which I drew two clinical scenarios with colored markers on large pieces of paper. A rich picture "is a pictorial representation of a particular situation, including what happened, who was

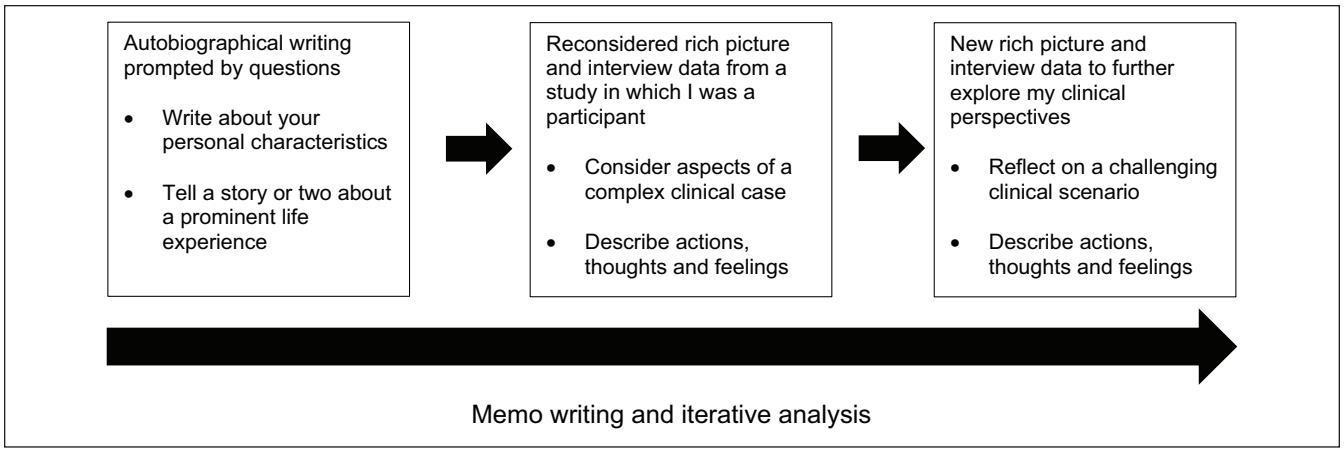


Figure 1. Timeline of data collection.
Note. Each box includes the approach and example of the kinds of specific prompts used.

involved, how people felt, how people acted, how people behaved, and what external pressures were present" (Cristancho & Helmich, 2019, p. 916). Rich pictures may be particularly helpful for supporting rich reflexivity by helping researchers express complex experiences and situations in which aspects of events may be either implicit or difficult to articulate (Cheng et al., 2017; Cristancho et al., 2015; Visscher et al., 2019). For example, in order to uncover experiences from my professional role that may impact my research, I described two complex and challenging patient encounters. These patient encounters provided me with an opportunity to critique my actions when patients requested care outside standard guidelines, generating thoughts of how to truly implement patient-centered care (PCC). One of the rich picture interviews was originally collected as part of a research study examining complexity in health care; with permission from the principal investigator, the visual and interview data were then re-purposed for this AE (Ladonna et al., 2018). The other rich picture interview represented a new care initiative regarding transitioning individuals with congenital chronic illnesses from a pediatric to an adult clinic setting. I presented the drawings in story form to my colleague interviewer (KAL), who in turn asked questions about the pictures to facilitate reflexivity. For example, to probe for hidden perspectives, KAL asked a series of questions such as "is there a specific reason you chose this color to depict the patient, what does the title of your drawing mean, and what does this drawing tell me about you as a nurse? The interviews were audio-recorded and transcribed.

Finally, I analyzed my autobiographical writing, audio recordings and interview transcripts to identify themes. The qualitative data analysis strategy included inductive open coding, thematic clustering and analytical interpretation (Chang, 2008; Maxwell, 2005). Understandings were drawn from analytical activities by searching for recurring themes, looking for cultural themes, analyzing for inclusion and omission of experiences, connecting the present with the past and analyzing relationships between self and others (Chang, 2008). While writing this manuscript, both memos capturing my thoughts about the research process and discussions with PhD committee members, two of whom are included as co-authors on this work, facilitated deeper reflection about the connections between my narrative and the clinical stories that I did not uncover in my initial renderings (Charmaz, 2014). A timeline of the methodological approach is presented in Figure 1. An ethics exemption was received from Western University.

