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**Understanding Reflection:
An Interpretive Study Among Selected Practising Long-Term Care Nurses**

by Nancy L. Brookes

A thesis submitted to the Faculty of Graduate Studies in partial fulfilment of the requirements
for the degree of Doctor of Philosophy

University of Ottawa

May, 2001

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Understanding reflection

Abstract

This hermeneutic phenomenological inquiry centered on the broad questions: how do practising nurses experience reflection? Where, when, and how does reflection enter the experience of practising nurses? Seven long-term care nurses, a culturally cohesive sample, each participated in two audiotaped conversational interviews. Through these conversations, I gathered and explored experiential narrative material. A focus group with long-term care nurses from a different region enabled expansion, clarification and verification of the data. Descriptions and patterns emerged from the texts/data and I linked them to reflection dimensions and four fundamental lifeworld themes. Images of watching a movie, puzzling through, and putting the pieces together, capture the complexity of reflection. Three constructions illuminate the nurses' experience of reflection: reflection and the geography of everyday life; reflection in the between; and reflection *is* relation. These original and innovative understandings address an absence of practising nurses' experiences in the extant literature and contribute to scholarly knowledge. Implications for practice include accepting the challenge from the College of Nurses, reflective inquiry culture and reflection for practice. Reflection is in two modes, annual and everyday. A culture of reflective inquiry frames practice. The nurses act knowledge in practice. There is a curious absence of reflection in action/practice, and an environment unsympathetic to reflection and reflective practice. Reflection in the geography of everyday life is a remarkable contrast to the almost reified conceptions of or formulae for reflection. The language of the everyday characterizes these nurses' experience of reflection. Reflection terminology has infiltrated practice, but it is unclear if practice has changed. Does reflection contribute to improvement in nursing practice and patient outcomes? The intersubjective nature of nursing and reflection is so strong that relationships, rather than individual functioning, might become the primary unit for

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reflecting. In the geography of everyday life, reflection moves from the mountain tops to the everyday. This creates the potential to develop a new and potentially different reflection discourse. This construction provides a direction for developing new ways of speaking in and about practice.

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CHAPTER ONE

Introduction

Let us take a word - reflection. Just what is this - reflection? What does it mean? How is it understood? What is in a word? Words describe things, events, and ideas; more than that, they define relationships. Reflection is a common, every day, frequently used word. Just listen during a class, or attend during a conversation and the word frequently crops up. A variety of meanings for reflection are possible. For example, Webster's Thesaurus (Laird, 1974) describes reflection:

noun 1. [Thought] consideration, absorption, imagination, observation, thinking, contemplation, rumination, speculation, musing, deliberation, study, pondering, meditation, concentration, cognition. See also thought. 2. [An image] impression, rays, light, shine, glitter, appearance, idea, reflected image, likeness, shadow, duplicate, picture, echo, representation, reproduction, see also copy.

verb 1. [to contemplate] speculate, concentrate, weigh, see consider, think; [to throw back] echo, re-echo, repeat, match, take after, return, resonate, reverberate, copy, resound, reproduce, reply, be resonant, emulate, imitate, follow, catch, rebound; [to throw back an image] mirror, shine, reproduce, show up on, flash, cast, or give back, give forth (p. 372).

So many possibilities. However, the College of Nurses has adopted reflection and within nursing and education our understanding of reflection is both expanded and ambiguous. This ambiguity also provides the impetus to seek understanding.

Reflection has a long history as a valued component of professional practice. In the closing decades of the 20th century, rekindled interest in reflection has been apparent in a variety of disciplines (Korthagen & Wrubbels, 1995; Tremmel, 1993). In nursing, a wave of enthusiasm

for reflection and reflective practice is evident. Reflective terminology has entered the discipline of nursing (Andrew, 1998) and Cumulative Index for Nursing and Allied Health Literature (CINAHL) has listed reflection since 1989. Participation in reflective practice has recently become a basic requirement for all College of Nurses of Ontario registrants signalled by their slogan - Reflective practice last year this year every year (CNO, 1999).

To discuss reflective practice, first it is necessary to consider reflection itself (Reid, 1993; Pierson, 1998). In requiring nurses to be reflective practitioners, there is an assumption that we know what reflection is. Espoused contributions of reflection to improving nursing practice pervade the literature, as do strategies proposed to promote reflection. Therefore, we are challenged to explicate the phenomenon of reflection, and to wonder whether reflection is a plausible or attainable reality. One significant unexplored knowledge gap remains: how do practising nurses, in particular, long-term care nurses understand reflection?

This study examines how practising long-term care nurses understand reflection. The investigation centred around the broad questions:

how do practising nurses experience reflection? Where, when, and how does reflection enter the experience of practising nurses?

Long-term care nurses self-selected into this study. We engaged in conversations around the notion of reflection, and we created the data through these conversations. Long-term care nurses described personal accounts of different aspects of living with reflection. My insights are interwoven with these descriptions and these insights and descriptions are drawn into the reflection related literature. Consistent with the hermeneutic phenomenological approach, the rich, detailed data in narratives and texts describe the nurses' experience of reflection. The data

are interpreted to uncover meanings, to understand and to create constructions around these reflection experiences. The nature of reflection as experienced by selected long-term care nurses is explored in this hermeneutic phenomenological study.

Organization

In this first chapter, we look at reflection as the phenomenon of interest in this study, particularly as it is a requirement for registration for Ontario nurses; my special interest is in the understandings of long-term care nurses. I introduce the reader to the phenomenon of reflection, the impetus behind this thesis, as it is presented in the literature. The prevalence of reflection as a topic in the literature is briefly examined and some ambiguities surface. Within the constructivism paradigm, hermeneutic phenomenology is the tradition that frames this study. Finally, I introduce myself to the reader, provide my perspective and some of my values and prejudices. This allows the reader to decide how I may have influenced the study. In the second chapter the conceptual and contextual basis for this thesis is set. The development of the concept reflection is briefly traced. A review of existing models of reflection which lie within their respective discourses suggests some aspects that form an orienting framework for understanding long-term care nurses' experience of reflection. Chapter three details the method used within this study. Interpretation brings together the nurses' descriptions and my insights, interwoven with related literature, in the fourth chapter. In the first part of chapter four, narratives constructed for individual nurses and a focus group represent the nurses' experiences of reflection. The nurses' descriptions are brought into or linked to the dimensions of the orienting framework and illustrated through excerpts from the narratives. The aim of this study is to describe the meaning long-term care nurses ascribe to their lived experience of reflection and to gain a deeper

understanding of this phenomenon. Not surprisingly, through interaction with the material, descriptions of and interpretations around the essential, fundamental themes of lived experiences - lived body, lived human relation, lived time and lived space, emerged as important; descriptions within these fundamental lifeworld themes comprise the second part of chapter four. Finally, in chapter five my insights and learning from this study are presented. Three core areas contribute to the advancement of scholarly knowledge in nursing and education. The essence of the reflection experience for long-term care nurses is found in the geography of everyday life, reflection in the between, and reflection is relation. Implications for nursing practice and for education are presented and areas for further study suggested.

Reflection - The Phenomenon of Interest

In everyday usage reflection is defined as the "act of reflecting or the state of being reflected; the result of reflecting; meditation, careful consideration, thought" (Funk and Wagnalls, 1989, p.1120). The Oxford dictionary defines it as: "mental faculty dealing with products of sensation and perception; idea arising in the mind, mental or verbal" (Sykes, 1986, p. 871). These definitions are not particularly helpful in understanding reflection. Katz and Rath (1985) contend that reflection may be a concept that is simply too big, too vague and too general for everyday use. "Reflection is a concept that is easy to support, but as a practice it is demanding and slippery like a wandering mind" (Williams, 1991, p.13). Benhabib (1986) suggests

reflection is to be understood not as an abstracting away from a given content, but as an ability to communicate and to engage in dialogue. The linguistic access to inner nature is both a distancing and a coming closer. In that we can name what drives and motivates us,

we are closer to freeing ourselves of its power over us; and in the very process of being able to say what we mean, we come one step closer to the harmony or friendship of the soul within itself" (pp. 333-334).

Reflection is concerned with discerning new meanings about our everyday experiences (Garrick, 1996). It may be a generic term for those intellectual and affective activities in which individuals engage to explore their experience and this leads to new understandings and appreciations (Boud, Keogh and Walker, 1985). Richardson (1995) supports reflection as an everyday occurrence, although she identifies a need to demystify it. "Reflection is a normal activity, often mentioned as one form of meta-cognition (thinking about thinking) that occurs both spontaneously and deliberately in adults and children" (Houston & Clift, 1990, p. 209). "We may wish to argue that reflection is a creative art ... it confers benefits to the person which are intrinsic to the pursuit of reflection and are ... not amenable either to empirical support or refutation" (Newell, 1994, p. 80).

The volume of literature on reflection in health care and education, particularly over the last decade, is testimony to the interest in reflection. As early as 1933 Dewey noted that "while we cannot learn or be taught to think, we do have to learn how to think well, especially how to acquire the general habit of reflecting" (p.10). For Kemmis (1985) reflection is not a purely internal psychological process, but action oriented and historically embedded; like language, it is a social process, political and shaped by ideology. In the nursing profession, promoting the concept of reflection and reflective practice, and helping students in reflection is evident in the literature (Dale, 1994; Johns & Freshwater, 1998). MacLeod (1993) speaks to the need to find new ways of understanding nurses' everyday practice and experience. She suggests reflection as

one strategy. Similarly, Morgan (1996) has identified critical self-reflection on practice as the cornerstone of modern nursing practice. French and Cross (1992) maintain that professional practising nurses must be self-reliant, critical and reflective practitioners. Johns (1996) notes the emergence of reflective practice as a major learning milieu, a context for reflection. Clarke, James, and Kelly (1996) suggest that the debate about whether nurses should be reflective practitioners is a sterile one. Nurses will be "obliged" to reflect as this is the way they make sense of their professional world, unless nursing becomes narrowly focused, technical and unproblematic (p. 175).

The College of Nurses (CNO) reminds us that reflection is not something new as most of us reflect regularly on events or situations. However, the frequency and depth to which we reflect differ in practice (CNO, 1996, p. 25). Others suggest that in practice reflection is a complex, multidimensional, challenging phenomenon that may refer to a complex array of methods and attitudes (Pierson, 1998; Reed & Proctor, 1993; Tremmel, 1993; van Manen, 1995). While reflection is common in everyday usage, when used in professional practice, notions such as experience and agency expand the definition. For Ontario nurses this is illustrated in a new program that requires reflective practice.

The College of Nurses of Ontario introduced a quality assurance program as mandated through the Regulated Health Professions Act. This program requires all registrants to participate in the reflective practice component (Witmer, 1997). Reflection is defined as "the process of reviewing an experience in order to gain insight and learning and prepare for future experiences and learning" (CNO, 1996, p.107). A competent professional nurse is expected to practise according to standards, and to engage in reflective practice and ongoing learning in order to

provide appropriate, effective and ethical care that contributes to the best possible health outcome for the client (CNO Communique, 1997, p.8). The reflective practice component directs registrants to engage in self-assessment, obtain peer feedback, and develop learning plans, while keeping personal reflective practice records. This new direction significantly affects the lives of practising nurses. Therefore, it is important to understand more about the nature of reflection, particularly in nursing, the relationship to reflective practice, the effect of such practice on nurses and nurse education, and the relationships among reflection, reflective practice and the experience of nurses.

My particular interest is in learning more about and understanding the experiences of practising long-term care nurses. As a mental health nurse I have practised for the past five years exclusively in long-term care. I provide consultation in four long-term care (LTC) facilities, and mental health education in the Ottawa Carleton region and in a neighbouring county. I am impressed with the thoughtful, committed, caring nursing practice I have observed. The nurses are bright, curious, and interested in their residents and families. They seem particularly suited to their practice area, comfortable in their practice and eager to learn. McBride (2000) asserts that people involved in caring for older adults are at the low end of the career pecking order. There is an unspoken hierarchy operating within nursing that values action areas such as critical care, intensive care, and emergency (pp. 22 - 23). Nolan (1997) considers gerontological nursing a professional priority but wonders if it will continue to be the eternal Cinderella. Gerontology and long-term care share this low end of the pecking order with mental health and psychiatry. Yet, aging brings increasing complexity and long-term care is highly complex, though not "high tech." It is an expansive, synthesizing clinical area as opposed to a traditional specialty

(McBride, 2000, p. 24). Everyday issues in LTC include personhood, end-of-life/palliative care, chronic illness and symptom management, quality of life and quality of care, health promotion and disease prevention, creating prosthetic environments and human habitats, to name a few. I was specifically interested in hearing what the nurses working in this very challenging area had to say about reflection and in representing their experiences.

Reflection - A Complex Activity

Reflection does not lend itself easily to definition. The variety of approaches, definitions and uses that have emerged has created much debate within nursing and education. In speaking of action research, Kalleberg (1990), cited in Holter and Schwartz-Barcott, (1993) termed the resulting confusion "terminological anarchism." This could well be applied to reflection. Reflection appears in the literature without any systematic identification of or debate over its core characteristics or the many diverging definitions, approaches, or uses (see Appendix A). Debates about core characteristics of nursing and the multitude of diverging descriptions are also evident. However, there is a common understanding of nursing as a complex activity. Nurses are required to make informed thoughtful decisions within a process that is not highly predictable, fertile grounds for reflection. Consequently, there is concern with developing the ability to perceive and respond to particular contexts and situations in ways that will facilitate development of informed judgement and skilled nursing. Reflection is suggested as one strategy that if developed, would contribute to that ability.

There is an increasing interest in exploring ways in which nurses learn, particularly through reflection (Atkins & Murphy, 1993; 1994; Darbyshire, 1993; Johns & Freshwater, 1998; Palmer, Burns & Bulman, 1994). For some, critical thinking is a cognitive process grounded in

reflection, with reflection informing practice (Boychuk Duchsher, 1999; Ford & Profetto McGrath, 1994; Jones & Brown, 1993). Reflection may also be found in the literature on such related concepts as experiential learning (Lowe & Kerr, 1998; Saylor, 1990), transformative learning (Brookfield, 1986; 1995; Cranton, 1994; Mezirow, 1991) tacit knowledge (Meerabeau, 1992), meta-cognition (Houston & Clift, 1990) and double loop learning (Greenwood, 1998; McCormack & Hopkins, 1995). Reflection is an aspect of different conceptions of learning and thinking. It is also primary in the notion of learning as transforming experience into knowledge through reflection.

Pierson (1998), echoed by Lowe and Kerr (1998), sees reflection as appropriate for the analysis of practice, a pedagogical method. Reflection is encouraged through contemporary nursing curricula, for example, through experiential forms of education, journaling, and group reflection sessions (Andrew, 1996; Baily, 1995; Burnard, 1995; Carhuff, 1996; Paterson, 1995; Richardson & Maltby, 1995), and critical incident analysis (Brookfield, 1990; Minghala & Benson, 1995; Rich & Parker, 1995). Self awareness, specified as necessary for reflective learning, can never be taught, it can only be learned (Burnard, 1984). Teachers or facilitators of learning cannot teach learners self-awareness but can set up opportunities for developing self-awareness and maximizing reflection.

Johns (1996) recommends helping the learner to expose and confront contradictions while supporting the person to challenge beliefs and habits of the mind through the role of a facilitator or guide. This process is likened to clinical supervision where the supervisor is present to guide and sustain the clinician's development. The clinician's responsibility is to share and reflect upon the meaning of self-selected experiences. The notion of supervision enabling others

"to see through a glass darkly" might be reframed as coaching, mentoring or engaging in genuine dialogue (Watson, 1998, p. 216). Johns (1996) cautions against guided reflection becoming "a technology to produce an ideal worker depending on the intent and emphasis of the supervisor" (p. 1142). Lauterbach and Becker (1996) designate the teacher as coach, partner, and guide, a facilitator of reflection. The teacher needs to be practiced and involved in self-reflection, and connected with a community of students and colleagues involved in conversations about learning. Teachers are mentors and models, modelling the "habit of reflection." Boud et al. (1985) also suggest facilitating learning potential through guided reflection, acknowledging that reflecting on experience may be difficult.

In nursing, a number of approaches have been embraced with the expectation of solving problems in practice: for example, process recordings, behavioral objectives and the nursing process, and now, reflection (Scanlon & Chernomas, 1997). Interestingly, Houston and Clift (1990) describe the problem-solving method (nursing process) as a stage model for solving problems that most people do not use; it is "a mythical model, generalized but not practiced, simple but of no value" (p. 211). Johns (1996) expresses concern that the nursing process encourages stereotyped, unimaginative, decontextualized approaches and conformity. This contrasts with a reflective practitioner who, to respond appropriately in clinical situations, needs to grasp and interpret the meaning of the particular situation while in it. There is a danger that registrants may see this enthusiasm for reflection as simply a passing trend, or, alternately as elevated to the point where it requires special powers (Burnard, 1994). Reflection may be in danger of becoming the new orthodoxy, unchallenged and unchallengeable (Reed & Proctor, 1993). Although there is no evidence to support or refute the claim, there is an implicit view that

each nurse can become a reflective practitioner. A pervasive message is that everyone can acquire reflective skills identified as self-awareness, perception, imagination, and ability to analyze, interpret and synthesize (James & Clarke, 1994). Can just anyone and everyone demonstrate reflection? What would this look like, how would it be recognized? Is reflection a skill, and if so is it learned or innate? Is reflection a habit of the mind, an ability, a disposition? Can reflection be learned or taught?

A common understanding of the term "reflection" is often assumed. Despite wide acceptance of reflection as a specialized form of thinking (Dewey, 1933), considerable lack of consistency, definition and clarity is present in the available literature (Jarvis, 1992; Reece Jones, 1995). Reflection may be equated with problem solving, critical thinking, synthesis, and such. There are different meanings ascribed to reflection, particularly when used as a modifier or adjective - reflective thinking (Dewey, 1933; Pierson, 1998), reflective learning (Boyd & Fales, 1983; Lowe & Kerr, 1998), reflective teaching (Boud, et al., 1985; Lauterbach & Becker, 1996), reflective practice (James & Clarke, 1994; Schon, 1987, 1991), reflective problem solving (Houston & Clift, 1990), and guided reflection (Fisher, 1996; Fowler & Chevannes, 1998). Differences in terminology may be subtle but may refer to different assumptions about the processes and outcomes of reflective activity. In nursing and in education, reflection has come to have more specific meanings. There is generally an affective component, plus a personal, conscious, complex, deliberate process of thinking about and interpreting experience (Boud & Walker, 1991; Reid, 1993). Tremmel (1993) expresses concern that our current understanding of reflection has been influenced by a western cultural heritage that emphasizes analysis and problem-solving. Perhaps there is a "taking-for-granted" that the same understanding is shared,

although the concepts and interpretations are different (Richardson, 1995). Reflection may be overused both in education and in nursing, to the point where it simply means thinking or thinking about something.

There is little consensus about what constitutes reflection or how it could be recognized (Fletcher, 1997). Goodman (1984) suggested that reflection can mean all things to all people. It may be an umbrella term for something that is good or desirable (Liston & Zeichner, 1987) or reduced to the level of "tinkling jargon" through uninformed use (Kotthamp, 1990). Generally, everyone has his or her own interpretation of what reflection means. Reflection may be seen as a process that we all use in everyday life; and reflection may be further developed for specific professional purposes (Scanlon & Chernomas, 1997). Differences in terminology, frames of reference, applications and use make reflection problematic (Kember et al., 1999, p. 22). Reflection surely requires further exploration.

Inquiry Paradigm

An absence of research documenting practising nurses' views and feelings about their experience of reflection, what they deem significant about their experience of reflection is evident. Studies in which the lived experience of reflection among practising nurses was described in depth were sought, but were absent. We know little about how practising nurses understand reflection and what they find meaningful in the experience. Clarke, et al. (1996) argue that any attempt to conceptualize reflection in professional practice must come from the experiences of the practitioners (p. 177). A practice discipline such as nursing is lived. Interestingly, no-one has asked nurses how they experience reflection, if they can articulate it, how they learned about it, how they understand it. Clearly, there is a need to bring the

perspective of practising nurses into the discussion of reflection. What does reflection mean for nurses engaged in practice? How do those who actually live the experience describe reflection?