Findings

Exemplars from the narrative data and clinical vignettes are presented to portray the learnings that were uncovered by using AE methodology and rich pictures for reflexivity purposes. While examining the struggles, attending to the silences and making sense of the surprises in the autobiographical sketch and clinical scenarios, I uncovered two overarching themes: fostering advocacy and favoring independence and autonomy. For clarity, I have used italics to signal my personal thoughts and reflections on the data.

Autobiographical Narrative

Possibly, as a result of my experiences as a child of Dutch immigrant parents, tenacity, assertiveness and perseverance are visible characteristics in my personal writings. Stories of participating in hard work with my siblings while holding my own ground are not surprising themes. I wrote "we, three girls and two boys, all pitched in and helped our mom get the chores done while my father worked at the local salt mine . . . as a middle child of five siblings I made sure I was heard and not silenced by the others." And even years later, these personal characteristics remain firmly in evidence, both personally and professionally. For example , at the age of 61 years "I worked hard to qualify and run the world-renowned Boston

Marathon. . .followed by an acceptance into the local university's PhD program." Although I am a mature runner and PhD student, "I was not going to be left behind!" While, I openly embraced the struggles and work associated with my personal and professional successes, *I wonder, how will I hear stories from my participants of unfinished work, lost opportunities, or personal failures? More importantly will I be able to listen to participants' stories with acceptance, curiosity and uninterrupted space?*

Stories of trials, pain, and loss also created opportunities to discover personal understandings important for reflexivity. The passion to care for those in need has its roots in my childhood where I often tended to the animals who were injured or ill on our family farm and I wrote "I could be found giving aspirin crushed in warm milk to cats or dogs who were suffering lost limbs or broken bones in farm mishaps." Broken family relationships, the deaths of close family members and friends, and the evolving dementia in my elderly mother compelled me to be the ear, shoulder or voice that offered comfort and support. I wrote, "Now I am the protective voice for my 96-year-old frail mom who can no longer advocate for herself. I tell her—I've got your back!" Then, *I wonder how I will respond to the stories of research participants who may be suffering alone. Will I be able to listen to their story without shedding a tear or wanting to reach out and comfort them? It is hard for me to hear about suffering without doing 'something' to alleviate the sorrow?*

I realize that it will be very challenging for me to turn off my "nurse practitioner" self and fully engage in being a researcher. While my personal story portrays traits that may potentially hinder an openness to different perspectives, it is not surprising that these peculiarities are also prominent in my professional life. I write "Formal nursing education spanned 28 years culminating in a graduate degree and Nurse Practitioner designation. . .the determination to 'never give up' continues as I pursue a doctorate degree." And then I wonder, *so what? does this really matter? How can this element of perseverance shape my openness to new understandings? Perhaps, the stories I hear from chronically ill patients in my research interviews will be ones where the themes are "I just can't do it." And then I ask myself: Will I accept this?* But more importantly will I understand this? Taken together, I consider this reflexive question—how will my able-bodiedness and tenacity influence how I interact with and perceive those who may be struggling with mobility or fatigue that impacts their ability or drive to advocate or be independent?

Exploring the relationship of personal experiences with culture, and cultural identity is an essential element of both AE and reflexivity (Ellis et al., 2011). My biographical notes include stories of how limited funding for education, how my gender as a woman and how mandated credentialing shaped my personal and professional trajectories. For example, regarding my early nursing education, I wrote:

The transition from secondary education to nursing school began at the age of 17 years (1971). The 2-year nursing curriculum was practice-driven. . . a stipend was provided in return for on-site student nurse services with free food and lodging. . .this was the training norm, while university-based nursing degree programs began to appear in the 1960's. *I wonder how my initial experiences of 'on the job' nursing training will impact my research endeavors? Will I be open to new ways of thinking about health professions education? What about health care? Am I stuck in the past? Will I be open to hearing participants' stories from a futuristic perspective, i.e., from those who do not share in my past? More importantly, will I be curious about perspectives that may not match where I came from?*