Constructivism involves a commitment to a belief that reality or meaning is not objective but is created by individuals. It is socially and experientially based, local and specific. This study is grounded in a constructivist paradigm and nested in the belief that there are multiple realities in how people understand their life experiences. Reality cannot be known independently from the creator, but is dependent upon individuals for its existence. It involves an iterative process (Guba & Lincoln, 1994). The constructivist paradigm focuses on "the complex world of the lived experience from the point of view of those who live it" (Schwandt, 1994, p. 118), in this study, the world and experience of long-term care nurses. The inquirer is directly concerned with understanding as nearly as possible some aspect of human experience as it is lived or felt, in this case, reflection; and the inquirer is the research instrument. The inquiry is bound within a particular, naturally occurring context, and in that context the experience has meaning (Schwandt, 1990). The findings are created as the inquiry proceeds. The aim in the constructivist paradigm is to identify the variety of constructions that exist about the phenomenon of interest and bring them into consensus or to reconstruct them. In this study this is accomplished through conversations about reflection with long-term care nurses. Guba (1990) suggests this process has a hermeneutic and a dialectic component, where "individual constructions are elicited and refined hermeneutically, and compared and contrasted dialectically" (p. 27). Through this hermeneutic and dialectic method informed (re)constructions are produced.

Hermeneutic Phenomenology

Qualitative inquiry is an interactive and transformative process, in which the inquirer seeks to learn about and interpret life experiences (Sword, 1999). Phenomenological research is the descriptive approach to the meaning of experience (Ray, 1997). Qualitative methods, such as phenomenology and hermeneutics are specifically suggested as appropriate to study reflection (Brookfield, 1991; Mezirow, 1996). The phenomenological-hermeneutic method has flourished in nursing in part because a language for the concerns, meanings, and practices of nursing may be found within this approach (Barrett, 1998; Benner, 1996).

The perspective of nurses is increasingly entering the literature through reports of hermeneutic and phenomenological studies. Rather (1992), for example, in a phenomenological study among registered nurses returning to study, notes an absence of research on the lived experience of returning students and what they deem significant about their school experience. Through hermeneutic analysis there was a glimpse of the study nurses' experience of reflection. Expertise was achieved through reflective thinking about all the nuances of a situation and its meaning. There remains a need to specify the meaning of reflection for nurses engaged in practice. We need to describe the meaning of reflection from the perspective of those who actually live the experience, grounded in their perceptions rather than imposed from without. One assumption underlying this study is that not all participants in the reflection discourses are heard. Front line nurses have not even been asked how they understand reflection. Do nurses engage in reflection, and we assume that they do. Are the nurses introspective about their practice? Are they conscious of using reflection in practice?

Phenomenological knowledge is empirical, based on experience though not inductively

empirically derived. Phenomenological questions are meaning questions, questions about the meaning or significance of certain phenomena, in this case reflection. Phenomenology places value on lived experience, the meaning of one's living as a person within multiple lifeworlds. Making sense of the world and creating meaning are socially constructed, in ongoing relations between people, through a dialectic process in everyday interaction (Nilsson, Ekman & Sarvimaki, 1998). The process is described as intersubjective. As an interpretive method, the question is not a problem to be solved but a question of meaning to be inquired into (van Manen, 1990). The point of this phenomenological research is to borrow other nurses' experiences to come to an understanding of the deeper meaning or significance of reflection. This is not necessarily a better understanding but a different understanding.

Hermeneutics is described as a systematic approach to interpreting text, human action, customs, and social practices (Allen & Jensen, 1990; Benner, 1985; Dieckmann, Allen & Tanner, 1989, p. 45). Hermeneutics is characterized by circularity and inquiry focuses on exhibiting the interconnectedness of parts within the whole. The whole cannot be reduced to those interrelated parts as it is more than the parts and their interrelations (Malpas, 1992). The individual is not the origin of knowledge, meaning is produced through a "fusion of horizons" between the text and the interpreter, the meaning is in the interaction (Allen, 1996). The goal of hermeneutic analysis is to discover meanings and achieve understanding, not to extract theoretical terms or concepts at higher levels of abstraction (Rather, 1992).

Lived experiences gather hermeneutic significance as we gather them by giving memory to them and through conversations assign meaning (Taylor, 1998). Language is used in interpretation to expose possible meanings in hermeneutics. We develop within a linguistic

environment, as we participate in this environment we reproduce and change linguistic heritage (Peiranunzi, 1997). We acquire understandings about concrete lived experiences by means of language. There is an immediate description of reflection as it is lived and an indeterminate (mediated) description as expressed in symbolic form, through language, in conversation.

Conversations are structured as a triad, a conversational relation between speakers and the notion of reflection. The speakers are involved in a conversational relation with the notion or phenomenon (reflection) that keeps the personal relation of the conversation intact (van Manen, 1990).

Gadamer (1975) describes the process of conversational interviews as having a dialogic structure of questioning-answering. Every time a view is expressed, one can see the interpretation as an answer to the question that the object, topic or notion of conversation asks of the persons who share the conversational relation. Conversation has a hermeneutic thrust. It is oriented to sense-making and interpreting. The art of the researcher in hermeneutic interviews is to keep the question (of the meaning of the phenomenon) open, to keep oneself and the interviewee oriented to the substance of the thing being questioned: "the art of questioning is that of being able to go on asking questions, ie. the art of thinking" (Gadamer, 1975, p.330).

Researcher Horizon and Prejudices

Fusion of horizons and prejudice are two metaphors for understanding within the hermeneutic phenomenological tradition. Horizon includes everything that can be seen from a particular vantage point. It incorporates one's background, meanings and frame of reference. Horizons are temporal and are always in motion. Fusion is the coming together of different vantage points. This requires that I as the inquirer have a willingness to open myself up to the

standpoint of the participants so I can let their standpoint speak to me and influence me (Higgins, 1998). Within this tradition, my horizons as the interpreter, my personal and professional background, interpretations within my study journal, and the interpreted and selected literature are fused to create new understandings or constructions (Hekman, 1984). Prejudices are the conditions by which we encounter the world when we experience something, the value positions we take with us into the research process. The nurses bring their pre-understandings (horizons) and prejudices and I bring my pre-understandings and prejudices to this study. Gadamer states that "... the hermeneutic attitude supposes only that we self-consciously designate our opinion and prejudices and qualify them as such, and in doing so strip them of their extreme character" (1976, p. 152).

This research process is shaped by my own biography, and my personal awareness of the influence of my self is an important consideration. I am not merely a neutral observer but an integral part of the generation of knowledge (Rose & Webb, 1998). My personal awareness, experiences, perceptions, and interpretations, my self, influence the research process. They affect everything from the choice of topic (reflection among nurses), to the choice of method (hermeneutic phenomenology) and through the interpretation of the data (Sword, 1999). The posing of the question came from my life, wondering about reflection. Like all Ontario nurses, I was aware of being exhorted to reflect upon practice by the College of Nurses. What does this mean? How do we understand this?

Within the inquiry process, my voice is that of a "passionate participant" (Nilsson et al., 1998). This is a logical extension of my interest in, my passion as a psychiatric and mental health nurse, and as a person, for understanding persons from their perspective and learning from

others. My practice is not objective and detached but involved and participative. I use myself as an instrument for healing and work with people through relationships. In a sense, I become unsure, questioning, wanting not to explain but to understand meaning. "I understand my experience through pre-understandings (prejudices) which situate me, which make me the kind of person who projects the kind of meanings that I do" (Usher, 1993, p. 170). The word question comes from the Latin *quaerere*. Within this study my quest is to understand how long-term care nurses describe reflection, to understand their meanings through asking, seeking, inquiring, and writing; in particular writing in a way that captures the essence of the nurses' experience of reflection.

My choice of topic arose from the strongly held belief that practising nurses have been neglected in the discussions around reflection and reflective practice. I was aware that my *etic* (outsider) theory of inquiry might have little meaning within the *emic* (insider) view of these nurses. Perhaps the nurses' experiences and understandings of reflection might not be congruent with extant frameworks or theories, at least not in all respects. My desire to represent their perspective through a hermeneutic phenomenological lens represents another bias. My many years of disciplinary training in mental health have focused on nursing as an interpersonal process, the therapeutic use of self and self-awareness. This is congruent with the choice of hermeneutic phenomenology as an interpersonal, interactive process and method. This is congruent with my recognition of my lifeworld stance that sees persons as ontologically hermeneutic. Interpreting experience and finding meaning is a foundational aspect of being, understanding an existential-ontological characteristic of human beings (Peiranunzi, 1997).

My prejudice is evident in the valuing and highlighting of experiential and constructed

knowledge. As well, there is a recognized bias in the selection of long-term care nurses to participate in this study. I see this group of nurses as innovative, creative, resourceful, highly skilled specialist practitioners who have much to contribute to discussions of reflection and reflective practice. These long-term care nurses are aware of my belief that long-term care is a specialized practice. They are also aware of my respect for and admiration of the work that they do, particularly within the current constraints of the health care system. This may also be construed as prejudice on my part. In addition, I assumed that these nurses could engage in conversations around reflection and that they were historical, traditional and embodied beings.

I was aware that the academic background from which I came differed from that of the participants and would influence my attempting to understand and interpret their reflection experience. I had the advantage of familiarity with the various discourses around reflection in the literature. Through my studies, I gained knowledge of the history of reflection and reflective practice in nursing and in education, the variety of extant models, definitions and descriptions. My career path differed with respect to education, although my initial preparation was at the diploma level, I am an advanced nurse practitioner. While specialized in mental health and psychiatry, my sub-specialty is geriatric mental health and psychiatry and I share long-term care as a practice setting. We also shared gender, social class, and in a general sense, ethnicity. In addition, I share with the participants the same requirements related to the College of Nurses. I live in a shared nursing culture, and carry a common (but not identical) repertoire of skills and knowledge. My own experience, in terms of historical, cultural, personal and professional background (horizon), and the "fusion" with those characteristics of the participants, contribute to understanding (Gadamer, 1979).

In hermeneutics, understanding is characterized by pre-understanding or foresight into reflection, which is the topic of inquiry. Circularity exists in that there is no way to understand without already having some prior understanding. To describe a term or articulate a phenomenon there must be some prior comprehension of the phenomenon of interest. Through practice, familiarity with the CNO standards, and immersion in the reflection discourses, I had some knowledge about reflection. I knew that reflection was described in many ways, with different meanings and little consistency. Reflection in the nursing literature has been consistently seen as central to learning from practice. Based on common background meanings given by nursing culture and language, I had a preliminary understanding of the phenomenon of reflection (Leonard, 1989). However, I wondered

how do practising long-term care nurses experience reflection? Where, when, and how does reflection enter the experience of practising nurses?

The final analysis is left to the reader, to form his or her own insights regarding reflection among long-term care nurses.

CHAPTER TWO

Conceptual Context for Reflection

In this chapter, I place reflection in a context that includes the evolution of the term, particularly as it relates to practice. Several discourses surround the phenomenon of reflection. Reflection-as-problem-solving represents the underpinnings of the most dominant view. Reflection-as-experience, reflective practice and reflection as critical inquiry, represent different perspectives, and are prominent in recent writings about reflection. Reflection as mindfulness or a habit of the mind is another discourse, just outside the mainstream. It represents a different perspective and expands our understanding. The pervasive influence of reflection in nursing at both a global and local level is briefly examined. However, reflection is also surrounded by much rhetoric and some of this is highlighted. Selected attributes or dimensions that figure in most writing around reflection are extrapolated and reviewed. These form an orienting framework in which to locate the data. Finally, several extant frameworks of reflection are presented as are studies in which reflection is addressed.

Evolution of Reflection

The notion of reflection is not new. Early philosophers such as Aristotle continue to influence thought and action in contemporary times. Reflection can be traced back to Aristotle's discussions of practical judgement, moral action and wisdom. Wisdom included knowledge plus the ability to analyze situations, recognize nuances, to think divergently and to propose solutions (Houston & Clift, 1990). Aristotle "recognized the fundamental limitations of reflection when claiming that intellectual activity itself can achieve nothing, instead he implies that practice professions must adopt a form of intellectual activity that aims at some end and is practical"

(Lauder, 1994, p. 92). Clearly, earlier notions of reflection suggest a purely cognitive or intellectual activity akin to contemplation, devoid of any sense of agency, affect or of the practical. It also suggests some limitations for using reflection in practice. However, this also foreshadows the reflective practice movement, where reflection is concerned with the practical. One might wonder why it took so long to arrive!

Sawada (1991) notes that Harry Garfinkle historically traced major shifts in Western consciousness since 1425 and places reflection as a major form of consciousness emerging in the period 1575-1658 (p. 364). According to the Oxford dictionary reflection takes on a modern, cognitive meaning only in the Enlightenment. Locke's definition of reflection as "that notice which the Mind takes of its own Operations" suggests belief in autonomy and introspection, and introduces self-examination into the act of knowing (Michelson, 1996, p. 443). Equally important to reflection, although largely absent in the literature, is the enriching influence of, for example, Eastern and feminist thought. Here, reflection is not limited by means-ends or rational thought and problem solving. It is not a method or strategy, but a way of life (Tremmel, 1993). Reflection has a relational and ethical quality (Noddings, 1984). This perspective, which also supports reflective practice, resonates for some.

The contemporary view of reflection as a way of thinking is generally attributed to Dewey (1933). He described it as "the active persistent and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further considerations to which it tends" (p. 9). This description, still important, remains in the level of thinking about things in a particular scientific, problem-solving way and introduces a sense of agency. The 1980s saw a flurry of interest and writing around the concept of reflection and

further expanded the notion from that of quiet contemplation to a more active nature, purposeful and deliberate. Mezirow (1981), for example, introduced the notion of critical reflection. Schon (1983) addressed the central role of reflection in professional practice, as a link between theory and practice, an epistemology of practice. The reflective practitioner movement was born.

The significance of reflection in learning was highlighted in the mid-eighties. Kolb (1984) described an experiential learning cycle where change and growth are facilitated by cyclic processes. Cyclical relationships are among four modes of learning and include concrete experience, reflective observation, abstract conceptualizations, and active experimentation. Reflection is one element in experiential learning, from which behaviour may be modified to aid new experiences. "Learning is the process whereby knowledge is created through the transformation of experience" (Kolb, 1984, p. 38). Although this learning theory is frequently used in nursing and education, and underscores much of the writing about reflection, it does not figure prominently or explicitly in the reflection discourses.

Boud et al. (1985) and Boyd and Fales (1983) provided key definitions of reflection, particularly reflective learning. These are now widely accepted and underpin much of the work on reflection. For Boud et al. (1985) reflection is a generic term for "those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to new understandings and appreciations" (p. 19). Boyd and Fales (1983) describe reflective learning as "the process of internally examining and exploring an issue of concern, triggered by an experience, which clarifies meaning in terms of self, and which results in a changed conceptual perspective" (p. 100).

Perspectives of reflection differ as to the contexts, focus, and nature of the material that

forms their basis. Lauder (1994) suggests that the reflective movement might even be better served using Aristotle's notion of practical wisdom and practical syllogism. However, the notion of learning from experience through reflection is common in the evolution of the concept of reflection and this is congruent with the various discourses.

Reflection Discourses

Reflection is a dominant discourse in the literature of practice professions and the rhetoric around reflective practice is pervasive (Korthagen & Wubbels, 1995). The same emphasis is happening in nursing, with effects on research, curriculum planning, views on sources of knowledge and generally in debate and discussion of nursing practice (Adler, 1991). "Everyone, no matter what his or her ideological orientation, has jumped on the bandwagon ... and has committed ... to furthering some version of reflective teaching practice" (Zeichner, 1994, p. 9-10) or reflection in nursing (Baker, 1996; James & Clarke, 1994; Johns & Freshwater, 1998; Mallik, 1998) with the potential for entrapment in this rhetoric (Glen, Clark & Nichol, 1995). Perhaps reflection has been popularized to the extent that it is insufficient, meaningless, a cliché, or at least ambiguous (Reed & Proctor, 1993).

Five reflection discourses are reviewed in this section. These move from Deweyan reflective thought, to incorporate experience as a basis for reflection, into reflective practice and critical reflection. Finally, mindfulness, a different perspective not captured in the first four discourses is introduced.

Reflection As Thinking and Problem Solving

Dewey's (1933) view of reflection is thinking towards the solution of problems, and includes analytic means-ends formulation of thought. Education is training one's powers of

reflective thinking. Reflective thinking, the process between the recognition of problem and its solution, is described as five stages: suggestions for a solution; clarification of the essence of the problem; the use of hypotheses; reasoning about the results of using one of the hypotheses; and testing the selected hypothesis by imaginative or event action (Dewey, 1933, pp. 6-8). Within Dewey's science of education, reflection begins when one defines an issue as problematic. This analytical method stresses objectivity and detachment. The person stands back from the situation, analyzes it, recognizes nuances within it, and proposes solutions which are then tested. This is very much a rational planning model. Openmindedness, responsibility and wholeheartedness are seen as characteristic attributes. This formulation is mirrored in the nursing problem-solving process but Dewey's ideas have not been an explicit part of the dominant discourse in teacher or nurse education (Adler, 1991).

That is not to say they have not been influential. The language of reflection is dominated by Dewey's formulation which emphasizes an analytical method and objectivity. Grimmett (1988) calls this "the ghost of Dewey" (p. 6). In this discourse, reflection is an analytic process guided by a hypothesis-testing model of problem-solving.

Reflection and Experience

Reflection has emerged as crucial to experience-based learning (Lowe & Kerr, 1998), which encompasses formal, informal, non-formal, lifelong, incidental, and workplace learning (Garrrick, 1996). In adult learning theory experience is probably the major theme of contemporary discussions (Michelson, 1996). There is a distinction or duality between experience and reflection. Experience is the raw material for learning and reflection is the cognitive process in which or through which learning takes place.

Mallik (1998) identifies an ideology of learning from experience through reflection, a theory of learning. In learning from experience one is able to generate alternate ways of viewing a situation or experience. Reflection is operative when individuals explore their experiences and this leads to new understandings and appreciations (Boud et al., 1985, p. 19). Boyd and Fales (1983) describe reflection as triggered by an experience, which results in a changed conceptual perspective (p. 100). The notion of experience in relation to reflection is highlighted. Reflection is not an end in itself but preparation for new experience. Experience happens first, reflection is the processing phase (Michelson, 1996; Stockhausen, 1994). This implies an action or goal orientation, as well as an interweaving of feelings and cognitive abilities. Individuals are in control of the activity. Reflection can take place in isolation or in association with others.

Boud et al. (1985) assigned key stages to the reflective process itself: a) returning to and describing the experience, which allows for attention to the significant elements of the event; b) attending to feelings which will clarify what might help or hinder learning, allowing re-evaluation of experience; c) re-evaluating experience through association and integration with previous learning; and d) through validation making learning their own (appropriation). Reflection transforms experience into knowledge.

Reflection is an essential part of the process of learning to nurse. There are numerous theories of learning and all emphasize the importance of learning through reflection from experience as well as from theory. The underlying assumption is that the reason for reflection is to make sense of experience; the sense that emerges becomes the kind of knowledge that may be recalled and used on other occasions (Taylor, 1998). This discourse presumes that knowledge is extracted and abstracted from experience by the processing mind; reflection on experience

towards the creation of knowledge. Reflection is a strategy for significant discovery learning (Shapiro & Reiff, 1993). Learning is seen as a change in the meaning of experience.

Reflective Practitioner

Reflective practice is proposed as an organizing framework for professional practice. The central role of reflection in the context of professional practice pervades the nursing and education literature. The reflective practitioner view is generally seen as an epistemology of practice (Schon, 1983). The reflective practitioner is one who can think while acting thereby responding to the uncertainty, uniqueness and conflict embedded within professional practice situations. The reflective practitioner is concerned with the practical. This contrasts with technical rationality which holds that "practitioners are instrumental problem solvers who select technical means best suited for particular purposes" (Schon, 1987, p.3). Taylor (1998) describes reflective practice as "the systematic and thoughtful means by which practitioners can make sense of their practice as they go about their daily work" (p. 138).

In nursing, James and Clarke (1994) identify three phases of practice in the historical evolution to reflective practice. Initially, nurses engaged in habituated, ritualistic practice where there was little attention to rationale, little encouragement to question or reflect on practice. Nurses worked within authorized structures, accepted the status quo and focused upon immediate demands. The assumption of empirics - what is known is that which is accessible through the senses - that which can be seen, touched and so forth followed. In this mode, nurses work deliberatively and with empirically validated knowledge; they function in a prescriptive diagnostic mode. Empirical knowledge, generated and tested through the scientific method evident in nursing, is important and necessary for the continued support of medical advances and

the evolution of newer and safer technical procedures. Feelings, beliefs and support are viewed as less substantive than hard data from laboratory reports, for example (Visinstainer, 1986, p. 37). This forms the basis of research-based practice and the "knowledgeable doer," but not the reflective practitioner. Reflective practice has many dimensions and facets making description difficult. Technical problem solving is incomplete. In the third phase tacit knowledge and intuition are also required for reflective practice, and the importance of the artistry of professional action is acknowledged (James & Clarke, 1994, p. 83). Reflective practice redresses the imbalance between science and artistry. In this discourse reflection before and after "action" is an important mental process necessary to transform experience into knowledge.

Schon introduced a time dimension with reflection-in-action and reflection-on-action, where thinking precedes and follows action. Two types of knowledge are also identified: knowledge used in action or in practice which may be intuitive and difficult for practitioners to articulate; and knowledge based "on action" in which academic/theoretical knowledge is entwined. Reflection-on-action is a commonly accepted description of reflective practice and is one of the two types of reflection within this discourse. Schon (1983) proposed reflection while action is occurring as the type of reflection that should characterize professional practice; also that practitioners stand back from their everyday practice and try to identify what problem-solving processes they used. Practice is based in part on previous experiences interacting with a particular situation (reflection-in-action). Schon (1983) urged a search for an "epistemology of practice implicit in the artistic, intuitive processes which some practitioners bring to situations of uncertainty, instability, uniqueness and value conflict" (p.49).

Schon's formulation moves the discourse away from "applied science/knowledge" or

application of theory, which have dominated, to practise-based knowledge and practical or practice theories. The ability and willingness to reflect on one's practice is valued as a means of dealing with the complexities, challenges and uncertainties inherent in professional practice (Sumison and Fleet, 1996). The metaphor of artistry is highlighted in Schon's (1983; 1987) formulation. "In the terrain of professional practice, applied science and research-based technique occupy a critically important though limited territory, bounded on several sides by artistry" (Schon, 1987, p. 13).

Reflection As Critical Inquiry

Mezirow, in his seminal 1981 article, brought Habermas' (1970) categories of cognitive interest into the adult education and nursing literature (Connelly, 1996). This critical social theory perspective emphasizes the emancipatory potential of critical reflection. The perspective of reflection as critical inquiry, questioning the otherwise taken-for-granted, is echoed in the work of Zeichner and Liston (1987; 1990). Three knowledge constitutive cognitive interests influence actions: the technical (concerned with instrumental action); the practical (concerned with clarification of conditions for communication and intersubjectivity); and the emancipatory (concerned with moral/ethical, social and political reality and its implications for self-knowledge). Taylor (1998) asserts that the language of reflection is typically of a critically reflective nature. By itself, reflection is not necessarily critical (Brookfield, 1995; Ecclestone, 1996). It requires moving beyond the acquisition of new knowledge and understanding, into questioning of existing assumptions, values and perspectives (Cranton, 1996, p. 76).

Unlike Dewey, Mezirow (1981) differentiates the type of reflection, the nature of the problem itself, the process of problem-solving and the premises or presuppositions. The latter

pertain to problem posing or making a taken-for-granted situation problematic, raising questions regarding its validity (Mezirow, 1991, p.105). Premise reflection distinguishes Mezirow's framework and places it in the critical social inquiry perspective. Experience and learning are also evident in this formulation: "to the extent that adult education strives to foster reflective learning, its goal becomes one of either confirmation or transformation of ways of interpreting experience" (Mezirow, 1991, p. 6).

The seven levels of reflectivity are grouped. The first four levels are considered processes of consciousness and the last three are the products of critical consciousness. The seven levels of reflexivity also divide into three types of reflection. Content reflection is on what we perceive, think, feel or act upon. Process reflection is an examination of how we perform the functions of perceiving, thinking, feeling, or acting and an assessment of efficacy in performing them. Premise reflection is becoming aware of why we perceive, think, feel, or act as we do, transforming our meaning framework and opening the possibility of perspective transformation. Mezirow also distinguishes three types of non reflective action: habitual action, thoughtful action and introspection (Mezirow, 1991, pp. 107 - 108). In this discourse the person is an autonomous rational knowledge-making self (Michelson, 1996).

Reflective thinking may also encourage a holistic, individualized and flexible approach where all knowledge is viewed as useful for some purpose (Burrows, 1995; Chinn & Jacobs, 1987). This holistic view where reflection is a way of life characterizes the final discourse.

Reflection as Mindfulness

Unlike other discourses in which reflection is bounded by rational mental processes, this perspective introduces the issue of the mind into the discussions of practice. It leads to a focus on

the mental processes that support reflective practice (Calderhead, 1989; Clift & Houston, 1990; Tremmel, 1993). Within this discourse, reflection is variously called an attitude, a way of life, even a way of being, a habit or state of mind, a disposition, mindfulness, intuition, embodied knowing. Rolfe (1998) suggests intuition as a form of conscious mindlessness. Consciousness is recognized as an attribute of reflective decision-making (Colton & Sparks-Langer, 1993). An expert practitioner responds to situations appropriately and with great skill. Intuition is highly sophisticated and holistic processing of information (Freshwater, 1998). Intuition as a manifestation of tacit knowledge, or knowing embodied, may be unable to be expressed in rational ways. Here, knowledge is substantive and internal. In contrast, Langer (1989, 1997) describes mindlessness as thought and action entrapped by reified categories and habitual automatic behaviour. One form is an outcome orientation that focuses attention away from the present toward fixed requirements for the future. The use of the term mindlessness illustrates one instance of ambiguity in terminology, where a term carries opposing meanings. Even the naming or categorization of this discourse is problematic!

Tremmel (1993) proposes the notion of mindfulness. This involves preparing our minds as an initial step towards reflection and using the art of paying attention as a way of nurturing reflective practice. Watson (1998) speaks to the need to be more aware, more mindfully, authentically present; "to be still, to find one's quiet centre ... to hold a conscious stillness towards self and other" (p. 217). "Receptive attending requires openness, heightened awareness, and a questioning frame of mind" (Moch, 1990, p. 155). An emphasis on negotiation, contemplation or enlightenment is supported by Clift and Houston (1990, p. 211). Mindfulness is extended to encompass the entire practice of living. Tremmel (1993) suggests that the ability to

reflect mindfully is the practice of a lifetime that just begins with initial professional education, perhaps even before this.

Within the ways of knowing in nursing, Munhall (1993) has advanced the notion of a pattern which paradoxically is unknowing. This parallels Varela, Thompson and Rosch (1991) who describe the mindfulness traditions of reflection not as skill acquisition but as letting go of habits of mindlessness. This is an unlearning rather than learning that requires a different effort from acquiring something new. In letting go rather than trying to achieve some particular state, body and mind are naturally coordinated. Mindful reflection is then a completely natural activity and reflection is the experience (p. 29).

Within this notion reflective practice would be intuitive, emerging out of the self rather than being rule bound. Reflection is initiated by paying attention to the salient features of a situation, which include self. Mindful practitioners attend to their own physical and mental processes during ordinary tasks and act with clarity and insight (Epstein, 1999; Langer, 1989; Varela et al., 1991). Where reflection is about the appraisal of work, that is, reflective practice, certain knowledge, skills and competence are required. Knowledge of self requires both insight and courage and courage is perhaps the most important. Reflection as a iterative process not reducible to separate elements, introduces tension between the holistic view and the more linear, analytic views. People may be helped to change the way their minds work so they are prepared for reflection. This is a different notion from changing their minds in the perspective transformation or changing perspective sense. In this discourse, reflection may be ungraspable as conceptual frameworks and structures found in academic discourse (Tremmel, 1993, p. 442).

van Manen (1995) describes a union of knowledge of the reflective method and reflective

attitude plus a habit of thinking in a reflective way. Benhabib (1986) suggests reflection is "not as an abstracting away from a given content, but as an ability to communicate and to engage in dialogue. The linguistic access to inner nature is both a distancing and a coming closer" (p. 333). Noddings (1984) suggests that in interaction, rather than viewing persons as objects, we attend to their subjective natures. Reflective thinking would then become a process of trying to understand persons and to see the world through their eyes. Such a view establishes an ethical and relational aspect to reflection. This also places reflection in the very contemporary context of patient-centred care where the focus is understanding the meaning of the person's experience (Mitchell, Closson, Coulis, Flint, & Gray, 2000).

Summary. Tremmel (1992) cautions against the possibility of the general and fluid process that is reflection, becoming reified and reducing reflection to a decontextualized and universal formula. These discourses, thinking on problems, reflection on experiences, reflective practitioner, reflection as critical inquiry and reflection as mindfulness each provide a different perspective and context for understanding reflection. The forgoing discussion illustrates that each discourse is based upon different assumptions and ideologies. Each of these discourses can be found among the discussions of reflection and reflective practice that pervade the nursing literature, although the specific perspective is often not explicitly identified. What does this mean for nursing?

Reflection In Nursing Globally and Locally

In nursing, over the past ten years, there is some evidence of reflection in curricula, either formally as content or informally as strategies to enhance learning. This is briefly described in the following section. Reflection and reflective practice are represented in both initial and

continuing education courses (Palmer, et al., 1994; Johns & Freshwater, 1998) and in some areas, reflection also figures formally as a graduation and registration requirement (Boud & Walker, 1998). The influence of Dewey, Schon and Mezirow and reflective terminology has been evident to some extent in the nursing literature since the early 1980s. Reflection has been listed in the Cumulative Index for Nursing and Allied Health Literature (CINAHL) since 1989.

In 1986 the UK introduced key national initiatives for reform in nursing education, in particular Project 2000 and the PREP proposal (Reid, 1993; Rich & Parker, 1995; Mallik, 1998). Reflection and reflective practice are explicit in the preparation of pre-registration nurses. The United Kingdom Central Council (UKCC) requirements for continuing registration include the maintenance of a portfolio of professional development, and continuing education (PREP). There is a statutory requirement to articulate and enhance professional knowledge using a portfolio, along with a system of peer review and defined clinical competencies. Future practitioners are expected to be flexible, adaptable, proactive to change and able to think critically (Burrows, 1995). The concept of reflective practice as encouraging critical thinking and problem-solving within nursing is understood implicitly or explicit within all Project 2000 curricula (Rich & Parker, 1995). Experiential learning strategies are recommended as appropriate to enhance reflection. Reflection as a process for examining practitioners' actions is congruent with this reform (Palmer, et al., 1994). In response to the reform there has been a flurry of activity around reflection and the reflective practitioner concept. For example, papers from the third reflective practice conference in Cambridge, where healing through reflection was the focus, were developed into Transforming nursing through reflective practice (Johns & Freshwater, 1998, p. ix).

In Australia in the late 1980s principles of critical theory and their connection to reflective practice were introduced in post graduate courses in education and nursing. Reflection was identified as a prerequisite competency for beginning nurses by the Australian Nurse Registering Authorities in 1990, thereby supporting the development of reflective practitioners (Mallik, 1998). Although the realization of the reflective practitioner developed within a variety of educational contexts, many curricula in Australia are grounded in critical social theory (Cruickshank, 1996; Mallick, 1998; Taylor, 1998). Nurses are encouraged to examine the status quo, identify constraints and then free themselves from these constraints thus establishing more empowered and effective practice. In the national document reflective practice is identified as "necessary for the improvement of the quality of teaching in nursing in higher education" (Executive Summary, 1994, p. 17, in Taylor, 1998). Reflection, reflective practice and emancipation is the language found in curricula and practice and in the appearance on nursing units of journals and reflective logs (Taylor, 1998, p. 134).

In New Zealand, at the Manawata Polytechnic, a new curriculum was designed. This was in response to evidence produced through phenomenological studies, technological advances and recognition of the value of humanistic and artistic skills, changing ideologies in education and nursing, and feminist research. Graduates of this program are expected to "become autonomous, reflective, critical practitioners, qualified and competent to practice not merely skills for health and healing but able to integrate those skills with the ethics of compassion and caring" (Owen-Mills, 1995, p. 1190-1191).

Unlike the emphasis on reflection in the UK, Australia, and New Zealand, in the United States, critical thinking is emphasised in nursing curricula. Standards of nursing accreditation,

instated through the National League for Nursing (NLN) Council of Baccalaureate and Higher Degree programs identify as requisites, critical thinking, communication and therapeutic nursing interventions (Boychuk Duchscher, 1999). However, the notion of critical thinking encompasses reflection. Critical thinking is considered an interactive, reflective, reasoning process. It is designated as a process of purposeful, self-regulatory judgement (Facione & Facione, 1996).

Walker and Redman (1999) from the University of Colorado provide an interesting departure from the critical thinking focus of most US nursing programs, where reflection is subsumed under critical thinking. The program realizes Nightingale's nursing praxis, where theory-guided, evidence-based reflective practice (praxis) is the core. They identify a view of nursing practice as reflective in nature because appropriate and effective research utilization depends upon the ability to reflect on actions past and present (p. 300). In their formulation reflective practice includes self assessment, therapeutic intervention and evaluation, utilization of philosophy, theory and research bases for practice; critical thinking, utilization of multiple patterns of knowing; and self-corrective reasoning. Reflective practice is seen necessary to fully integrate evidence-based care into practice.

The Canadian Association of University Schools of Nursing (CAUSN) and the Canadian Nursing Association are also exploring the development of critical thinking as a construct for nursing education, practice and research (Boychuk Duchsher, 1999). What is not clear is how or whether reflection will figure in the construct. Like the US, this move toward critical thinking may bring reflection into the Canadian nursing discourse through a reflection aspect of critical thinking. In Ontario specifically, reflection is already evident in the reflective practice requirement.

Reflection Requirement For Ontario Nurses. The College of Nurses of Ontario introduced a quality assurance program as mandated through the Regulated Health Professions Act. This act requires each professional college to develop and implement a quality assurance program, although the particulars are not specified. The College of Nurses has developed a quality assurance program one component of which requires all registrants to participate in reflective practice (Witmer, 1997). Reflection is defined as "the process of reviewing an experience in order to gain insight and learning and prepare for future experiences and learning" (CNO, 1996, p.107). A competent professional nurse is expected to practise according to standards, engage in reflective practice and ongoing learning in order to provide appropriate, effective and ethical care that contributes to the best possible health outcome for the client (CNO Communique, 1997, p.8).

In January 1998 the reflective practice requirement was implemented for all nurses in Ontario. This is seen as actualizing what nurses have "been doing for decades, continually monitoring their own performance" (CNO, 1999, p.10). The lives of practising nurses are significantly affected by this new direction. All practising nurses in Ontario are required to complete the reflective practice process every year. This includes declaring one's reflective practice experience on one's annual payment form. Reflective practice is described as a five step process and includes: completing a self-assessment (document is provided annually); obtaining peer feedback; creating a learning plan; implementing the learning plan; and evaluating the learning (CNO, June 1999, p. 23 & 25), while keeping personal reflective practice records. This thread is woven through the various documents including, for example, the standards for the nurse-client relationship. "The nurse engages in reflective practice/self-awareness: to achieve an

effective relationship with a client, the nurse continuously reflects on her or his interactions with clients, his/her own personal needs, wishes, feelings, fears, strengths and weaknesses, which can interfere with understanding and providing care to the client. At times, a nurse may need to seek help from others to assist in reflection on her/his practice. (College of Nurses of Ontario, 1999, p.7). It is assumed that nurses know what reflection and reflective practice are, and that this is congruent with the College of Nurses formulation.

Reflection Rhetoric

A common understanding of the term "reflection" is often assumed. Despite wide acceptance of reflection as a specialized form of thinking (Dewey, 1933), considerable lack of consistency, definition and clarity is present in the available literature (Jarvis, 1992). This is illustrated by Dewey and Mezirow who identify different concepts and thought processes but with similar names in each framework. There is a common assumption in the literature that these are the same concept (Atkins & Murphy, 1993; Burnard, 1995; MacKintosh, 1998; Richardson & Maltby, 1995). Common assumptions underlying reflection include reflection enhancing professional practice, bridging the gap between theory and practice, a universal ability, and an agent of empowerment. These assumptions underlying the phenomenon of reflection are explored in this section.

Enhance Professional Practice

Reflection is assumed to enhance professional practice (Schon, 1983, 1987). Many professional preparation programs, particularly in education and nursing aim to promote reflection in developing practitioners. In Western society, which is dominated by professionalism, reflective practice is seen as a central characteristic of professional action

(Gavin, 1997, p. 695). Nursing is part of the professional society and part of the dynamic of professionalism. A movement towards "new nursing" developed in the 1970s; this was a move from a bureaucratic organizational model to a professional model of nursing practice. This movement is still in progress (Cook, 1999).

Sumison and Fleet (1996) assert that reflection is expected to lead to informed, thoughtful and deliberate analysis or contemplation of one's beliefs and actions, thereby enhancing professional practice. Mallik (1998) identifies the "most hopeful model to emerge" as that of the reflective practitioner. Levels of clinical competence and decision-making are based upon knowledge and experience encompassed within a framework of reflection on critical incidents and/or everyday practice events (p. 52). The contemporary move to evidence-based practice is considered by some to complement reflective practice in the current climate. "Discriminating between knowledge based on opinion and practice, as opposed to scientific evidence, is an important stage in the development of a professional group" (Kitson, 1997, p. 34).

As professional practice becomes synonymous with reflective practice, the use of reflective practice models may have value in enhancing the professional status of nursing (Johns, 1995; MacLeod, 1993). Developing reflective practitioners becomes an avenue to generate explanations of practice situations and build upon practice knowledge; as well, there is the potential to provide more meaningful learning for students and more rewarding teaching experiences in the practicum (Stockhausen, 1994). Reflection may be a powerful means to improve practice for those who so wish, but it is not a panacea (James & Clarke, 1994). Johns (1998) cautions against reflective practice being used to control and manipulate towards certain ends.

In nursing there is an accepted view that reflection will lead to better practice and greater competence (James & Clarke, 1994). However, the link between reflection and quality of practice is unclear (Glen, Clark, & Nichol, 1995). It is widely accepted that professionals need to reflect on their actions. Most practice situations involve novel elements to which there is no defined solution (Kember et al., 1999). Out of reflection comes learning and a focus on gaining further knowledge to improve practice. An examination of the literature reveals the general assumption that reflection in professional behaviour is desirable. However, there is very little guidance on how to confidently determine that reflective behaviour exists (Day, 1993). Reid (1993) suggests that reflective practice has potential as a way of learning and as "a mode of survival and development once formal education ceases" (p. 307), a form of lifelong learning. Scanlon and Chernomas (1997) express concerns that an over-reflective orientation could lead to the inability to act quickly and appropriately when the situation demands. In one study a participant attributed her difficulties in practice to being over-reflective. She wondered if reflection caused over-questioning of herself and difficulty acting (Smits, Friesen, Hicks & Leroy, 1997).

Nurses are exhorted to live up to the expectation that good practitioners are reflective practitioners but they have not learned where and how reflection should enter practice. To what extent is it desirable to engage in reflection? Is there a point at which reflective thought debilitates action?

Bridging the Gap

Reflection in the context of professional practice is often seen as a way of bridging the gap between theory and practice (Andrew, 1998; Ashworth & Longmate, 1993; Clarke, 1986;

Clarke, Maben & Jones, 1997; Davies, 1995; Maeve, 1994; McCaugherty, 1991; Rolfe, 1993; 1997). Schon (1987) explicitly describes reflection as a link between theory and practice, or between thinking and doing. Lauder (1994) contends that the reflective practitioner movement has failed to bridge this gap because the outcome of reflective processes remain solely within the cognitive domain (p. 97). Noffke and Brennan (1988) suggest that the act of reflection provides an opportunity for the intersection of theory and practice and theory and theory (p. 21). Slevin and Lavery (1991) wonder if it would be possible to bridge the theory-practice gap through adopting discovery-oriented approaches and experiential learning. Minghella and Benson (1995) used critical incident analysis as a teaching and learning strategy to enable critical reflection and report finding it useful in integrating theory with practice.

Patients present an excellent resource for meaningful learning, for bringing theory and practice together (vertical integration) and uniting theory (horizontal integration)(Hollis, 1991). Each patient provides a unique learning situation and unique source of knowledge (Durgahee, 1996). Bright (1996) asserts that with reflective practice, knowledge must be content specific, and that all patient situations are unique. The notion of a theory-practice gap supports the perspective of applying theory to practice. On the front line there is perhaps another gap which may have more salience with the move to understanding the client's experience, knowing the person, patient-focused care, client-centred care, and honouring personhood. Each nurse-patient encounter is a unique and human encounter, with the emphasis on understanding both the meaning of the experience for the person and the situation. Responses may be unpredictable because situations are influenced by past experience and knowledge (Lumby, 1998). The idea of theory prescribing practice does not fit well with this view, although there is a need for the

practitioner to examine extant theory for its relevance and usefulness within particular situations (Johns, 1998). Perhaps the gap is in knowing and understanding particular patients' experience and how they understand their illness experience. This is opposed to a perspective that supports the notion of applying theory to practice and creating a theory practice gap.

In the literature on clinical supervision, reflection is seen as a bridge to therapeutic practice, a strategy for bridging the gap (Fisher, 1996; Johns, 1996; Magnussen & Trotter, 1997; Severinsson, 1996, 1998). Rather than supervision in the conventional modern sense of the word, Watson (1998) wonders about reframing supervision as coaching, mentoring, or dialogue. Through these supportive processes, the method would become more accurately described as "reflective caring inquiry" (p. 218).