While I succeeded in graduating as a registered nurse, the opportunities to maintain up-to-date professional credentialing were challenged by the gender and family norms of the 1970s. I wrote: "I was expected to be a 'stay at home mom'. But . . . in the 1980's, the College of Nurses of Ontario (CNO), our licencing body announced their goal to have all registered nurses achieve a university degree by the year 2000 (Wood, 2003a) and then in 2008, CNO legislated NP licensure." Although I fulfilled some of the norms of the day—for example, my husband and I had five children—I circumvented other standards. I was not, for example, a stay at home mom; instead, I pursued ongoing education and finally achieved university training and a nurse practitioner designation. And so, I wonder why do my doctorate now? My nursing education has been a lifelong endeavor. Is this just another one of my life goals? To leave a nursing legacy. I suppose that is reasonable, but how will this personal aspiration shape how I hear stories from participants who may be unable to pursue their dreams due to the limitations of their illness or other personal circumstances. *Will I appreciate and understand their experiences? Will I even be interested?* While the biographical sketch revealed prominent personal characteristics of assertiveness, determination and single-mindedness, engaging in reflexivity using clinical practice stories uncovered how these attributes are also visible as an insider researcher (Collins & McNulty, 2020; Greene, 2014).

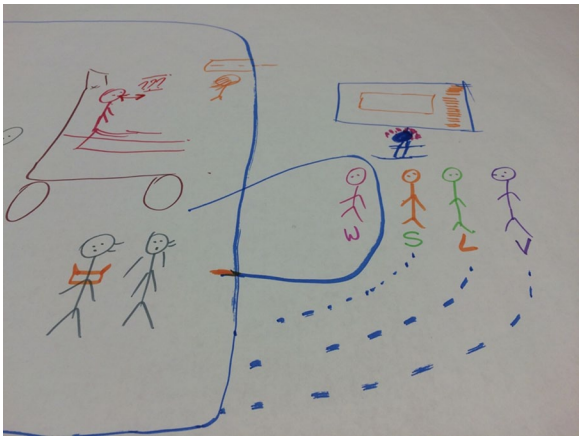
Clinical Vignettes

Since stories of practice encounters create novel opportunities for insider researchers to engage in reflexivity (Egeli, 2017; Gair, 2012; Huang, 2015; Pitard, 2017; Spry, 2001), I embraced the opportunity to delve into some of the questions raised during my narrative exploration. The interviews prompted by rich pictures yielded a wealth of data. While I share one of the rich pictures associated with the clinical scenarios as an example of how the drawings contributed to the analysis and interpretations of the story, the findings will not focus on the aesthetic properties of using drawings but on how the two exemplars uncovered the themes of fostering advocacy (Working Magic)

and favoring independence and autonomy (That's just me) as important considerations for reflexivity.

Exemplar: Working magic. The first vignette recounts a discussion of initiating treatment with non-invasive ventilation (NIV) in an outpatient setting with a gentleman I had known for over a decade. While the trajectory of his illness is one of progressive respiratory failure and death, options to support breathing such as NIV were newly available as a life-extending treatment option. Following a lengthy discussion about the role of NIV in his current clinical situation, he agreed to a treatment trial. Due to the severity of his respiratory symptoms and the complexity of organizing and optimizing the use of NIV, a short hospitalization is a standard requirement. For various reasons, he refused an overnight stay in hospital. I remember thinking, if he does not start NIV today, he may die overnight. The respirologist in this case supported home initiation of NIV if the necessary medical supports were put in my place. That's my job. I thought to myself. . *.its Thursday afternoon before a long holiday weekend, how will I ever be able to have home care in place with extra medical support and monitoring in such a short time*? ***What are the chances that I can work this magic?***

The anecdote associated with this clinical scenario was initially portrayed with drawings in keeping with the method of rich pictures (Cristancho, 2015; Rees, 2018).



The patient is colored red (to indicate an emergency, sitting in a wheelchair with a fan blowing, and the clinic door open while he performs "guppy-like" breathing. His two sons, depicted in grey give him "a reason to live," with an upcoming high school graduation (see orange diploma). His wife (W), the health care team (S, L, V) are located outside his blue circle while we wait to be invited into the conversation. I draw myself, small at the desk with fire coming from my head as I brainstorm solutions for the current challenge.

While the pictorial representation of the clinical scenario was created when I was alone, the story was recounted to my collaborator (KAL) using the drawing and her questioning to facilitate reflexivity. I wrote: "As I gazed at the drawing, I was pleased to see the patient as the central image." When telling this story to the interviewer I said "You know how some patients move into the background? He never moved into the background; he was always in control and central to the discussions. I am relatively small, I facilitated things for him, but he made the decisions."