There is a suggestion that reflective practice is the antithesis to theory driven practice (Watson, 1998). Instead, there is a "dialectic tension" instead of a divide or dichotomy (p. 16). That much of nurses' work is necessarily "concrete" is not often acknowledged. What does reflection on necessarily technical, discrete tasks, interventions or treatments within a helping relationship look like?

Universal Ability

A common assumption is that all nurses share an ability to reflect in a meaningful way (Mackintosh, 1998). However, some studies bring this into question (Cavanagh, Hogan, & Ramgopal, 1995; Richardson & Maltby, 1995; Wong, Kember, Chung, & Yan, 1995). A pervasive message is that everyone can acquire reflective skills or capabilities. These have been identified as self-awareness, perception, imagination, ability to analyze, interpret and synthesize (James & Clarke, 1994). Reflective thinking is not an easy skill or capacity to develop. Hollis

(1991) suggests that we do not necessarily learn from experience unless it is reflected upon. This is coupled with the concern that by challenging nurses' values and assumptions, reflection may expose uncertainty and/or limited competence (Burrows, 1995; Leino-Kilpi, 1990; Saylor, 1990). "By reflecting in a committed way we may come to see that many of our deepest beliefs about our nursing world may be contradicted in ways we think and act," (Cox, Hickson, & Taylor, 1991, p. 387) surely a deterrent to engaging in reflection. Haddock (1997) found that nurses when "confronted and challenged by others ... found it difficult to avoid examining personal values and the extent to which they affect attitudes, beliefs, and ideas which one holds on to" (p. 382). Brookfield (1995) asserts that critical reflection may lead to self-doubt, feelings of isolation, and uncertainty. Reflection as knowing the self may be disconcerting if competence and ways of coping with anxiety, which are taken-for-granted, are revealed as inadequate. It could even precipitate a crisis when incongruities between actual and desired ways of being or ways of working are exposed (Johns, 1998). However, Moccia (1990) asserts that if all nurses developed self-knowledge in the emancipatory domain, recognized and challenged the limitations and constraints on practice, we would have a "revolution." Of course, this assumes that the nurse is in control of deciding whether to reflect or not and upon what to reflect (Kotthamp, 1990).

There is a pervasive notion that with appropriate coaching, nurses would achieve systematic and purposeful reflection, but also that this is not an innate ability. Houston and Clift (1990) assert that it is naive to expect that a few courses or workshops could create a reflective person out of one whose practice consists of mindless, automatic actions. Alternately we cannot assume that nurses do not think about their practice and attempt to improve upon it (p. 208).

Mature practitioners, in particular, might be expected to build upon life experiences to make sense of their work (Knowles, 1980; Taylor, 1998). Schon (1987) suggests that practitioners require coaching to manage practice problems. Greenwood (1993) and Conway (1996) support that coaching is necessary and that it promotes collaboration. Belenky et al. (1986) note that coaching promotes cooperative communication. The coaches, mentors or supporters also require support and time in learning about reflection so they can help others. Perhaps, there are nurses who are just naturally reflective, irrespective of any educational process. Can all nurses reflect? Could there be something in the initial selection process that admits only those who have this ability? Do all nurses reflect? If they do, on what do they reflect?

Empowerment

In the literature are suggestions of myriad benefits of reflection. For example, connections created and developed through reflection lead to more holistic nursing practice (Fonteyn & Cahill, 1998). Reflection in nursing is variously portrayed as a way to empower nurses to become fully cognizant of their knowledge and actions (Burrows, 1995), the personal and professional histories that have shaped them, the symbols and images inherent in the language they use (Brookfield, 1993), the myths and metaphors that sustain them in practice (Morgan, 1996), their nursing experience, and the constraints of their work setting (Palmer, et al., 1994). Within the critical theory tradition, reflection is seen as a way to more empowered and effective practice. This is accomplished by examining the status quo and constraining factors and liberating ourselves from them (Noffke & Brennan, 1988; Watson, 1998). Lauterbach and Becker (1996) describe self-reflection as a route for self-empowerment and self-fulfilment. In 1991, Gibson was distressed to find that nurses were either unwilling or unable to empower

themselves. They appeared to have little knowledge of their experience, expertise and potential strength, suggesting perhaps empowerment does not come naturally!

Houston and Clift (1990) identify freedom and empowerment as twin assumptions of reflection. In order to reflect a person needs to be free to think and feel empowered to think. They tie freedom and empowerment into contexts that encourage reflective activity. The greater the constraints on thought and freedom, the less reflective activity (p. 213). Practitioners can only enlighten, empower or transform themselves, although people can motivate, energize, inspire, challenge and support others (Watson, 1998, p. 19).

Empowerment through reflection, clarification of values, and development of individuals' self-esteem is envisioned by Keegan (1988). Stern and Keffer (1996) also envision reflection as empowering nurses and clients, and empowering the profession through the advancement of knowledge. Learning through experience may be a means of individual empowerment, where learners actively define their own experience by attaching meaning to events (Garrick, 1996). Carr (1996) notes the usefulness of reflection in developing clinical expertise and valid knowledge among practitioners. The process of reflection is an integral factor in the organization of daily activities where we replay in our minds the events of the day, often analyzing and re-examining (Stockhausen, 1994). Davies (1995) suggests that there is a new professionalism that involves promoting a power-sharing model. It emphasizes engagement, interdependence, the use of client-centred interactions, and a reflective use of expertise and experience in a creative problem-solving process (p. 150). Tied to empowerment is an implicit theory of change.

Mackintosh (1998) questions what reflection has to offer nursing either as a learning strategy or to promote reflective practice, since studies indicate only a small percentage of

students think beyond a concrete level to a reflective level. She believes that reflection is just a passing fad that will be superseded by another fad in 10 years time (p. 556). "Reflective doctrine has become the holy grail that will rescue nursing practice and education from ignorance and the performance of ritualistic behaviours" (Lauder, 1994, p. 92). Kotthamp (1990) expresses concerns that reflection and reflective practice "may become only the latest in the casualty list of ideas with great potential that have been reduced to the level of tinkling jargon through uninformed use" (p. 184).

An additional tension must be acknowledged. While the rhetoric is seductive, most nurses work in bureaucratic settings, where there is an expectation of compliance. Here rules abound, questions are discouraged, and alternate or competing values are not sought (Lieberman, 1989). It may be easier to accept current conditions and "adopt the line of least resistance" than to change (Smyth, 1987, p. 40).

Clearly, reflection has much promise and potential. However, there are cautions, concerns, and hurdles as well. Nevertheless, embedded within the reflection rhetoric are several important attributes.

Reflection Attributes

Central to an understanding of reflection, is that reflection involves thinking and affect. Experience is important to reflection and reflection is context-bound. These attributes are evident in much of the literature on reflection and it is reasonable to expect that they would be identified by practising nurses as important to reflection. These attributes may provide an organizing framework for locating nurses' descriptions of the experience of reflection. Four attributes of reflection are explored in more detail in the next section.

Specialized Thinking

Reflection is connected in some manner to thinking, thinking back on something of interest (Dewey, 1910; van Manen, 1991). Pierson (1998) elaborates Heidegger's (1966) notion of reflection, where reflection is not seen as a separate entity from other forms of thought, but as an outcome of the integration of calculative and contemplative thinking. Each constitutes an important facet in reflective thinking. Reflection may be mulling over recent events, thinking about, trying to discover what went wrong, and considering what helped to make things go well (James & Clarke, 1994). This process of deliberation is more complex than simple reflective activity (Lauder, 1994, p. 92). Von Wright (1992) identifies reflection as a meta-cognitive skill, thinking about thinking. Reflection is a process of thinking back on a project or situation to explore the information gained and identify other influencing factors (Saylor, 1990). The integration of knowledge with action through thought is another description (Andrew, 1998). Houston and Clift (1990) suggest that to improve reflective thinking, there is a need to involve people in situations in which such thinking is required. It then becomes a habit of thought through use and further reflection upon such use; this differs significantly from an information processing model of thought. Paying attention (Tremmel, 1993), awareness, (Schon, 1987), mindfulness (Calderhead, 1989; Langer, 1997; MacKinnon, 1996; van Manen, 1991), and thinking skilfully (MacLeod, 1993) are necessary to engage in reflection. Reflection thinking is conscious, deliberative and purposeful. Rather (1992) identifies nursing as a way of thinking.

Affective Dimension

Feelings influence one's ability to reflect. Boud et al (1985) suggest that following experience the first stage of reflection is "returning to the experience." One recollects events and

examines reactions, preferably in a descriptive not judgmental manner. "Attending to feelings" follows where emotions are identified, examined, and/or challenged. This focus on feelings heightens self-awareness, enables one to question and retain positive emotions and discard negative feelings. Events from the experiential phase are processed or reconstructed in order to make sense of them; this requires in-depth reflection and introspection (Stockhausen, 1994). The process of reflection involves both feelings and cognition, which are closely interrelated and interactive (Boud & Walker, 1991). However, feelings are not viewed as a resource for learning, knowledge or experience. They either promote positive attitudes to or impede learning. They also figure as "triggers" to reflection, particularly feelings of discomfort, or "doubt, surprise, even shock" (MacIntosh & Wiggins, 1998, p. 14). Tremmel (1993) highlights the influence of feelings on the ability to reflect, to interpret and respond to situations. Reflection may be temporarily "frozen" by intense feelings (p. 48). While affect is identified as important to reflection, its roles and relationships are not well articulated or understood.

Experience-based

Eyles (1989) identifies everyday life as experience and the "the unquestioned background to our lives" (p. 103). Everyday life is "simply the fundamental reality which creates, maintains, and transforms every one of us as self-aware and self-conscious individuals" (p. 102). Everyday life is the world of experience. Through self-awareness we perceive it as both under our control and determined by outside forces and events. It is familiar, even taken-for-granted, but not static. It is a dynamic process which is constantly unfolding and emergent (p. 102). Environments are matrixes of past and present and they provide a framework for experience. Through reflection on everyday life, which includes work/practice, leisure, family and such, we discern the significance

of everyday life itself. In this way we may construct knowledge or meaning in everyday life, or experience.

Like reflection, the word experience is ambiguous. It may be either a noun or a verb. The Oxford Dictionary cites experience as a noun as "actual observation of or practical acquaintance with facts or events; knowledge or skill resulting from this... an event that affects one; fact or process of being so affected" and as a verb, experience is "meet with, feel, undergo" (Sykes, 1986, p. 339). Boud et al. (1993) note that there is a lack of recognition of learning from experience, life experience. They assert that experience cannot be separate from what is experienced. Similarly what is experienced cannot be separate from experiencing. They tie learning to experience noting that "learning is all around us, it shapes and helps to create our lives, who we are, and what we do" (p. 1).

Learning from experience is a central way that people create their world and give meaning to it, that is, create knowledge (Cervero, 1992). Moch (1990) suggests experience as an aspect of personal knowing. Belenky et al. (1986) share that women have a propensity to be more fully engaged in teaching-learning situations that are experience based. Boyd and Fales (1983) see reflection as thinking about and exploring an issue of concern, which is triggered by experience; the aim is to make sense or meaning out of the experience and incorporate this experience into one's view of self. Reflection involves more than a concrete and rational looking back on experience, it is itself an experience and requires participation, involvement and commitment (Pierson, 1998). Learning by experience involves the ability to reflect on personal happenings and through a process of analysis come to understand those happenings (Lowe & Kerr, 1998). "Unless an experience is examined and reflected on it has no educative value"

(Criticos, 1993, p. 162). Reflection is "not idle meanderings or day dreaming but purposeful activity directed towards a goal" (Boud et al., 1985, p. 11). Antrobus (1997) suggests that reflecting upon the lived experience of nursing enables learning and understanding and ultimately the construction of nursing knowledge. Reflection provides access to past experiences thereby developing a reservoir of tacit knowledge.

Aristotle in speaking of practical wisdom, noted that young people could be experts in theoretical subjects. However, knowledge of the particular can only be learned from experience and experience necessitates involvement in practice over time (Lauder, 1994, p. 94). Boud et al. (1985) note that experience alone is insufficient. Learning from experience requires reflection, which begins with a description of the experience and from which key issues within the experience can be focused upon for reflection. This is echoed by Hollis (1991), Jarvis (1987, 1992), and Westburg and Jason (1994). Clarke (1986) and Leino-Kilpi (1990) stress the importance of experience providing a repertoire of examples and understandings for reflective thinking to be effective. Johns (1995) identifies reflection as a method to access, make sense of and learn through experience. Through reflection personal knowledge becomes visible and communicable and this reflective knowledge is particular, dynamic, and context-bound. The likelihood of learning from experience (Johns, 1995) is increased through paying attention to experience (Tremmel, 1993), awareness, (Schon, 1987), or mindfulness (Calderhead, 1989; Langer, 1997; van Manen, 1991). Schon (1983) suggests that through reflective practice students develop an understanding of the "repetitive experiences of specialized practice."

In the novice to expert work initiated by Benner (1984) a consistent finding is that the experts' mental networks are more complex than that of novices. There are more categories,

greater detail, and more interconnections. Reflection and experience provide the nurse with the knowledge to act intuitively and holistically, although the nurse may be unable to articulate this. When confronted with a problem or decision, experts have access to previously learned patterns and information, built from intensive periods of reflection on experience (Antrobus, 1997; Sparks-Langer et al., 1990). Experience is viewed as the "master teacher." Berliner (1986) found that experience provides experts a "special kind of knowledge" that is different from that of a novice. Expert learners are described as strategic, self-regulated and reflective (Ertmer & Newby, 1996). Experts respond intuitively to situations, responding to whole situations. This contrasts with novices who rely on breaking down situations into stages with linear decision-making processes. This resembles the nursing process of assessment, planning, intervention and evaluation. Intuition is based upon understanding the situation and this knowing is embedded within the self. This enables the practitioner to grasp the whole situation in an instant and to respond based upon past experience, the basis of tacit knowledge. Metacognition facilitates the performance of expert learners and reflection provides the link between knowledge and control of the learning process. Concepts of metacognition, experience, expertise and reflection are central to this formulation, although the relationships among them are not fully articulated.

In a phenomenological study among returning registered nurses, Rather (1992) noted the importance of reflection to experience. We do not often become aware of a change in our preconceptions/experience except through conscious reflection. In attempts to put experience into words, we interpret it, reveal its meaning, and bring it into sharper focus. Experience is achieved through reflective thinking about all the nuances of the situation and its meaning (p.54). Ferry and Ross-Gordon (1998) found that reflecting practitioners used experience gained by reflecting

on their practice to reinforce their personal, intuitive problem-solving. The use of reflection not experience was the more significant indicator, not just gaining experience but how that experience is used as a learning strategy. Many experiential techniques have been proposed but there is a shortage of evidence about their effectiveness (Rawlinson, 1990). To develop reflection exposure to more complex, advanced, and sophisticated modes of thinking and encountering controversial issues are necessary. It is also helpful to mine experiences as material for reflection, and to examine various points of view, how these views differ, and what assumptions they share (Strange, 1992).

Some ambiguity and contradiction exist in the relationship of experience to reflection. Experience is seen as the master teacher, as a trigger for reflection, as a method or requirement to learn from reflection. Alternately, experience may be seen as a reconstruction of experience through reflection, the result of reflection. Perhaps reflection *is* experience. How do practising nurses relate experience to reflection?

Context-bound

Brookfield (1991) views reflection as inextricably context-based. Learning and living incorporate contextual contradictions and ambiguities. The character and significance of reflection are embedded within a context (Dewey, 1910). We exist in a phenomenological world, a world of things and people, where we give meaning to some things and people and ignore other parts. This context or world of meanings, not a world of things, involves an appreciation of the meanings. We feel emotions and assign meanings through our biology and our neural networks. But the experience we process, and the context in which we process it comes from our environment (Johnson, 1989, p. 55). The socio-cultural environment is subject to the values and

assumptions held by its members. This includes the person's position within it, and the historical, political, cultural and ethical factors that influence organizations (Richardson, 1995). The environment or context is dynamic and changing, not static.

Sufficient support, resources and conducive environments provide a positive context for reflection (Lauterbach & Becker, 1996). Structured, non-threatening environments, with nurturing, supportive supervision, sufficiently challenging to provide opportunities with moderate ambiguity and dissonance promote reflection (Hollingsworth, 1989). Supportive environments and close associates facilitate reflection (Houston & Clift, 1990). Supportive environments also help to overcome stress and enable the development of a sense of belonging which promotes personal involvement in the environment (Winter-Collins & McDaniel, 2000, p. 104). James (1995) asserts that nurses are "in continued conversations with context, grasping it, analyzing it, interacting with it, reviewing their intentions and refining their actions." (p. 162). Palmer et al. (1994) see reflection as having the potential to enhance and illuminate the realities of the context in which practice takes place.

All nursing work is contextual. Glen, et al. (1995) maintain that the ability to reflect on practice is dependent upon context. Nursing practice takes place within specific situations and involves interaction between two or more people (Lumby, 1998, p. 13). The way we conduct ourselves in daily practice is shaped by the communities of practice in which we participate (MacKinnon, 1996). Williams (1998) notes that the clinical area is the key place in which knowledge and skills are developed. Nursing in the clinical area is contextual. Experiences lie within a lived context connected to the nurses' reality within the context (Stockhausen, 1994). Nurses are familiar with their work settings or contexts, and this familiarity provides relative

security for daily activity. This familiarity, comfort and tenure within the work setting enables nurses to manage novel situations with reference to past, like experiences. Expertise is not achieved through the unthinking practice of mechanical skills. Experts view situations contextually and as a whole (Benner et al., 1996). Johns (1998) suggests that knowing in practice is constructed knowledge, subjective, holistic, contextual knowing. Cameron and Mitchell (1993) speak to the need for a safe environment, as a context for reflection, and this is reinforced by Pierson (1998). Reflection enables one to appreciate the changes in context, meaning, and usefulness not only day by day but also minute by minute (Houston & Clift, 1990). Contextual sensitivity, which includes an appreciation of the particulars of time and space, is required for reflection (Astrom, Fruaker, & Norberg, 1995). What contexts encourage reflective activity? What is it in the context that promotes reflection? Does the presence of a reflective community enhance reflection? Do reflective communities exist?

Time. The issue of time required for reflective thought is clearly documented in the literature. So is the importance of the time factor in understanding professional behaviour (Chandler, Robinson, & Noyes, 1990; Eraut, 1995; Newman, 1996; van Manen, 1995). Time may be located in the reflection context. Time is required for reflective thought to occur, particularly in complex practice situations. It also requires slowness of pace (Allen & Farnsworth, 1993; Chandler, et al., 1990; Pultorak, 1993; Wedman & Martin, 1991). Shapiro and Reiff (1993) advance the notion that reflection in or during practice is "very difficult to accomplish for the busy practitioner, beset by multiple demands and if anything, an overload of professional knowledge" (p. 1380). The work of nurses is often pressured, intense and constrained by time. It may be difficult, in a busy day, to find the time to reflect (Johns, 1995).

James and Clarke (1994) caution that when nurses rush from one activity to another, they risk mindlessly repeating bad habits and failing to reflect or learn from experience. Nurses are short on time and clinical facilities are difficult environments for reflective thinking (Fletcher, 1997). There is no provision for time to reflect or time to share reflections (Heath, 1998). Porter and Ryan (1996) showed that nurses are very aware of time constraints, and this may engender feelings of helplessness. For example, they found the reason behind speedy assessments and the non-use of care plans was not a lack of awareness of theory but a lack of time and experienced nurses. Nurses may be too busy to be truly reflective, but may thinkingly act and do things with immediate insight (van Manen, 1995). Burrows (1995) and Tremmel (1993) also suggest that time is required to develop reflective ability and this is reinforced by Houston and Clift (1990), Wildman and Niles (1987). Time to reflect is a major issue.

These attributes of specialized thinking, experience and context are evident in the language of most models or frameworks of reflection. Generally, there is an implicit acknowledgement that feelings are in some way intertwined in the activity.

Orienting Framework for the Study of Reflection

A variety of models of reflection have been developed. Situated within these models is the notion that reflection involves both thinking and experience. A recurring difficulty with existing models of reflection is that, although they delineate particular authors' understandings of the process, they provide little direction for study of the concept. The phenomenon of reflection is the interest in this study. Writers who approach reflection as mindfulness also identify thinking and experience as central to reflection, and situate reflection in a context (MacKinnon, 1996; Pierson, 1998; Tremmel, 1993). Extrapolating from the literature, thinking, affect, experience

and context are central to any formulation of reflection. These attributes of reflection are helpful for beginning to understand the phenomenon of reflection.