It was in this moment that I recalled how this gentleman often asked me questions for which I had no clear answers or how he requested help with a problem that had no perfect solution. I struggled with these thoughts and I wrote: *he makes me feel inadequate and intimidated during these conversations. Sometimes, I felt attacked, especially when I couldn't answer his questions—hard questions like: How will I die? Will I be in pain? Will I suffocate? After I attempted to reassure him with my platitudes of "we will do the best for you" he would ask me "how can you know for sure? He made me squirm. I would think "Why don't you ask the doctor? They are supposed to know all the answers." I asked myself, was he taking advantage of my gender as a woman while he is a powerful businessman, or was he taking advantage of our long-term relationship? And yet I wanted to help him. There are no answers to his questions—only silent compassion.* During this exercise I chose to refrain from sharing some of my thoughts and feelings with KAL. While they were too personal to recount here, I reflected about why I left these experiences and details out, and what it may mean about the usefulness of this exercise for reflexivity. I*s reflexivity too emotional for me to do well? I wonder why I can't be completely honest*. While struggles and silences are prominent themes in both clinical vignettes, the second vignette is noted for the uncovered surprises.

Exemplar: That's just me. The second vignette involved a young man with a congenital progressive chronic disease who is transitioning from a pediatric to adult clinic setting. He currently lives with his parents who provide all of his care and they accompanied him to this appointment. He has been in a wheelchair for 8 years. As I begin the conversation about future life planning, I say to him "have you ever thought of a work placement? Are you interested in discussing options about independent supported living?" The parents answer for him. "He will be with us; we take care of him." The patient does not respond. *I am surprised by his silence*. And then I write, *is that what he wants or is this what is expected of them, the parents? Are the parents struggling to both let go of long-standing care responsibilities and seeing their son as an autonomous decision-maker? I feel like both the patient and his parents are trapped in a care relationship that no longer works now that the patient is an adult?* I was frustrated that the patient did not speak up or exert his independence. I reflected on this conversation with KAL. I discovered that "I value independence, and that people who are not

independent drive me crazy. I know I strongly encourage independence in patients as well." My drawing and telling of this story revealed unexpected elements of my perspective as an NP namely, I used words such as "that's just me, that's just how I am," as if that validated my approach in advising him "to move on and be independent." But what does this mean as I begin my research journey? *Will I be unable to hear stories of dependency? How will I react to stories that may not align with my drive for autonomy?*

While the learnings from these pre-emptive reflexivity exercises offered insights into who I am, ongoing intentional reflexivity during the research process will be important to discover and disclose how the themes of fostering advocacy and favoring independence and autonomy shape the understandings of my qualitative research endeavors (Holloway & Wheeler, 2010).

Discussion

Reflexivity is a valued strategy to promote validity and quality in qualitative research, especially for researchers who are insiders (Darawsheh & Stanley, 2014; Denzin & Lincoln, 2000; Holloway & Galvin, 2016; Houghton et al., 2013). In insider research, reflexivity makes transparent the researchers' stance regarding the research question, methodology, process and interpretations (Darawsheh & Stanley, 2014). In this discussion, I will focus not only on what I learned through this exercise and how it will impact my planned PhD research and ongoing clinical practice, but also how the features of this unique approach to AE helped generate these insights.

While engaging in the analysis of my AE interviews, I became more attuned to how individuals shape stories to present themselves to the world. And then I began to think about how my life story will impact my research and my practice. For example, although women's rights, educational grants and lifelong learning are no longer in its infancy, memories of a different time as I described in my autobiography, may close my mind to current perspectives about these challenges. In addition, my personal attributes of determination, tenacity and drive were prominent traits in the clinical vignette "that's just me" raising concerns about how I understand dependency or weakness in less-able-bodied patients. Because my research centers on hearing stories from individuals with chronic diseases, I can no longer disregard the potential influences of my personal tendency to favor independence and autonomy that could limit interpretations of research and practice stories. And specifically, as an insider researcher, with a long history of listening to stories from individuals with chronic illnesses, I may be at risk of dismissing aspects of the research stories as mundane or uninteresting due to their familiarity. In other words, as an insider, I need to be cautious about my nursing lens overpowering the research one. I will need to learn to hear patient stories in a way that's different from how I was trained to do so clinically. Specifically, I need to be mindful that details that might be clinically uninteresting may actually be interesting from a research perspective. While AE offers a novel way to discover important personal insights, the process may also be unsettling.

Reflexivity sometimes reveals hard truths that require opportunities to process and debrief the understandings that are revealed. While I initiated this facilitated autoethnography, the vulnerability I experienced in this undertaking opened my eyes to how research participants may make deliberate choices about what story to share and to whom they will share it. I wrote "Now I truly know what it is like. I have walked in their shoes." I recall instances where KAL 'pushed and poked me' to reveal more of the story during the interviews. And I felt uncomfortable, struggling to tell my stories, perhaps like patients who tell their stories for clinical or research purposes. I have a new understanding of how patients might experience vulnerability during interactions with health care professionals. I remember thinking *she wouldn't understand why I felt unable to continue the story.* I wrote "We live in two different worlds. She is not like me. We did not share the same values." I was worried that she might not understand or empathize with some of the experiences I chose to keep silent about. In some instances, these experiences were particularly upsetting, and I did not want to revisit these incidents again. Other areas of silence were in stories I wished to keep private to avoid feelings of weakness or exposure. In many ways I wonder what I would have shared if the interviewer was a nurse. Would I have shared deeper nuances that surround the challenges of complex clinical experiences scenarios? Nurses often do not know how to communicate what they do as our work lacks articulation and visibility (Allen, 2015). While, I found the AE reflexivity exercise beneficial, researchers choosing to engage in this way should consider the affordances and limitations of those they chose to help them facilitate the process. For example, I chose to use a non-clinician who was an expert in qualitative research and reflexivity. Perhaps the questions asked seemed naïve to me, yet they helped me to think differently about my practice. On the other hand, if I had asked a nurse colleague, I may have been able to overcome the challenges of articulating the ways we think about engaging in patient care. But perhaps having a shared language would have prevented me from un-packing items that are taken-for-granted or implicit in our profession.

As qualitative researchers, our voices are essential instruments for data collection, yet analytical techniques are largely based on transcribed interviews. While some researchers may transcribe their interviews, others may use a transcription service where the nuances of pauses, laughing, or crying may be noted but not heard by the researcher. As I engaged in analyzing the research interviews by audio and text, I was surprised by the sound of my voice. And I wrote "the intonations in my voice are sharp when I was speaking about patient encounters and family interactions. I thought my voice would be soft and caring. I recall feeling empathy for the patients." *And then I asked myself, Are my words*

really that harsh? How will these 'sounds' affect the stories I collect for my research? Efforts at reflexivity may merit thoughtful consideration of how we use our voice to gain understandings from research participants. In addition, the pauses, hesitations, and silences in the narratives may be a lost opportunity for knowledge production when we read transcripts rather than listening to interviews. I remember thinking . . . *Why did I not tell a complete story? Why did I pause? Was I afraid to reveal my true feelings or emotions that may not be characteristic of what a health professional should portray? Are participants also telling us only what they think we want to hear? This may be especially important for researchers who are insiders to think about.* While meaningful, empathetic and gentle questioning during interviews safeguards the experiences of participants (Charmaz, 2014), enhanced reflexivity by qualitative researchers regarding how their interview techniques may unknowingly influence data collection by listening to the audiotapes may also be enlightening (Sinding & Aronson, 2003).

While taking an analytical gaze at the autobiographical sketch and the clinical vignettes interviews, overt struggles, covert silences and unanticipated surprises uncovered prominent life experiences and personal characteristics that I bring to the research process. Struggles were apparent in the stories of finding my voice as a middle child and as an adult while caring for my mother; silences appeared at key moments when my personal narrative was incomplete leaving many secrets untold; and unanticipated surprises included discovering my inner strengths as an age group runner and becoming a PhD mature student. The experience of writing and analyzing my life story suggests that full disclosure of intimate personal details may be impossible, and our efforts at reflexivity may also incomplete. While advocacy, autonomy and independence as a child, woman and nurse were themes in the autobiography, engaging in reflexivity using clinical practice stories uncovered how these attributes are also visible as an insider researcher (Collins & McNulty, 2020; Greene, 2014). As my inner voice is one that values independence, hard work and success as a person and a nurse, I am more sensitized to the perspective that I may bring to the research process especially when collecting and interpreting data. The awareness of how advocacy, independence and autonomy are key personal attributes may prompt deliberate efforts to consider alternate explanations or interpretations for the stories and problems that unfold in the data. With the recognition of a personal tendency 'to jump to conclusions', the possibility that I may project my personal values on patients deserves ongoing reflection in conversations with patients about their needs and goals. Importantly, thoughtful and deliberate accountability of these characteristics in future research are now transparent, enhancing my skills as an interpretive researcher.