Within this orienting framework, thinking is identified as central to reflection. Thinking is deliberative or purposeful and involves paying attention to a situation. Reflection is associated with both intuitive and rational thought. Experience is also important in reflection, although the role of experience is ambiguous and contradictory. Experience may be the method or requirement for reflection, alternately reflection may be the method through which experience is achieved. Reflection is nested in context. A more specific understanding of the attributes and the relationship among them may be elaborated as this study progresses. Although oriented by the attributes, these are not reified categories, and there are no predetermined ideas of how these might be expressed, even if they might be expressed.

Selected Models and Frameworks of Reflection: A Summary

A number of models of reflection have been developed and are summarized in Appendix B. In this section, some models and frameworks for reflection are briefly addressed. The structure identified by Atkins and Murphy (1993) and Mezirow's (1981) framework predominate the literature. These models generally present reflection as a process and break the process into hierarchically-arranged levels or stages. Many authors, Kim (1999), Stockhausen (1994) and Chambers (1999) for example, view reflection as inquiry. The purpose of reflective inquiry is to bring disparate data, ambiguous situations, and conflicting perceptions together and into focus. One model of reflective inquiry is represented by Shapiro and Reiff (1993). Fish (1991), Noffke and Brennan (1988) and MacKinnon (1996) propose frameworks that circumvent some concerns with the aforementioned models, but raise questions as to the place of action in reflection

models. Finally, in this section, a model of structured reflection, representing the messy marsh or practice perspective, is provided by Johns (1998).

Current theory and practice seem dominated by two perspectives. These are understanding through experience by reflection and analysis as a way of apprehending experience (Fenwick, 1999). Reflection encourages practitioners to challenge the way they think, feel, and believe. It allows them to analyze their own experience, identify their characteristic assumptions and beliefs systems, and scrutinize the origins, validity and consequences of their ideas (Burnard, 1989; Brookfield, 1990, p. 177). Key stages of reflection - awareness/trigger, analysis, synthesis/evaluation, and action - have been identified by Atkins and Murphy (1993) as common to a number of models (Baker, 1996; Boud et al., 1985; Griffiths & Tann, 1992; Reid, 1993). The first stage is often triggered by uncomfortable feelings and thoughts; this is followed by critical analysis of the situation in the second stage; the third stage of evaluation or synthesis leads to the development of a new perspective on a situation where the outcome is learning of some sort; in the fourth and final stage is a commitment to action, action is the final stage. Boud et al. (1993) describe their model as: going back through experience and drawing out what seemed significant (return to experience); working with any feelings that come out of it, that might help or hinder reflection (attending to feelings); then going on to reappraise the experience in light of what had arisen (re-evaluation). The final stage involves singling out an aspect of the experience and relating it to previous experience and learning (association), integrating new experience with previous learning (integration), testing its validity (validation), and making it our own (appropriation) (p. 73). In these models of reflection an implicitly linear process is set in motion by a problem or dilemma and ends in action. These models suggest reflection-as-

problem-solving, as something embedded in the nursing process.

Models using Mezirow's seven levels of reflexivity derived from Habermas' categories frame many studies (Pultorak, 1993; Richardson, & Maltby, 1995; Wedman & Martin, 1986, 1991; & Wong, et al., 1995). Consistently, the findings of such studies indicate that unless specifically directed, participants rarely reflect at the critical or emancipatory level (Ballantyne & Packer, 1995). This level is proposed as the highest level of reflection, realized through a critical inquiring professional (Korthagen & Wubbels, 1995). An implicit criticism of models based upon Mezirow's work is that the hierarchical levels define away most practitioners' thinking. There is not a clear contrast between the levels and the content is obscure. Most practitioners fall within the lowest levels, with the exceptional few achieving critical reflection. This model has obvious appeal for academics but may not resonate for practitioners whose interests are not in the critical domain.

Shapiro and Reiff (1993) present a five-level model as a framework for reflective inquiry on teaching practice. The levels are arranged in a vertical hierarchy labelled from top to bottom in boxes of decreasing size: philosophy, basic theory, theory of practice, technique, and moves. Descending from theory into practice one begins with philosophy to deduce a basic theory of practice, and so on, until a particular move is specified. Alternately, one can ascend "from practice to theory" beginning with a specified move in practice to infer a technique, then from technique to infer a theory of practice and so on, until one arrives at an overarching philosophy. The two forms of reasoning (top down, and bottom up) are purported to work in tandem to relate theory and practice in a hypothetical-deductive system. This model also is limited by linearity and hierarchical configuration and the mechanistic character of proceeding from one level to the

next.

Noffke and Brennan (1988) provide a model of reflection depicted as a cube. There are two focusing "faces," the sensory and determinants dimensions, connected by the ideals/ideology and the historical-comparative dimensions. Reflectivity might be judged in terms of area or volume, with several, non-hierarchical points of entry. They emphasize that within this model the goal should be understanding and action in relation to all of the dimensions. Rather than hierarchical, this model is more lateral, with no sense that greater understanding in one dimension is better than that of another dimension (p. 25). This very elegant and comprehensive model incorporates many factors not addressed in other models of reflection. It circumvents the hierarchical nature of other models, and is also complex, but then so is reflection! Its utility may be less suited for actual practice situations and more for an exercise in understanding reflection in all its complexity.

Fish (1991) provides a Strands of Reflection Model. The four strands (not categories) which are both cognitive and affective are: factual, retrospective, sub-stratum and connective. The factual strand involves reconstructing practice, drawing mainly upon procedural knowledge of it. The retrospective strand develops holistic theory about and critiques the entire piece of practice, again with mainly procedural knowledge. The sub-stratum strand involves uncovering and critical exploration of the personal theory underlying that piece of practice along with consideration of how formal theory relates and could be helpful. Propositional knowledge supports this strand. The connective strand considers how present theory and practice will relate to future theory and practice, again featuring propositional knowledge. Learners are enabled to learn to theorize, moving toward propositional knowledge. Values and beliefs of learners are

incorporated; learners are assisted to use a range of data and consider a range of interpretations. This framework has utility for reflection-in-action and reflective learning and avoids the linearity and hierarchical nature found in other models.

MacKinnon (1996), concerned about the static, hierarchical, and linear quality of reflective models, introduces the image of a propeller as an alternate metaphor. Each level or stage in the other frameworks could be represented as one blade of an airplane propeller viewed from a seat on an airplane. In flight (action, practice) the propeller spins quickly, so that none of the blades is clearly visible. We can see the blades together as a blur, detecting their function only as they work as a whole to move us forward or even backwards. In the absence of activity the different levels or stages are not distinct. "Further, we could look through the propeller upon a distant landscape, we would be aware of a blurring in our vision that reminds us that our theoretical representations and beliefs about practice may distort the world as it is" (MacKinnon, 1996, p. 654).

Johns (1998) developed a model of structured reflection (MSR), through ten iterations. His intention was to enable practitioners to "know" what it means to reflect and to explore the meaning of experience. The MSR is described as a heuristic device to enable practitioners to penetrate the essence of experience (p. 4). This model does not prescribe how the practitioner *should* reflect. Through its use, the practitioner may internalize the model, "fusing cues in her own reflective lens." The practitioner begins with writing a description of the experience and then is asked "what are the significant issues I need to pay attention to?" Reflective cues focus the practitioner on Carper's (1978) fundamental ways of knowing: aesthetics, personal, ethics, and empirics. The empiric, ethical and personal ways of knowing converge upon the aesthetic

response. Reflection leads to the process of grasping and interpreting the situation, envisioning what is to be achieved, and responding with appropriate action. Carper's ways of knowing are not in themselves a model for facilitating reflection; they need to be contextualized as historical and cultural processes (White, 1995). Therefore a fifth way of knowing, sociopolitical, was added. Experiences are part of a continuous flow over spatial and temporal time, not isolated moments. Present experience bridges past experience and anticipates future experience. Johns constructed grids that draw attention to the factors in practitioner experience, for each reflective cue, although the model is represented as a spiral. The reflective cues incorporate cognitive, affective and temporal aspects of the experience and the five ways of knowing. Heath (1998) commends Johns' integration of the ways of knowing into his model. There is a concern that nurses require considerable expertise and reflection abilities so that they can appreciate the complexity and diversity in their practice. They could see Johns' model as merely an academic exercise to connect activities with the labelled ways of knowing. The model of structured reflection depends upon guided reflection or supervision for its utility. This model's utility in practice with experienced and knowledgeable nurses is confirmed. There is evidence that through use of the MSR, practitioners internalize the model and fuse the cues into their reflective lens (p.4). In essence, practitioners are invited to tell a story, sharing a description of the aesthetic response. They are prompted to a more complete description through the reflective cues.

Reflection and Action: Where does action figure in reflection? While there is a concern with engaging in the dualism of reflection/action, the relationship is both ambiguous and intriguing. Action is proposed by some as initiating reflection (Korthagen, 1985; Tremmel, 1993; Zeichner, 1990). Others propose feelings of surprise, puzzlement or confusion (Schon, 1987),

uncomfortable thoughts or feelings (Atkins & Murphy, 1994; Boyd & Fales, 1983) or any situation of self-examination (Kim, 1999) as necessary precursors to reflection. Reflection may begin with action and develop interactively with the situation as it unfolds. Johns (1995) asserts that reflection has to be consciously activated, for example when questioning why an outcome has occurred (Jarvis, 1992). Schon's (1983, 1987) formulation places action within reflection: reflection-in-action, as the processes are taking place and reflection-on-action, occurring after the action has happened. A commitment to action as a consequence of reflection is proposed by Stockhausen (1994). Kemmis (1985) suggests that reflection *is* the action and not a process that "goes on in the head." The rationale for reflection may lie in its relation to action and its potential to improve professional practice (Boud et al., 1985; Smith & Hatton, 1993; Smyth, 1989). It seems then, that reflection may either begin or end with action, or it may be the action, the experience.

While not situated within the models of reflection, some prerequisites for reflection are identified. Dewey (1933) proposes three prerequisites as openmindedness, responsibility and wholeheartedness. Johns (1995) proposes being open and curious about practice. Reflective engagement and concern with ideas and beliefs is suggested by Richardson (1995). Tremmel (1993) identifies the need to approach reflection with the right disposition and sufficient experience. van Manen (1995) describes a union of knowledge of the reflective method, a reflective attitude plus a habit of thinking in a reflective way. This review of the predominant attributes of reflection, and attributes of the person may be arranged/configured as an orienting framework within which reflection may be studied.

Inquiring Into Reflection: A Critical Appraisal

Three traditions are represented in the study of reflection, empiric-analytical, hermeneutic-phenomenological, and critical-dialectic. These traditions share some common features. They are all concerned with deductive and inductive thinking and they all require scientific designs in the sense of being systematic and rigorous. All three traditions bring change through the generation of new knowledge. The empirical-analytic tradition emphasizes logical-positivist methods; questions centre on issues related to "techniques, control, and with means-end criteria of efficiency and effectiveness." Empirical knowledge is generated and tested through the scientific method. Knowledge is considered absolute. The emphasis is upon making cause and effect links, it is predictive and generalizable; objectivity is important. Empirical knowledge is evident in nursing. It is necessary for the continued and updated support of medical advances and the constant evolution of newer and safer technical procedures, for example (Taylor, 1998).

The view of knowledge as relative, context-dependent and subjective is shared within the last two traditions. The hermeneutic-phenomenological tradition emphasizes qualitative methods, with questions of validity, understanding and communication. Within this tradition, the researcher asks participants to confirm that interpretations are faithfully represented and clear. Thinking moves from specific instances toward the general pattern of combined instances. Interpretive knowledge is relative and centred. The critical-dialectic tradition emphasizes political and historical methods; questions focus on "worthwhile ends, in self-determination, community, and on the basis of justice, equality and freedom" (van Manen, 1977; Wellington 1996). What differs between the hermeneutic and critical tradition is the intentions for, and processes of, knowledge generation and validation (Taylor, 1998).

There is a lack of agreement about what constitutes reflection, and little is known about how it might be promoted or measured. There is no evidence to indicate whether reflective practitioners are more effective than those who are non-reflective. There are no reports describing the effect of reflection upon professional practice as it affects clients (Newell, 1994, p. 79). No widely accepted means of identifying or assessing reflection exists (Sumison & Fleet, 1996). Research has mostly been carried out with students, both pre-registration and post-registration. Much of the literature on reflection and reflective practice remains at a discursive level. There are reports on nursing students' experiences of using reflection in their practice and descriptions of various strategies presumed to promote reflection.

A contribution to understanding reflection has been made through action research which arises from the critical paradigm. Action research is frequently associated with reflection particularly in the UK, Australia and New Zealand. The focus is critical reflections. In 1986 Carr and Kemmis proposed a much used Action Research Model with four cyclical phases of planning, acting, observing and reflection; action is based upon understandings within the continuous cycle of action-reflection-action. Practice is situated within a political, economic, historical and social context.

Kim (1999) developed a critically reflective inquiry approach, based upon action science, reflective practice and critical philosophy. This inquiry is designed to encompass three phases, descriptive, reflective, and critical/emancipatory. It provides understanding of the nature and meaning of practice. Correcting and improving practice is through self-reflection and critique. Models of "good" practice and theories of application are generated. This method is illustrated with an analysis of a narrative. In response to Australia endorsing reflective practice as a

prerequisite competency for registering beginning nurses, Stockhausen (1994) proposes an action research clinical learning spiral. This is a framework for reflective practice, to promote reflective practice of both students and clinical teachers. Chambers (1999) describes critical reflective analysis as a means of evaluation. Three participants, herself - a nurse doing her master's degree in Health Professional Education, her teaching practice supervisor, and a nursing student used the vehicle of a "drug round," as the focus of the analysis. Minghella and Benson (1995) use critical incident analysis as a teaching and learning strategy to enable critical reflection. They report finding it useful in integrating theory with practice. Brookfield (1994) provides an analysis of how one group of adults felt as a result of their critical reflection. This was particularly useful in identifying some of the promise and perils of reflection and five themes emerged: impostership, cultural suicide, lost innocence, road running, and community.

Powell (1989) using observation and interviews in open-ended inquiry, studied eight registered nurses and their use of reflection in everyday work. The purpose was to draw conclusions about their reflective ability. A tool based upon a modification of Mezirow's (1981) seven levels of reflexivity, and retaining Mezirow's language, was developed to differentiate various aspects of reflection; however, there was not a description of the coding used. Reflection was present in description and planning of actions, with little recognition of value judgements or those areas leading to learning. These nurses lacked higher levels of reflexivity as described by Mezirow. Richardson and Maltby (1995) randomly sampled 30 second year undergraduate nurses' reflective diaries used during their community health care rotation. They used the research tool developed by Powell. Based upon Mezirow's levels of reflexivity, 94% of total scores were in the lower levels, with 1% at level four, 2% level five, 3% level six. Only 6%

percent of the students demonstrated higher levels of reflexivity as described by Mezirow (1981). However, the authors concluded that writing reflective diaries did promote reflection and learning, self-evaluation and evaluation of clinical learning.

Wong et al. (1995), Wong et al. (1997), and Kember et al. (1999) provide a subset of studies about reflection using quantitative methods with ratings derived from Mezirow's (1981) work. Wong et al. (1995) describe the use of reflective journals to study the level of student reflection. This group attempted to develop and test coding systems for written reflective journals based upon a synthesis of Boud et al. (1985) and Mezirow (1981). The students' journals were submitted for content analysis. Forty-five students were allocated to one of three categories, non-reflectors (13%), reflectors (76%), and critical reflectors (11%). Identifying textual elements within the journals and allocating them to the different levels of reflection was more complex and difficult than anticipated and less reliable. Kember et al. (1999) developed a measure with categories based upon Mezirow's seven levels of reflexivity to estimate quality of reflective thinking in students' writing of reflective journals. Generally, there was little evidence of higher level reflection. What is notable in these studies is the large proportion (76%) of nurses who do reflect! How nurses themselves understood and experienced reflection is absent in these studies.

Sparks-Langer et al. (1990) developed a seven point scale for measuring pedagogical language and thinking. They were not able to account for all instances of reflection identified, especially those that appeared intuitive or emotive. They also found the seven-level scale made inter-rater reliability difficult. A three point coding system used by Surbeck, Park Han, and Moyer (1991) categorizes participants as highly reflective, moderately reflective, non reflective. Others have created additional categories, more-than-moderately reflective, less-than-moderately

reflective. Most coding systems have focused only on the analytical aspects of reflection, which are linear and hierarchical, and have been unable to capture other possibilities. Within these studies, reflection is clearly located within the person. There is little attention to such things as the influence of social, interactional, or contextual factors. Over and over again, the studies in the critical traditions report that the majority of nurses do not reflect at the critical or highest levels, suggesting they are somehow deficient. The results are consistent and clear and presumably would continue. Changes in conceptualization, in the measuring tool, in the method of assessment, or in the conditions preceding measurement could lessen the negative nature of the interpretations. A substantial proportion of participants are identified as reflectors, in other traditions this might be celebrated! Participants engage in reflection, but not in critical reflection. Is reflection on a continuum from none to more? Maybe reflection and critical reflection are in two different dimensions. Can one be "just a little reflective?" Is this even a useful consideration? Is written work the best vehicle within which to judge reflection?

There are inherent problems in using written work as the basis of assessment. Sumison and Fleet (1996) express doubts about the value of data from written sources to determine evidence of reflection. It is difficult to differentiate between reflection and mastery of a reflective writing genre. Reliance on written reflection may disadvantage those who have not mastered an appropriate reflective writing genre. There is a suggestion in the findings that it is possible to be reflective without being academically able and vice versa. In addition, there are substantial difficulties involved in attempting to identify and assess reflection. Assuming reflection could be identified and assessed, what relative assessment weighting should be given? There is an assumption that one can identify reflection through writing and that it will fall neatly into

predetermined categories or levels. The "highest" level, critical reflection in these formulations, is generally absent. Classification systems are of limited use in providing insights into the nature of reflection, or appreciation of the complexity of reflection. Reflection appears unsuited to quantitative measurement.

Andrew (1996) describes the different perceptions, expectations and reflections of participants and facilitators as they engaged together in learning in palliative care. As the researcher, she kept a diary/reflective journal in which she recorded analytical or methodological items. Prior to a palliative care course the participants and facilitators received a questionnaire. Details about previous palliative care experience, experiential learning activities, and fears, hopes and concerns about the facilitation and methods proposed for the course were collected. Respondents were asked how they hoped to be different both personally and professionally at the end of the course. Throughout the course short, spontaneous and informal interviews were conducted and formal interviews were done toward the end of the course. The study describes how the participants' reflections on the facilitator-led activities led them to "infiltrate" the facilitators' strategies. The purposes of these strategies and the implications of the students' uncovering of them are described within Schon's framework of reflective practice. This study in the hermeneutic-phenomenological tradition demonstrates its usefulness in course evaluation.

The perspective of nurses is increasingly entering the literature through reports of hermeneutic and phenomenological studies. Rather (1992) in a phenomenological study among registered nurses returning to school, notes there has been little research on these nurses' lived experience in relation to their school experience. Through hermeneutic analysis, expertise, for these nurses, was constructed as reflective thinking about all the nuances of a situation and its

meaning. There is a need to specify the meaning of reflection for nurses engaged in practice, to describe the meaning of reflection from the perspective of those who actually live the experience, grounded in the nurses' perception rather than imposed from without.

Wilkinson, et al. (1998) describe a hermeneutic interpretation of narrative evaluation data from 97 students participating in an introduction to nursing course in an undergraduate nursing program in Manitoba. This practice-driven, phenomenological approach to the course and the evaluation included the opportunity for and exercise of reflection, integration and analysis. One pattern of learning identified through hermeneutic interpretation involved moving from a position of being observers and passive recipients of information to being active participants in learning about nursing (p. 227).

What is absent in most studies is attention to the world of practising nurses: the actual concerns in nursing work, how practice constrains or supports reflection, and provides the substance for nurses' reflections. Much of nursing work is necessarily concrete (Noffke & Brennan, 1988). Within nurse-other relationships there is essential attention to the technical, procedural, concrete interventions or treatments. This needs to be identified, clarified and supported. The values of caring and nurturing, connectedness with persons, within nursing need to be incorporated and addressed. These may be more salient for nurses than for instance, the values of justice and equality found within the critical perspective (Noddings, 1984). Who is the reflector in these studies? The nurses are not known except as a group of students or practising nurses. There is a need to go beyond the individuals and honour the social process that is reflection. What are the actual concerns and questions of practising nurses?

In summation, a gap exists in understanding practising nurses' experience of reflection as

has been illustrated in this chapter. Research-based efforts intended to contribute to the resolution of this gap have been virtually non-existent and no studies investigating the meaning of reflection to practising nurses have been reported. No-one has asked practising nurses how they understand and experience reflection. The incompleteness of our understanding of reflection among practising nurses presents a challenging notion that needs phenomenological exploration and hermeneutic analysis to unravel the meaning of this experience. The orienting framework may have utility as nurses describe their experience of reflection. The relationships among these attributes or dimensions may emerge as we understand practising nurses' experience of reflection.

CHAPTER THREE

Method

In this chapter the method of this interpretive study of long-term care nurses' experience of reflection is set out. The method includes the research approach, purpose and research question, the interview and selection process. The setting and participants, data collection and interpretation, rigour and trustworthiness and finally, a summary of the method is presented.

Research Approach

Qualitative methods, such as phenomenology and hermeneutics are suggested as appropriate to study reflection (Brookfield, 1991; Mezirow, 1996). Qualitative inquiry is an interactive and transformative process. Phenomenology, used in this study, is a descriptive approach to the meaning of experience, in this case, reflection. It seeks to learn about and interpret life experiences and come to a deeper understanding of the nature of the experience of reflection (Ray, 1997; Sword, 1999). Phenomenology, through the use of subjective, intersubjective and first person experiences as the source of knowledge, attempts to study phenomena as they are consciously experienced. It respects the capacity of long-term care nurses for self-knowing (Beck, 1994; Robertson-Malt, 1999). Knowledge is produced, not discovered, and is understood as the creation of an interaction between myself and the participants, between the text and myself (Bailey, 1997). Reality is assumed to be multiple and constructed, rather than singular and tangible (Sandelowski, 1993, p.3).

Several concepts and frameworks have been used to explain reflection. However, there have been no attempts to explore reflection from the perspective of practising nurses and therefore no coherent theoretical framework in which to orient research. My interest was in first

person accounts of nurses' understanding of reflection, because this particular perspective is absent in the nursing literature. These nurses, who have lived with reflection, are the best source of expert knowledge about their experience of reflection. Through conversations we assign meaning and we acquire understandings about our lived experience through language. In understanding what it means to reflect, we may also understand the meaning structure which comes to restrict, widen, or question the nature of reflection. To understand long-term care nurses, I needed to gain access to the nurses' lived experience of reflection. My interest is in process, context and discovery rather than confirmation (Merriam, 1998). Interviews, discussions or conversations are particularly important methods in understanding the world of long-term care nurses.

While we engaged in interviewing, I often use the term conversation interchangeably. Conversation more accurately and fully describes the actual process. Interview implies that one person asks questions of another person, whereas conversation implies a discussion and more closely captures the tone of the interactions. Like interviews, the conversations had a focus, but were not one-sided, there was a give and take, a pooling of ideas. The conversations involved descriptions of experience and consideration of those descriptions (Morse, 1991). Conversational interviews were modeled upon Kvale (1996) where the interest is in the participants' lifeworld.

van Manen (1990) identifies six research activities within the hermeneutic phenomenological tradition: a) turning to the nature of the lived experience; b) investigating experience as we live it rather than as we conceptualize it; c) reflecting on the essential themes which characterize the phenomenon; d) describing the phenomenon through the art of writing and rewriting (van Manen, 1984, p. 2); e) maintaining a strong and oriented relation to the

phenomenon; and f) balancing the research context by considering parts and wholes (pp. 30-31).

Purpose and Research Questions

The importance of reflection for professional practice is widely recognized. In Ontario, the College of Nurses requires all nurses to engage in reflective practice and to document this on their annual registration renewal forms. We know little about what practising nurses find meaningful about their experience of reflection, how they might describe this experience, or if they reflect at all. Reflection, as experienced by individual registered nurses engaged in active practice, has not been systematically explored.

The central goal of the study was to come to an understanding of the nature of reflection in the experience of practising nurses, for the purposes of description, interpretation and the advancement of nursing knowledge. The aim of illuminating nurses' experience of reflection is accomplished by providing a construction of these nurses' experience. The purpose, to describe the meaning of reflection from the perspective of registered nurses engaged in active practice, was guided by the central phenomenological questions:

How do practising nurses experience reflection? Where, when, and how does reflection enter the experience of practising nurses?

Research Design

In these sections the research design is presented. This includes the conversational interview process, the setting and context, and the participants. The data collection process, including the conversational interviews and the focus group interview is described, followed by my study journal and the creation of the texts. A brief description of the data interpretation is provided.

Conversational Interview Process

To explore and understand the experience of reflection, I participated in seven interviews and one focus group interview with long-term care nurses. I invited the participants into ongoing conversations where data arose in the interpersonal situation, coauthored and co-produced by myself, the researcher (Kvale, 1996, pp. 10-11). These interviews were shared experiences; we both shaped, and were shaped by, the conversations (Allen, 1996). The approach in the conversations was open, allowing the participants to take me with them in their narration. The goal was to understand the nurses' descriptions of reflection experiences and questions flowed from the participants' responses. Within the conversations I used orienting questions and probes (see Appendix C) as determined by the conversation. They were used to elicit more detail, help focus the participant, and ensure that the participants had the opportunity to address many facets of the phenomenon of reflection (Cranton, 1994). Asking the nurses to talk about reflection and some of its attributes prompted the nurses to think and talk about things which otherwise they might not. Through description I tried to retrieve the meaning and to capture the interpretations the participants brought to their experiences.

To ensure that my bias or overenthusiasm did not skew the findings, a second interview, in which the developing interpretations were subject to challenges or refinements, was built into the design. I provided the participants with a descriptive interpretation of their initial conversation in the second interview. The very act of engaging in a conversation produced new insights and awareness (Sandelowski, 1993); the participants changed, enhanced or confirmed their descriptions or meanings. This second interview provided the opportunity for a more robust description of reflection. It ensured confidence that interpretations are grounded in the data and

representative of the shared realities (Thorne, Kirkam & MacDonald-Emes, 1997).

Selection Process. Following approval from the Faculty of Education Ethics Committee, the Directors of Care at three long-term care facilities in Ottawa-Carleton were informed about the study and their cooperation sought. I have a prior relationship as a consultant to these facilities and with the nurses. Permission to present this study to the facilities' ethics committees was not required, as the participants were not residents of the facilities. In most facilities the Directors of Care informed the potential participants of the study and invited their participation. I developed and posted an invitation to participate, in the form of a fuchsia flyer, in the nursing stations of each facility (Appendix D). While on site during my regular visits, I spoke with nurses about their potential participation. Long-term care nurses who participated in a regional five day geriatric mental health education program were also invited to participate.

I informed the participants about the purpose of the study and how the data would be collected and used. Copies of the modified abstract (Appendix E) to review in the days prior to engaging in conversation about reflection were provided. The participants did not have to prepare for the conversational interviews and this encouraged their participation. I specifically addressed the possibility that discomfort might be experienced, for example if they were uncomfortable talking about their experiences, or that through reflection they might be challenged in the way they thought, felt and believed (Burnard, 1989). Some possible positive consequences of the experience such as gaining additional insight into reflection and/or fulfilling the annual registration requirements (self-assessment and quality assurance) of the College of Nurses also encouraged participation. I reinforced my belief that these nurses, who have lived with reflection, were the best source of expert knowledge about their experience of reflection.

Participation was entirely voluntary and the nurses were free to withdraw from the study at any time without negative consequences. Confidentiality and anonymity through the use of pseudonyms was assured. Max and Six actually chose their own names! Work settings while not identified by name, were three of seventeen long term-care facilities within the Ottawa-Carleton region. Tapes remain carefully and confidentially stored. Access to the data was limited to the researcher and the thesis committee. The nurses who freely decided to participate in this study were invited to sign the consent (Appendix F). All of the nurses expressed interest in the results of this study and subsequent publications.

Setting and Context

Nurses from three long-term care facilities in Ottawa Carleton participated in this study. I have a relationship with a number of long-term care facilities in Ottawa Carleton as a mental health nurse consultant. Over five years, I have developed relationships both with the facilities and with the staff where I am a resource to the facilities, the staff, residents and their families. Long-term care is my practice setting.

The nurses had learned their place within the organization and culture and they knew how and where they were situated within the long term care hierarchy. They had learned the meaning of place with respect to practice. They were familiar with having responsibility for their units, and for non-professional staff, although with no line authority. The nurses practice alongside residents in the residents' home, which is also an institution. The nurses are separated in space while doing their work because they work on separate units within the facility. They are responsible for a minimum of 36 residents, and may be responsible for the entire facility on evenings or weekends. None of the nurses work together on the same unit as there is at most one

registered nurse working on a unit at any time. On weekends they cover other units besides their home unit. This provides the nurses with some familiarity with each other's units and with the residents throughout the facility. So, while they work within the same facility, they do not practice together on the same unit.

The nurses are all female, and in this case comprise a representative sample in the sense that there are no male registered nurses in the three long-term care facilities. The homes are all not-for-profit. One facility, on the outskirts of the city, has four units, two of which are special care units, in total about 160 beds. Another, within the city has 195 beds and is divided into three units each with about 60 residents. The last home is a small (70 bed) new home with two units of 35. One unit is a special care unit. Special care units are specifically designed for persons living alongside dementia and having behaviour problems or psychiatric symptoms, and a propensity to wander.

Long-term care nurses have frequently been the subject of study, for example, as participants in continuing education programs and in exploring attitudes towards seniors (Davies, Slack, Laker, & Philip, 1999). I believe that nurses "self select" into clinical areas. Long-term care requires a specialized skill set and approach to care, an orientation to care that is different from acute or episodic care (Gibson, 1999). Very real differences also exist between primary (community) care, secondary (long-term) care and tertiary (acute) care with respect to scope of practice, status, and staffing among other things. Nurses working in long-term care are particularly appropriate for this study. They work with a population of residents possessing a rich history of life experience. Residents experience complex issues such as chronic illness and end-of-life issues. These residents are not experiencing an episode of care. They are living and dying

in these facilities, and the nurses accompany them on their journey. Palliative care is a component or dimension of long-term care and the nurses share palliative care as a focus in practice. The nurses collaborate with the residents and with their families, so the families can also care for their loved ones. In the homes, at least quarterly, a memorial service is held, attended by staff, residents and families. The nurses' involvement with these residents, who are known in their uniqueness and with whom there is a long term engagement emphasises the personal rather than the technical, providing rich material for reflection (Kitwood, 1998).

However, in long-term care there is also increasing complexity of resident care needs, and changes in philosophies of care (Barnes, 1999). Organizationally there is an espoused commitment to "resident-centred care." In fact, the emphasis is on capturing and documenting time spent on tasks (managing behaviour, physical care), in order to acquire funding. Each facility is faced with an annual care need classification by the Ministry of Health and Long Term Care, called case mix index (CMI). This derives from documentation of the time spent providing care, and funding for each long-term care facility is based upon its CMI. Long-term care facilities are increasingly turning into subacute care facilities, although the increased acuity is met with the same level of total staffing (McBride, 2000). The increased care needs profoundly impact upon long-term care facilities and this is juxtaposed with the paradigm shift to resident-centred care, within a health care climate of fiscal restraint.

The context also includes the College of Nurses (CNO) requirement for reflective practice that is shared with all Ontario nurses. Each nurse would have completed the 1998 renewal registration form, which required documentation of reflective practice. However, as with most nurses, I did not expect this group to have formally encountered the phenomenon of

reflection during their nursing studies.

Relationship With Participants As consultant to facility, staff and residents, I visit each facility monthly. I may also visit or consult by phone with the staff around particular residents and/or systems concerns. I have provided mental health education programs in each facility. Two nurses from each of 17 regional long-term care facilities attended mental health/long-term care education programs. These were provided by a colleague and me and funded through the Ministry of Health or through a Community Investment Fund initiative. I mentor long-term care nurses as they progress through their post-basic education programs. As an advanced practice nurse, I have years of working with and developing supportive relationships with front line staff. In this particular community and these particular facilities, I had established myself as someone who understood their situations and experiences.

Within the study, I was not merely a privileged observer, I was involved. Our everyday lives were filled with work and home. Mine included the study of the nurses' experience and a penetrating investigation of the literature about reflection, reflective practice and hermeneutic phenomenology. We were all immersed in our own life histories, but we also enjoyed a shared history. As the nurses were struggling to understand reflection, so was I. However, I was very interested in exploring their experience, they were not exploring mine. Although the mutuality was inevitably skewed by the research intentions, there was a sharing of common concern and experience (Morse, 1991).

Participants

Practising nurses working in long-term care in the Ottawa-Carleton region were invited to participate in the study and seven nurses comprised the intentionally, purposively selected,

cohesive sample. Nurses entered this qualitative study by virtue of having direct, personal knowledge of the experience of reflection that they were willing and able to communicate with me (Sandelowski, 1995). Nurses were full- or part-time, practising in one of three long-term care settings in the Ottawa-Carleton region. These experienced nurses had between three and 30 years of nursing experience generally, and from three to 17 years experience in long-term care.

Participants approached me either by phone or in person and they were invited to take part in the study, at a time and a place convenient to them. A total of 13 women took part in either a focus group or individual interviews. Two nurses from the smallest home, one who works the night shift, the other, evenings volunteered but did not participate due to scheduling problems. The nurses, all female, ranged in age from 25-58, the majority were married, one had been separated for about fifteen years. All but two had children. All were English speaking.

Beth, Lora and Edi are from different units in the same facility; they work days. Beth and Edi practice on special care units. Beth and Lora are pursuing post-basic baccalaureate nursing degrees. Ruby, Miranda and Six practice in the same facility; Miranda works days, Ruby and Six evenings. Ruby and Miranda have university nursing degrees. Max is from the smallest and newest home, she practices on a special care unit, and is baccalaureate prepared. Of the seven nurses, three had generic baccalaureate degrees in nursing, each from a different Canadian university. Two nurses were enrolled in the post-basic baccalaureate program at the local university, and two were diploma graduates with many years of experience. I was surprised that so many had a university affiliation. Interestingly, none of the participants had encountered reflection within their basic nursing education programs. Two of the baccalaureate nurses, in retrospect, identified anecdotal notes as a form of "forced reflection."

Most participants were articulate, thoughtful, and eager to share their views (Morse, 1991, p. 127), particularly after the initial unease with the tape recorder passed. One nurse, who is generally outspoken and has no trouble speaking her mind, was particularly intimidated by the tape recorder and did not achieve comfort in that respect. Purposeful selection of the nurses revealed elements that were to a large degree shared by others although not all the data share this common nature (Coyne, 1997). Seven nurses working in long-term care in Ottawa-Carleton comprised a culturally cohesive sample (Morse, 1995). These nurses described their experience of reflection through language, where words can be interpreted by the reader or the researcher.

The nurses were "honoured" to be included in the study. I wondered if they would perceive what I was trying to achieve as worthwhile. They endorsed the value of the project and were particularly pleased that front-line nurses practising in long-term care were the focus of the study. Kvale (1996) suggests that the interview may be a positive experience. People enjoy being interviewed, having someone listen for an hour or so, trying to find out what the interviewee is saying, and helping to clarify the meaning of significant themes. I avoided the possibility that participants might have been patronized or the possibility for hurt through implicit suggestions that things were in need of improvement, by my respectful stance and a demonstrated interest in their experience of reflection (Leino-Kipili, 1990). Nevertheless, there was a strong, unanimous perception that reflection had much to do with improvement. Consistent with Wellington's (1996) observation, the nurses related that they had never thought about how they reflected. They were aware that they reflected, but had not considered this as something they could control or use as a learning tool. The mere naming of the process was a significant aid to the use of reflection (Boyd & Fales, 1983).

Data Collection

The conversational interviews took place between February 1999, following approval from the Faculty Ethics Committee, and May 1999. In order to explore nurses' experience of reflection, seven practising nurses with whom there existed a prior, collegial relationship, engaged in two private audiotaped conversations, at a place and time chosen by each participant. The conversations took place on site for the most part, with one in my office and one at a participant's home. After obtaining informed consent and assuring the participants of confidentiality, I asked the nurses to narrate what they regarded as reflection from their point of view. This required each participant to define what she believed constituted reflection and multiple realities emerged around the phenomenon of reflection. van Manen (1998) notes it is a "simple phenomenological precept to always try to understand someone from his or her situation, from the way he or she experiences the situation" (p. 8).

I encouraged the participants to speak freely and to respond to any orienting prompts or questions (Appendix C). Like all other professionals, these nurses were assumed to be situated within their practice, relying on background understandings that might not be fully articulated, but operative. I encouraged everyday language, complete with multiple meanings, ambiguity and nuance (Benner, et al., 1996). The nurses did have trouble when asked for examples to illustrate their ideas; some were unable to provide one. Others, although they were assured that "just a little example" would be helpful, recounted long, elaborate and intricate examples of situations, where the nature of reflection remained unclear.

Consistent with van Manen's (1984) view of phenomenological research as the attentive practice of thoughtfulness, a "caring attunement" (p.1) pervaded the conversations. I concentrated

upon the process of attentive listening. The nurses developed interest in this research project in which they had willingly involved themselves. They began to care about the study and the research question. Now, when I encounter these nurses, they inquire about the progress of the study and sometimes, they relate that they have been reflecting or have come to an understanding through reflection. I developed a certain moral obligation to participants that prevented an exploitive situation (van Manen, 1990). The interviews were set up to encourage collaborative hermeneutic conversations. I positioned myself as learner who valued the nurses' "expert" knowledge in my learning about issues related to reflection. This likely contributed to my success in gaining entry and engaging the nurses in the research process. Their eagerness to share their ideas and have their voices heard was a factor in developing our relationships. Each interview was transcribed verbatim and the resulting texts were interpreted.

Conversational Interviews

The interview situation is the locus of knowledge in interview research, a conversation between two partners about a common theme of interest where knowledge is constructed in the dialogue. I invited the participants into ongoing conversations. It was crucial to engage the nurses and I used a number of strategies to promote acceptance of my presence and purpose in the researcher role. Throughout the conversations I emphasized importance of understanding the nurses' concerns and perspectives. I chose words so as not to distance them through inappropriate language; I noticed myself echoing their words, terms and phrases. The nurses readily entered into dialogue with me, demonstrated relaxed postures, and shared personal information, suggesting that they felt comfortable conversing with me. Most, initially, seemed intimidated by the tape recorder; it was a passing concern for all but one participant.

Within the qualitative phenomenological interview process several phases are identified by Kvale (1996) and these were evident in this study. Initially, the nurses described unrehearsed thoughts and feelings concerning reflection, without any distinctive interpretation. This was in response to a general question asking what reflection meant to them. While they had been assured that no preparation was necessary, when asked what reflection meant to them, they unanimously provided a brief initial description and then stopped as if their description and participation were complete. They were lost about how to continue and the probes provided some direction.

Another phase involves the participant discovering links and connections or new relations; that is, discovering new meanings in the experience of reflection. Following their initial descriptions, the nurses were helped towards a fuller description by considering different aspects, attributes and characteristics. None of the nurses had difficulty speaking to my invitations to consider different aspects. They willingly shared their thoughts often in response my interjecting a question directing their attention to another aspect of the phenomenon of reflection. The nurses found the questions helpful to see other perspectives or consider other ideas and we had different conversations than we might otherwise have had. They created fuller, more "rounded" descriptions and we explored different aspects of reflection more fully.

The questions or probes arose from my familiarity with the literature around reflection. Some aspects such as the possibility of it being a deliberate, purposeful activity, had been identified. I wondered about an affective component to reflection and whether nurses engaged in reflection. Were nurses aware when they were reflecting? Were nurses introspective about their practice? When they reflected, what sorts of things did they reflected upon? How they came to

know about reflection? I also wondered about the relationship of problem-solving to reflection, and whether they perceived a purpose and/or outcome with reflection.

Kvale (1996) identifies another phase in which the interviewer condenses and interprets meaning from what is described. Interpretation is done together with data collection (Merriam, 1998, p. 181). Throughout the interviews, I summarized and clarified the content. Descriptive interpretations were offered for participants' consideration and they had the opportunity to clarify, accept, modify or reject these interpretations. These nurses were quick to correct any misinterpretations and to validate correct interpretations. This process allowed the refining of meaning through an exchange, and the immediate verification or repudiation of meaning. I had also informed the participants right at the outset of their right to decline to answer questions. When they chose not to respond I respected this, particularly as this is essential in collecting valid data (Sword, 1999).

Within the interpretation phase, self-understanding enables the interviewee to clarify meanings, with interpretations remaining within their frame of reference. I moved beyond the interviewees' understanding of a theme. This involved getting a sense of what was said, listening for what was not said, and reading between the lines, moving outside the interviewees' frame while remaining within the theme.

A final phase involved re-interviews following initial analysis and interpretation. I offered back the written transcripts/interpretation to the nurses for their consideration. Once descriptive themes are identified, they become objects of consideration in follow up hermeneutic conversations in which researcher and participant collaborate (van Manen, 1990). I encouraged the nurses to modify interpretations. Themes were deepened within the re-interview (Kvale,

1996). During this phase, I encouraged the nurses to voice any ideas that had occurred to them during the intervening time.