Although autoethnographies are generally presented by a single author, for the purposes of reflexivity, facilitated activities may prove useful. There were points along the way, like being interviewed (KAL), writing this paper and having ongoing discussions (KAL, CW) about my experiences, that revealed perspectives necessary to consider during my PhD journey. For example, the drawing and telling of a complex case from my practice jarred my assumptions of how I deliver patient centered care (PCC). Specifically, I was surprised about how I responded to the litany of inquiries about death in the "Working Magic" scenario. I am trained in palliative care, yet I wanted to defer the hard questions to physicians, not meeting the patients' need for an end of life conversation with me. In addition, the questioning and probing around aspects of the drawings such as color choices and individuals' positionings and my thoughts and feelings associated with the pictures and their stories uncovered the realities of how implementing PCC is not always what I really wanted to do—"It's a lot work." The drawings afforded me a tool to dig into not only how I see and do my clinical work from a new vantage point, but also how my ways of caring may impact the research process.

I am not reflective by nature and the 'forced' aspects of confronting the clinical vignettes revealed sensitive and potentially problematic personal attributes. In many ways, for me, the ability to do this type of in-depth scrutiny was essential. Sitting in a room thinking and reflecting on my own, which is often how reflexivity unfolds, would have been shallow and insufficient. For various reasons, researchers and practitioners may chose not to do the often uncomfortable work of reflexivity, possibly limiting the richness of the data and lifelong learning opportunities. The discussions with my co-authors and the use of rich pictures to reflect, think and confront who I am as a person, a nurse and a novice researcher aptly strengthened the outcome of this reflexivity process.

While using analytical autoethnography (Chang, 2008) is a systematic approach to reflexivity, the efforts were time-consuming and emotionally taxing, but also rewarding. This experience humbled me both as a researcher and a nurse practitioner. But it also gave me a very real sense that no matter what I do and no matter what kind of sensitivity I bring to the table, interview participants and patients will shape their stories in the way they wish to or are able to; there may be some limits to what their stories will offer. This insight matters because we often think there is 'something important' in there, and we just need to read carefully through the transcripts. Perhaps, this is a nice reminder that sometimes there are things that are areas of silence and if they were said it may change our impression of what is going on. In addition, this autoethnography fostered in me a kind of empathy for the research participants which may be useful to how I approach qualitative interviews and analysis. Although it may not be realistic for all qualitative researchers and health professionals to undertake such an in-depth method to reflexivity, researchers who are 'insiders' to the topic of inquiry may find as I did that a more comprehensive approach to reflexivity especially useful.

Future considerations for reflexivity. Autoethnography, visual methods and collaborative activities are underexplored

approaches to reflexivity. Given the strengths of using autoethnography for reflexivity, the addition of collaborative and visual activities offers innovative strategies to articulate buried perspectives that require visibility in my future research work. In addition, as an experienced nurse working in hospitals for a long time the cultural aspects of health care including how the work of nurses may be challenging to communicate raises an important theoretical perspective. Using aspects of autoethnography to further explore nurses' work may give voice to an underexplored yet important aspect of how PCC is practiced and taught in health care settings and educational institutions.

Conclusion

In this paper, we present ways to make reflexivity actionable. The tenets of autoethnography (Chang, 2008) coupled with collaborative and creative activities are presented as an example of novel, stimulating and provocative approaches to lay bare the lens of a novice researcher who is also an insider. While the 'work' involved in this reflexivity exercise should not be overlooked, we feel that this effort is worthwhile, as it can yield critical insights that sharpen the analytical lens of the researcher and strengthen the quality of their research.

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ORCID iD

Wilma J. Koopman https://orcid.org/0000-0001-5074-5711

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Author Biographies

Wilma J. Koopman NP MScN is a Nurse Practitioner at London Health Sciences Centre and a PhD candidate at Western University, London, Ontario, Canada

Christopher J. Watling MD, MMEd, PhD, FRCP(C) is Professor, Department of Oncology and Director of the Centre for Education Research and Innovation at the Schulich School of Medicine and Dentistry at Western University in London, Ontario, Canada.

Kori A. LaDonna, PhD is an Assistant Professor in the Department of Innovation in Medical Education and the Department of Medicine at the University of Ottawa, Canada