Focus group interview. Following completion of the first individual conversational interviews, long-term care nurses in a neighbouring county attending a mental health education program were invited to participate in an audiotaped focus group. This was to explore their experience of and perspective on reflection and as a follow-up of individual interviews to clarify findings (Morgan, 1988). In the focus group six nurses gathered to discuss their experience of reflection, after having the opportunity to review the modified abstract about the study. Following explanation and informed consent (Appendix G), I engaged this group of six participants in an audiotaped focus group interview. These nurses, all over 25, were given the pseudonyms, Alex, Mary, Connie, Pia, Suzie and Vera. They are all married with children. Two nurses worked in each of three different facilities, in three different rural communities. The purpose of this data gathering technique was to elicit these nurses' descriptions of reflection, explore new ideas and to validate themes from the individual interviews (Morgan, 1988). The group chose to meet for 45 minutes the last day of a five day an mental health education program. A colleague with whom I was providing the mental health education program, was the recorder. She took field notes, participated in debriefing, and verified the transcripts (Pearson & Smith, 1985). My role with the focus group was to listen and learn from the participants, while directing the discussion, encouraging participation and probing without biasing the responses. I selected this group of long-term care nurses because differences in geographical (rural) location and culture might provide new insights and/or confirm initial interpretations.

The recorder was my colleague, Margaret. We met over 15 years ago as graduate students

in nursing. We both practise within the McGill Model of nursing. Over the last ten years we have both subspecialized in geriatric mental health and psychiatric nursing. We have worked in the same program and shared the same role although with different long-term care facilities, for the last five years. My colleague has followed with interest my progress through this graduate program and we have enjoyed opportunities to integrate some ideas, knowledge and skills into our work. She is a valued critic and a valued support.

Initially, I gave each focus group participant a small piece of paper. Then I asked them to just take a few minutes and write how they understood reflection, what it meant to them (Morgan, 1988). They then shared this with the group. This served as a jumping off point for discussion and a lively conversation followed. To ensure that this group addressed descriptive themes arising from the individual conversations, I asked them if they thought there was for example a purpose, or outcome, or affect associated with reflection. I transcribed the tape and reviewed the transcript with my colleague the recorder. Later, she also reviewed the focus group narrative.

Study Journal

Maintaining a thoughtful approach is essential in this research process. This journal provides the opportunity to record "speculation, feelings, problems, headaches, impressions and prejudices" (Bogdan & Biklen, 1992, p. 1221). Koch (1996) identifies a journal as essential to get into the hermeneutic circle and to contribute to textual data. I wrote about the way in which my insights were generated and interpreted. This included the influence of my values (prejudice) and a record of the way in which a study was accomplished. For example, I wrote of the "pull" of the critical reflection model for myself, acknowledging that this perspective was outside the

frame of the participants. Following the conversations and as I read and thought I included my thoughts, feelings and reactions in my journal. I explored the effect of myself within this research process as an integral part of the generation of knowledge, not merely as a neutral observer (Rose & Webb, 1998) and I come to new understandings. I used my own experience and background and how these interacted with the nurses' stories as data. I recorded conceptual and theoretical notes. For example, I wrote of collaborative reflection and the notion of bracketing. Plans for analysis and interpretation were written in this journal. I also linked perspectives and ideas from the literature with my thoughts. Some ideas were retained, some discarded and some incorporated in other areas of my life. I experimented with different metaphors to illustrate the reflection experience. Webs, rainbows and spirals, for example, in the end did not capture the essence of the reflection experience. Reflection in the geography of everyday life emerged and does capture the essence of the reflection experience. My journal in a sense is dialogue with myself.

I entered all my notes and the transcripts into computer files. Selected passages from my journal, individual and focus group interviews were saved in thematically oriented files. Concepts and metaphors related to reflection were captured, analyzed and compared to and sometimes linked to those in the literature. Related data were linked by moving them or joining them within related files.

Creating the Texts

I was aware that some of my interpretive thoughts would shape the creation of the textual work. Therefore, I transcribed the conversations myself and this led to an intimate understanding of the participants' experience. Listening to the tapes, transcribing the tapes, and then listening to

the tapes with transcripts enabled familiarization with the texts. I recognized in transcribing that some interpretation had taken place within the interviews. Where participants had not considered different aspects in relation to reflection, I had directed their attention to these areas. We had discussed responses that were less than clear and this helped to clarify the responses.

I transcribed the first seven conversations verbatim and common descriptions emerged. This was useful for the focus group, as it enabled confirmation, expansion, and the identification of differences. The focus group conversation was transcribed verbatim with the initial the written descriptions included. During the second individual interviews, I gave each nurse her own transcript to follow along. Within these conversations I also shared some data from other participants, including those in the focus group. These conversations were also transcribed verbatim. I took care in maintaining the fidelity of the recorded and written text. The first review of the conversations comprised listening to the tape and correcting errors in the transcribed text. Shifts in meaning that might have been introduced by small errors in transcription were eliminated. The process of transcribing and reviewing journal entries enabled closeness and familiarity with the data. This facilitated the identification of preliminary themes (Poland, 1995), and was an initial step in analysis (Higgins, 1998).

The transcribed conversations formed the texts. Gregory and Walford (1989) maintain "our texts are not mirrors which we hold up to the world reflecting its shapes and structures immediately and without distortion, they are instead creatures of our own making, though their making is not entirely of our own choosing" (p. xiv). Phenomenological text is descriptive in the sense that it names something. It aims at letting something show itself, it is interpretive in the sense that it mediates or is mediated through language (van Manen, 1990). Interpretation occurs

through the deliberate act of describing aspects of the experience in textual form (van der Zalm & Bergum, 2000).

Following reading and re-reading the transcripts, and considering notes from my study journal, thinking, writing and rewriting, I developed narratives for each participant and one for the focus group. Creating the narratives was like a distilling of the content, shifting (Morse, 1994) or winnowing. It was a way of managing the considerable volume of data accumulated, and illustrating each nurse's story of the reflection experience. Writing the narratives involved a continual moving back and forth between the interpretive writing and the transcripts, highlighting and selecting particular descriptions. I identified key descriptions and returned to examine them against appropriate contextual data. This was a part to whole and whole to part approach across the conversations, a hermeneutic. Then I reconstructed these descriptions within the context of each individual story. Verbatim quotes are included as it is important to let the data speak for themselves. The emerging constructions echoed and connected across all the transcripts and narratives (Tapp, 2000). The narratives provide a glimpse into the history and context of reflection for these nurses. They help to situate our understanding of the experience of reflection, for this group. Within the narratives, these nurses describe their experience of reflection, including why nurses reflect, what nurses reflect upon, when reflection takes place, and how nurses reflect. In searching for deeper levels of understanding the data spoke to me. I came to appreciate that the reflection dimensions in the orienting framework would be a useful structure within which further interpretation could occur. Through inductive interpretation the relation of reflection within the fundamental lifeworld themes emerged. The rich imagery in the narratives is expressed through several metaphors.

I took the narratives back to the participants to ensure accuracy and a true to the participant representation. The recorder checked the focus group interview. These narratives or stories of each nurse's experience of reflection were interpreted accounts. Each person's conversation had been precised, but in their own words. The use of the participants' language ensured that I did not impose my concepts, theories or jargon and that the language fit with the nurses' understandings. Within the conversations there had been self-correcting. When the participants recognized their descriptions as "not quite right," they elaborated or corrected the descriptions and only these self-corrected descriptions were used. The participants had also corrected my interpretations when they were not accurate. I checked with the participants that nothing had been added to the narratives, or misinterpreted, nothing relevant excluded, and that there was a true representation in the "tone." Participants recognized the accounts as their own and they were surprised at their eloquence. They gave a phenomenological nod to their stories. I had "cleaned up" their conversation, removing the uhs, ums, I means, you knows, and such which had not substantively affected the content. The participants concurred with the interpretations of their transcripts and narratives and were satisfied that relevant issues had been identified. They confirmed that their experience had been faithfully and clearly represented. No changes, additions or deletions, were suggested, but there were affirmations that these constructions rang true and I was confident that these were "true" representations. I included their initial statements about reflection and narratives were constructed so that "growth" of their understanding was evident.

Data Interpretation

Tape recorded, interactive, personal and group conversational interviews provided some of the data. These were enhanced with notations in my journal which included thoughts and responses to the interviews and to relevant literature. Morse (1994) identifies the first step in analysis as having in-depth knowledge of the phenomenon, leading to comprehending and understanding. Comprehending reflection was achieved through thinking about my own experience with reflection, reviewing the literature on reflection and reflective practice, and engaging in conversations with the nurses to develop an understanding of their experience.

Reading, writing, thinking and dialogue are the central activities of hermeneutic scholarship. I was also aware of the relevance of theory and practice to understanding. The interpretation of the data was linked to other facets of my background, including my clinical nursing experience. I read the interviews initially to get an overall picture, to look at the data to see what to look for (Sandelowski, 1995; Thorne et al., 1997). I focused on getting a sense of each interview. This involved attending to inconsistencies, endings, repetitions, and silences. I took care to avoid word overload yet to get a sense of the whole (Poirer and Ayres 1997). I read to look for descriptors, descriptive statements about reflection. Previously encountered reflection concepts were helpful in providing an orientation for interpreting the data. I interpreted within my current understanding, which resulted in discretionary selection of events and details (Poirer & Ayres 1997). The meanings related to different forms of understanding. Through these iterative interpretations I achieved a better understanding of the texts and generated a different appreciation of reflection than had been presented in the literature. Researchers "coax their definitions and accompanying names from the data" (Millar & Dzruec, 1993, p.18); I also

embarked upon naming the text. Conflicting or incompatible interpretations were worked out by relying on thoughtful rereading of the text for evidence about the interpretation.

Early leaps in understanding often occur when encountering a particularly vibrant example that stands out from other examples when one is considering the whole text (Benner, 1994). Part of interpreting was puzzling through, with close attention to the text, how and why those particular instances stood apart and caught my attention. Some surprises included the strong notions of improvement and collaboration related to reflection. Another surprise was the firm, consistent, intriguing declarations that the nurses do not reflect in action.

Another process of analysis may be thought of as "sifting" (Morse, 1994, p. 31) or winnowing the insignificant parts from each data source, leaving only common but significant features. The most effective way to tell the story and to stay close to the data was through the narratives I created for the individual nurses and the focus group. These may be seen as another level of interpretation, a construction of the reflection experience for each participant. The narrative may be considered a poetic, expressive form that is a reconstruction of the experience from which it originates (Denzin & Lincoln, 1994).

While there is no correct interpretation, I was aware it would be easy to miss or overlook some parts. There was the danger of jumping in with analysis before hearing what is really being said. I entered the hermeneutic circle in a way that was shaped by my early grasp of the phenomenon, reflection. I respected the possibilities of the phenomenon of reflection showing itself in new ways, always mindful that "we must show the entity or, more precisely, let it show itself, not forcing our perspectives on it. And we must do this in a way that respects the way it shows itself" (Packer & Addison, 1989, p. 278). I was also mindful that the goal in hermeneutic

analysis is to discover meanings and achieve understanding.

Data sources included the participants' and focus group's transcribed conversations and narratives. My journal notes, reflection literature including reflection models and discourses, and attending to my own personal experience throughout the process were further data sources. These provided the context in which the emerging descriptions linked to existing knowledge and provided a way of demonstrating the utility and implications of the findings (Morse, 1994). New understandings or constructions of reflection emerged that are grounded in data and these accommodated the diversity of perspectives and experiences. This constructed reality of the nurses' experience of reflection is "as informed and sophisticated as it can be at a particular point in time" (Guba & Lincoln, 1989, p. 44). The descriptions, themes and patterns emerged from the data through inductive analysis. Deeper levels of interpretation emerged from the conversations/narratives, my study notes, and reflection literature and were not imposed before data collection. There was no imposition of frameworks or theories on the data. It was through reading and writing, rereading and rewriting that the data spoke to the reflection dimensions or attributes and to the fundamental lifeworld themes. These were not reified predetermined categories. They emerged well into the interpretation stage of the study and are represented through carefully and thoughtfully selected passages from the texts. The writing and rewriting, the constant search for deeper meaning, changed not only my understanding of the particular part of the study but also the whole study, which again required rewriting. This constant search for new understanding has been called the hermeneutic circle, which contains the possibility of deeper understanding. The recognition that it is not yet finished is very real (Morse, 1991, p. 66)

Making something of a text by interpreting its meaning and recovering the embodied

themes, is a process of insightful understanding, discovery or disclosure, grasping and formulating thematic meanings. Phenomenological themes may be understood as structures of experience, and fundamental lifeworld themes include: lived space (spatiality); lived body (corporeality); lived time (temporality); lived human relation (relationality or communality) (Morse, 1991, p. 64). Not surprisingly these fundamental lifeworld themes emerged from the texts and were a focus in interpretation.

Rigour and Trustworthiness

I kept a journal throughout the process. This contributed to self-awareness/self-reflection and enabled the context, process, and reaction to and within conversational interviews to be captured. Issues emerging from the research process and the related literature also created material for study. My journal notes include the nurses' reactions to me, how I was collecting the data, and engaging in the conversational interviews, what I was observing and hearing. Random thoughts and ideas were captured and explored. My approach to thinking about and interpreting the data, the decisions made with my justification of what was done, and how this study was accomplished are also included in my study journal. Descriptive precision corresponds to exactness in quantitative research. This decision trail helps in establishing trustworthiness. The multiple data sources, journal entries, individual and focus group conversations help to create the best construction of the nurses' experience of reflection. This also contributes to the trustworthiness of the research process. These journal data also provide a context for my study of reflection among nurses.

I paid attention to maintaining rigour throughout the process. Rigour in analysis was enhanced by returning to the texts again and again. It began with being "present" at the

conversations, listening to the tapes, transcribing, reading and re-reading the transcripts to ensure familiarity. Familiarity with the texts enabled thinking/assimilating/intuiting and finally interpretation and understanding. Familiarity with the texts also allowed understanding to occur through the mediation of my past academic training with rational and intuitive comprehension (Rose & Webb, 1998). Representativeness is enhanced through repeated reading of the transcripts, checking the data or themes against others; this aided in discovering and resolving distortions or inaccuracies.

Credibility is evident in this study as the nurses immediately recognized descriptions and interpretations of the reflection experience as their own, a "phenomenological nod" (Guba & Lincoln, 1981; van Manen, 1990). As this research was conducted from the point of view of the nurses being studied (Mohr, 1997) relevance and credibility were enhanced. I have a personal, historical relationship with the participants, and first hand situational knowledge, which enhanced the process (Mohr, 1997). We shared the common meaning of history, culture, and the language of the world as it is lived together.

Smith and Biley (1997) suggest that establishing credibility may be enhanced by using several types of triangulation, and these were used in this study. A variant of the constant comparative method where a word, phrase or comment repeatedly appears helps to verify its existence. Two other types of triangulation contribute to establishing credibility. Data were collected through individual interviews and a focus group interview. There were some differences but much similarity in the data increasing the credibility. The variety of participants is another form of triangulation. The more the participants indicate the importance or relevance of an issue or idea, the more the data can be trusted. This lends credibility to the findings and

contributes to dependability (Hall & Stevens, 1991). Appleton (1995) argues that the process of triangulation increases the accuracy of qualitative research findings. Data from different sources can confirm veracity, one of the principal benefits of triangulated methods.

There are probable limitations in how I interpreted the meanings of the descriptions, as the interpretation is limited to my perspective. The process of analysis depends upon the unique creative process between the inquirer and the data (Munhall & Boyd, 1993; Schultz, 1994). Familiarity with the participants' world and the data also affects interpretation. To ensure that my bias or overenthusiasm did not skew the findings, the design included repeated interviewing. The developing conceptualizations were subject to challenges or refinements. Hermeneutics, as the theory and practice of interpretation, aims to disclose for understanding the meaning of the experience of reflection (Ray, 1997). Taking the transcripts and narratives back to the participants for their critical consideration, for credibility checks, ensured confidence that the conceptualizations are grounded in the data and representative of the shared realities (Thorne, et al., 1997).

We started with the participants' existing constructions of reflection and worked towards increased information and depth in their constructions, and my own constructions and reconstructions. These may be evaluated for "fit" with the data and the information they encompass; the extent to which they "work," that is, provide a credible level of understanding; and the extent to which they have "relevance" and are modifiable (Guba & Lincoln, 1989, p. 179).

Summary of the Study Method

In this interpretive study seven long-term care nurses participated in conversational interviewing with me to develop conversational relations about the meaning of the reflection experience. Conversational interviewing served as a resource for exploring and gathering experiential narrative material and for developing a richer and deeper understanding of reflection, true conversations (van Manen, 1990, p. 66). Following the first audiotaped 45 minute conversations, I transcribed the texts and named descriptive themes. I also facilitated a 45 minute focus group with long-term care nurses from a different region. This enabled expansion, clarification and verification of these initial themes. A second round of audiotaped conversations took place with the same seven long-term care nurses. They had the opportunity to review their initial transcripts, to clarify, correct and/or expand. These conversations were also transcribed and analyzed. The texts for this study were created through transcribed conversational interviews. To get a sense of reflection for each of the seven nurses, I created narratives and shared them with the participants. These constructions represented meaningful descriptions. The nurses found that they were true representations of their experience of reflection. I interpreted the texts in a hermeneutic phenomenological frame and drew the nurses' descriptions into the fundamental lifeworld themes of lived body (corporeality); lived human relation (relationality or communality); lived time (temporality); and lived space (spatiality) (Morse, 1991; van Manen, 1990).

What follows in the next chapter is my story of reflection and discovery as I interacted with these women as study participants and interpreted their voices and experiences.

CHAPTER 4

Interpretation

This is my story of reflection and discovery as I interacted with these women as study participants and interpreted their voices and experiences. The conversational interviews provided an opportunity for these nurses to consider and talk specifically about reflection. Max says "it's the first time I ever really *thought* about it, and I find it interesting." She had not "actually reflected with anyone on the whole concept of reflection... As I talk about reflection this is probably the first time, it's the first time I've actually talked about it." Congruent with Kvale's (1996) notion, the nurses welcomed this opportunity for protected and private time to think and talk about reflection, and have someone listen to their ideas. Not surprisingly, these nurses had not been informed by the literature on or rhetoric about reflection, and our conversations were unencumbered. In this chapter I illustrate the nurses' experience of reflection by considering the parts and the whole, writing and rewriting and maintaining a strong and oriented relation to the phenomenon of reflection. The research question: how do practising nurses experience reflection is described and interpreted through carefully and thoughtfully selected excerpts from the reflection narratives. Where, when and how does reflection enter the experience of practising nurses is similarly elaborated within the four fundamental lifeworld themes.

There are two main parts of this chapter. First I explore the call to reflection and the themes drawn from the reflection narratives. This is followed by a section exploring the four lifeworld themes. In the first part, reflection is explored through narratives constructed for each participant and the focus group. While the narratives were interpreted accounts, each used the participant's own language. This retains naturally occurring meanings, while distilling the

content of the conversations. These faithfully constructed narratives illustrate commonalities and differences across accounts. They provide insights into the phenomenon of reflection, and help us to understand what is most common. In passages from the narratives, the nurses describe their everyday concerns and understandings of reflection. Reflection imagery summarizes this first part.

In the remaining part of this chapter, descriptions of reflection from the whole text are linked to the four existential and essential fundamental lifeworld themes of lived body (corporeality), lived human relation (relationality or community), lived time (temporality), and lived space (spatiality). We are always bodily in the world and we have a physical or bodily presence. With lived other we maintain a relation with others in the interpersonal space we share with them. Lived time is subjective time, our temporal way of being in the world. Past, present and future perspectives are incorporated in lived time. Lived space is felt space, the space in which we find ourselves. It affects the way we feel. Phenomenologically the structure of the reflection experience asks for a certain space experience. Exploration of the nurses' experience in relation to these themes helps to construct the meaning of reflection for this group of nurses (van Manen, 1990, p. 101-106).

Drawing Out Themes

One purpose of hermeneutic phenomenology is to bring views about the phenomenon to a consensus (Denzin & Lincoln, 1998). Among all the nurses participating in this study, most technical aspects of practice, the lifeworld of nursing and many aspects of the social, economic and political context of practice are jointly held. We shared practice language and common understandings. While there was much similarity across the narratives, some held alternate views

not considered by the others. These were not really differences. They were expansions or elaborations. They did not impact upon the essence.

Excerpts from the reflection narratives provide a glimpse into the history and context of reflection for these nurses. I was curious about how these nurses came to know about reflection, and why they reflect, to help understand and situate the context of their experience of reflection. A call to reflection prefaces the narratives and describes where or how the participants' first encountered reflection, and why they reflect. I brought the nurses' descriptions of reflection into and linked them to dimensions within the orienting framework described in chapter two. These include specialized thinking renamed reflection thinking, affective dimension, experience-based and context-bound.

A Call to Reflection

How did these nurses come to know about reflection? Without exception, these nurses took up the challenge to reflect as mandated by the College of Nurses. Within the quality assurance program developed by the College of Nurses, reflective practice was selected as the framework for nursing practice in Ontario. The interviews took place several months after the program was formally begun. The documentation of reflective practice activity, self-assessment, peer review and learning plans was required in December 1998 for the 1999 registration year.

These nurses unanimously identified having formally encountered reflection as it was becoming a College requirement for annual re-registration, within the quality assurance program. Most had attended short information sessions by the College around the different aspects of the quality assurance program. In the year leading up to the program's implementation, all registrants had received CNO *Communiqués* which addressed the different aspects and expectations.

Perhaps this is why some initial understandings of reflection were incorporated with quality assurance. Reflection and quality assurance were initially used interchangeably by some nurses. Initially, some identified the entire quality assurance program as reflection. Through conversation and discussion, clarification of reflection and reflective practice as one element in the program evolved. Reflection and reflective practice were mandated by the College of Nurses, and this was a call to reflection.

These nurses also identified the curious absence of an actual focus on or discussion of reflection and reflective practice in the CNO educational sessions. However, it was clear to the nurses that the direction was to reflect upon their practice. As Beth said "reflective practice was the one thing that wasn't explained at all, the reflective practice part just seemed left out." She continues "we didn't know it was labelled, before I would have thought I was thinking about something... Really what I'm doing when I'm thinking that way, is reflecting." Lora "hadn't really thought about it before the College brought it up." Ruby "came to know about reflection through the College of Nurses, the literature which had been sent out." She summed it up with "it's an annual reflection." Or as Max put it "it's simply an annual assignment."

Despite education sessions and a continuing column on reflective practice in the monthly *College Communiques*, which every nurse receives, reflection and reflective practice were poorly presented and poorly understood. Vera found that reflection was "something new, can be challenging." She was "understanding or trying to understand exactly what they [CNO] wanted, what the reasoning was for reflective practice to come into being." Pia confirms this with "when we first heard about this, we all thought, well, they're checking up on us. Like from the first it wasn't a good thing." Alex further described this as "it's a scary thought of having to put it on

paper and just prove." Edi echoed "it totally frightened everybody." She wondered "what are they talking about, when it first came out from the College."

Reflection and reflective practice became less threatening "as we got to learn more and more about it, we just realized it's something we did all the time. It's just now, I guess the College wants to make sure that we kinda keep track of what we are doing a little bit more," according to Pia. Mary adds "I think we're all familiar with the word reflection. I think it's more just the act of doing it, putting it on paper and preparing a plan for ourselves, that's the new part." She offered a further interpretation "I think that we have been reflecting all of our lives... I think we've always done it, it's just new terminology now."

Pia remembered "a few years ago, they used to say by the year 2000 you're gonna have to have your degree." She "got scared and I thought, jeepers, I have to get going here and I did my degree. But now they are not doing this any more." Pia's perception of reflection and reflective practice as possibly a short-lived requirement may parallel Bolin (1990). He points out that some pre-service teachers viewed engaging in reflection as just another hurdle to pass on the way to becoming a real teacher. Engaging in reflection may not have a lasting impact. With respect to the College requirement, this group described it as an assignment, a buzz word, perhaps not even the "right" word. This echoes the view that reflection may be little more than a passing fad, unlikely to stand the test of time (Burnard, 1995; Jarvis, 1992). However, the choice of reflective practice as the framework for nursing practice within the quality assurance program and as the re-registration requirement of the CNO would encourage its continued use.

Max questions the use of the term reflection. She agrees that

putting an emphasis on wanting to keep up your practice, and provide some sort of

structure... Is it more kind of a basic analysis or feeling that you must put something down on paper that is pretty reflective? But is it a natural reflection? I never felt like [it was] what I described as my definition of reflection. It is more forced. You're told what to reflect on. You go through the process, but it shouldn't be something that's forced, should be something more spontaneous. Should we call it reflection? Maybe we should call it something else. Is that reflection? I don't think so, because to me reflection is very personal, something that kind of comes to you. There should be a different term for it. I don't think the term is really applicable or a fair term to use, I'm sure there is a better term.

Nevertheless, most of the participants had uncritically accepted the use of the terms reflection and reflective practice as advanced by the College. They had their own understanding of the terms both personally and as related to the College. They were committed to the mandate and they had many good reasons to reflect. Why do these nurses reflect?

Why reflect? Initially, most of the nurses spoke of reflecting in response to the CNO requirement. However, they moved quickly to expand upon this with such notions as "review life and come to terms with it;" "make myself better and improve on things;" "makes us more aware;" "drive to improve," "unwind;" "feel good;" "it can be a warm fuzzy;" and "learn more, try new things, develop skill, knowledge." Clearly, for these nurses reflection is not restricted to practice but is also present within their personal lives. They describe remarkable breadth in reflection content. The CNO mandates reflection for practice but as Boud and Walker (1998) note, reflection cannot be restricted to mandated matters.

With respect to practice, Ruby "see[s] situations more clearly when I have the

opportunity to reflect." For Edi, reflection "benefits myself and the rest of the team in the future from what I reflected on." Also "reflection benefits me, I stop and think how many people's lives I've touched that day, to try to anticipate the day a little better." Vera believes "it makes us more aware. We sit back and think of all the accomplishments we have done."

Beth reflects upon "some nice things" like her faith, family, and her work. She reflects "to learn, to keep up to date, helps me problem solve, set goals, know where I am in the scheme of things ... take stock... for personal growth." While Miranda enjoys "feel good reflection," reflection is "important to improve." It may be a way "to do something, to get through something, to start something, sort out in my mind... come to terms with whatever has taken place." "Reflection is like breathing, essential, valuable learning for me... for my practice, and ultimately as a human being," for Max. "Initially reflection is to feel more settled; to better myself, self improvement."

Why then, do these nurses reflect? Having been called to reflect, the nurses constructed many meanings for reflection. Reflection enables them to know themselves, better themselves, improve themselves, and grow personally. A future orientation with reflection is a benefit to them and their colleagues. It helps to anticipate the day better, to grow professionally and to improve their practice. With reflection they are able to locate themselves in their lifeworlds, to get in tune with themselves, to take stock, to feel better, or to feel good. The nurses learn, gain knowledge, keep up to date, set goals, and improve through reflection.

Summary. There was a sense that these nurses shared a similar idea of what reflection meant for the College, or what the College required with respect to reflection. A clear consensus emerged that these nurses had been introduced to reflection for practice through the terms

reflection and reflective practice exclusively through the College of Nurses. These nurses had no prior experience of formal reflection, reflection for practice (Mountford & Rogers, 1996). For many practitioners reflection is tacit. They do not realize they engage in reflection until they encounter it in their reading, in their interaction with colleagues or as part of their professional training (Wellington. 1996, p. 313). In the conversations, these nurses acknowledge that they have been reflecting for some time, although their awareness was triggered by the College of Nurses. This new use of the term, had not been well articulated by College in information sessions or through the CNO *Communiqués*. However, the CNO perspective, provides an important window to our understanding of the context and history of reflection for nursing in Ontario.

For these nurses, reflection is not bounded by the College requirement to reflect upon practice, presumably to develop practice knowledge. Reflection, as described by these nurses, while not purposeful, "has a *huge* purpose." It is useful for gaining knowledge, learning and for improvement. In a seminal article Carper (1978) identified four patterns of knowing in nursing which parallel these nurses' perceptions: knowledge of the sciences or empirical knowing, "learning new skills," for example; knowledge of aesthetics or aesthetic knowing, for example, "feeling good;" knowledge of self, others, and relationships or personal knowing, "for personal growth;" and knowledge of moral reasoning or ethical knowing, "having the best interests of the residents and fellow staff." "Becoming a more productive person of the greater society" is an example of a socio-political pattern of knowing, in the extended framework. Nursing practice is a sophisticated intellectual pursuit that incorporates a variety of ways of knowing (Cox et al., 1991, p. 374). These patterns of knowing are not mutually exclusive. They do not remain static. The

various ways of knowing in nursing shed some light on the purpose and content of reflection, in which they are embedded. These nurses reflect to gain knowledge within any of these patterns of knowing, to learn, and to improve. They reflect to make sense of experience and to manage feelings. These purposes may involve each or selected patterns of knowing.

Through silence, there was a suggestion that these nurses had not formally encountered this particular use of the term, reflection, elsewhere, for example through their formal studies. No one had pursued reflection into the academic literature. These nurses had no preconceived models, nor had they encountered reflection within their formal education programs or within their workplace.

The nurses struggled to articulate their understanding as they conversed. Clearly there were no models to follow so they were constructing their own. Within their lives and their practice, reflection had not been recognized or identified, although it had been realized for a long time. Now that they had encountered and embraced reflection as a meaningful activity even beyond the College requirement, there was a strong sense that reflection would be a lifelong companion for these nurses.

Reflection Dimensions

What is reflection? How can we understand the nurses' experience of reflection? How do the nurses' descriptions of reflection link with the orienting framework of specialized thinking, affect, experience and context? In this section excerpts from the nurses' reflection narratives are drawn into these orienting dimensions and they describe reflection. Reflection thinking is natural, both personal and professional, about improvement, and distinguished from problem solving. Thinking-in-action and acting knowledge further describe this dimension. In the

affective dimension, the nurses describe the good and the bad with respect to the reflection experience feelings and they describe getting started reflecting. Reflection content illustrates the experience base of reflection. The context for reflection includes a reflective disposition, supportive environments in which there are limited distractions and a sense of connectedness. Carefully and thoughtfully selected passages from the reflection narratives link to these dimensions. The research question, how do practising nurses experience reflection, is described and interpreted.

Reflection Thinking

Reflection has been described as specialized thinking, conscious, complex, deliberate and purposeful. It may be mindful, a habit of mind or a habit of thought and it is highly personal. These nurses had no predetermined ideas about reflection and the content seemed infinite, not restricted to practice. They describe reflection as natural, both personal and professional and as about improvement. They distinguish problem-solving from reflection, and suggest problem-solving might comprise some reflection content. Reflection comes to these nurses, calling into question the notion of reflection as deliberate. A recurring description was 'pop comes reflection.' Thinking-in-action and acting knowledge provide an alternate view to reflection in the midst of action.

The initial descriptions of reflection were very similar. "Reflection, the word itself, means looking at things and thinking about them and getting something back as well," says Beth. Lora describes reflection as "looking back on what I have done... looking back." For Max "it's an opportunity to review something that has happened and to make improvements in the future, a method of analyzing what has transpired... it goes towards feelings." "It's a time to think back. I

think of what's gone on in the past, or in my day, how it went, how things made me feel, and how I would do things differently," for Miranda. To Six "the word itself means to look at what I have done." Ruby finds it "a time to stop and think about experiences I've had ... an opportunity to address my curiosity." The focus group also spoke of thinking back on particular occurrences and putting them to use in the future. They described making improvements, gaining knowledge, looking back at something and evaluating how it went, how it could be improved, reviewing, and contemplating decisions.

Reflection is natural. These nurses believed that "reflection is quite natural, it just kind of flows, comes naturally... a natural thing for me to do ... an innate ability, instinctive... a habit of the mind," as expressed by Beth. Edi considers reflection "a natural part of doing things. It's a natural process... It's neither right, wrong, or green or black, it just is." Miranda expanded "it's something I feel I *need* to do, natural, spontaneous. It just comes so naturally, it's almost like breathing to me." "I've described reflection as natural, spontaneous... very beneficial" says Max. This is echoed with the focus group where Suzie, for example, describes reflection as "just part of our lives." For Mary, "we been reflecting all of our lives" and "it's just been part of my being."

Both Personal and Professional. As Beth noted "most people if they have any growth at all in their profession have been doing it all along... We've been reflecting on our practice a long, long time. It's the same as reflecting on life, I think it's a carry through of that." Reflection may be personal and professional, the difference would be in focus. "If you are focusing on your practice, you are looking at the things in your nursing practice that you do." In reflecting on life "you obviously are reflecting on different parts of it, your goals and your aspirations, and how things are happening and going in your life." Beth continues "how I reflect is a very personal

thing." Miranda reflects "about other than work issues, personal issues, how it makes me a better person, not just my home life... in my personal life, things I hope for, pray for." Six has described reflecting about "pretty much everything - personal, professional, spiritual, cultural, not just my life, other people's lives." The focus group confirms that they reflect upon "particular occurrences, life style, raising children, ideas, practice, home life, personal life."

Within the focus group, Vera and Mary highlight the notion of personal and professional reflection. Vera was "more specific on reflection at my work... I often review, assess, contemplate the decisions that I make in my day and wonder if I had the best interest of the resident and fellow staff that I work with and that sort of thing." Mary considers reflection as personal and individual in that "others may view the situation differently, it's individual." She expresses the intertwining of personal and professional reflection as ".. reviewing things that we have done every day, whether it's at work, at home, whatever. I think they all work together. And to me that's what reflection is, reviewing our whole life and coming to terms with that."

Jarvis (1987) identifies reflection as a personal process, asserting that people reflect in different ways and bring their own personal accumulated knowledge to experience. Others, such as Atkins and Murphy (1994) and Lauterbach and Baker (1996) confirm that reflection is a very personal process. Within this personal process, practice or professional matters may be the focus of reflection.

Reflection is about improvement. Edi asserts that "as human beings we want to do better, we want to perfect what we've done, think about what I am going to do to make it better, change it or improve it." However, she is "not sure reflection is totally about improvement. It's not always to improve and make better, not always." Mary also notes reflection is "not necessarily to

improve, you may be satisfied with how you did it and that's fine too."

Beth reflects on "things I am not contented with, how things are going at the moment, and what can be done about that. I reflect about where the gaps are, if I need to learn other things." Six looks "at what I am doing or not doing and then try to improve upon it, improve on what I am doing or try to do." Miranda sees reflection as "something to work on and improve upon, reflection on a plan of what I might do to improve." Ruby finds "self-awareness is the hardest part, realizing there's an area that needs to be improved self-wise." Suzie might "wish I could have handled that better. So it can be a warm fuzzy, but on the other hand there is certainly room for improvement." Alex is "always looking at ways to improve."

Pia suggests that "you see where maybe you have a bit of weakness or maybe where you could improve and then you kinda take it from there. Either you're gonna read a book to improve that particular area, or you might have to take a course." Mary thinks "we have always looked at what we have done and how we could improve because we do want to be better. We want to be better for ourselves, and for the residents we work with, the fellow staff we work with." Even "all the reading of articles and newspapers is all improved knowledge we are gaining... Reflection is reviewing things that I do in my practise/job every day, and looking back at what I feel satisfied with, and trying to find ways of improving areas I feel I could do better with." Suzie confirmed this, "we are doing it in our minds, how to better improve communications, how we could have dealt with that better." She describes thinking back on "particular occurrences, practices, problems, ideas and put them to use in the future or change them to make improvements."

The notion of reflection for improvement suggests both looking back, recollection, retrospection or review and looking forward, or anticipatory reflection. With recollective

reflection, one considers the success of actions and interventions (van Manen, 1990). Fitzgerald (1994) suggests that the retrospective contemplation of practice may uncover the knowledge used in a particular situation, by analyzing and interpreting the information recalled. The reflective practitioner may speculate how the situation might have been handled differently and what other knowledge would have been helpful. This knowledge may then be used in an anticipatory framework. "Anticipatory reflection allows us to deliberate about possible alternatives, decide on courses of action, plan the kinds of things we need to do, and anticipate the experience we and others may have as a result of expected events or our planned actions" (van Manen, 1991, p.101).

We undertake reflection not to revisit the past or become more aware of meta-cognitive processes, but to guide future actions (Killon & Todnem, 1991, p. 15), to improve. This perspective, improvement, resonates with what the Japanese call kaizen, or continuous incremental improvement. With kaizen the aim is to do whatever we already do, only to do it better. Overwhelmingly, these nurses considered that reflection had much to do with improvement, although not exclusively. There was an unquestioning acceptance of this. It was considered a good thing. There was no suggestion of deficiency, just that one could always improve or learn, move and change. Again, this is not a deficit model of improvement, but a continuous incremental improvement or kaizen. While there was no question that reflection is recollective, looking back on practice or life, there is also an anticipatory, future direction, with improvement.

Reflection distinguished from problem-solving. I wondered if these nurses would distinguish between problem-solving and reflection. This issue did not arise spontaneously in the conversations, but rather in response to my inquiry. It was not something these nurses had

previously considered but they gamely formulated responses. "Reflections aren't all problem-oriented," for Beth.

Edi initially described reflection as the nursing process, a problem-solving method applied to nursing. However, she moved away from this understanding as the conversations progressed. She noted that problem-solving "would be *how* I have solved a problem, what I did, why I did that, would I do it again. I would reflect *on* a problem... why that *worked* on that particular day with that particular group." As the conversation unfolded, Edi was "not sure you do steps when you reflect, I think you just do it. Actually reflection is not step by step." Beth noted that reflection "helps me to problem-solve, set goals, know where I am in the scheme of things." "Problem-solving is taking a problem and solving it, with a problem it's a now thing, get on with it, don't have time to be looking at everything with problem-solving" says Six. For Lora problem-solving "is a problem I have to solve. If I was reflecting and identified a problem, then it becomes a problem to be solved, and there are the steps in problem solving." Interestingly, Lora asserts that she has not done any problem-solving "like the stages" since she was in training. "I look at the problem action and I think of the most unlogical way to solve the problem... and see if it could work that way. 'Cause often that's the best solution." Ruby may

problem solve through my current reflection by drawing on previous experiences;
problem-solving is always part of my reflection, wanting to reach an outcome... maybe
problem-solving is the objective of my reflection... Problem-solving may be the result of
reflection - reflecting is identifying things that I would like changed, or things I don't
think are going as well, or things that I should know more about in order to improve.
Problem-solving comes after. It's an outcome. It's what I do after I've reflected upon it.

These nurses each demonstrate considerable expertise as long-term care practitioners. When faced with situations or problems, we don't start from scratch. We activate stored patterns, while being responsive and sensitive to context (Yinger, 1990). Severinson (1998) suggests that the capacity to understand problems increases by reflection. Benner (1984), Benner, et al. (1999) and Daley (1999) describe experts as responding intuitively to situations, and responding to the whole situation. In contrast, the novice is reliant on breaking down situations into stages within a linear problem-solving or decision-making process. This parallels the nursing process, which, characteristically breaks down situations into assessment, planning, action/intervention and evaluation (Johns & Freshwater, 1998). The nurses in this study have moved along the novice to expert continuum. They function at the proficient or expert level and have moved beyond linear problem-solving. Problem-solving may comprise some reflection content. Within these descriptions are elements of decision-making and judgement. Is reflection deliberate?

Reflection comes to you. For Miranda reflection "comes to mind. It kind of just comes to you." Beth finds "the majority of times things just come to you;" Reflection "catches you off guard, in a passive way, just floods into my brain...kind of creeps in... enters my mind... I don't go looking for it, it comes to me... something I do spontaneously," says Max.

Lauder (1994) suggests that the belief that reflection is synonymous with deliberation is often accepted in uncritical way. Atkins and Murphy (1994) for example, describe reflection as a deliberative process, a conscious process not occurring automatically and with a definite purpose (p. 50). Some participants spontaneously described reflection as "pops into my mind." There was a strong sense that while reflection was not a passive activity, it was not actively sought out for the most part. This contrasts with the notion that reflection is deliberate and purposeful.

Pop comes reflection. Reflection may "pop into my mind," says Ruby. Beth finds reflection will "pop into my mind." With Max "something twigs in my brain, just pops back into my head... jumps into my brain... items come to me as passive reflection as it pops into my head." For Lora "something is always popping in [my mind]... pops into your mind... It comes and goes... it just pops in, I think about it and it's gone." Within the focus group reflection was spontaneously described as popping into their minds.

Lora does not "think I have ever sat down and consciously thought, I'm going to reflect," or as Beth says "it kind of flows, it's not necessarily that I sit down and think." Entering purposefully into reflection was not within their description, although Miranda "might do it purposefully to make you feel right or feel better." Max notes that reflection begins passively, and then "becomes a more active process." However, once reflection comes to these nurses, it may become more deliberate.

Thinking-In-Action

The notion that theory is created at the moment of action through a complex, inadequately understood process of reflecting in action is the basis of reflective practice (Clarke, et al., 1996). However, these nurses do not step back or step away from situations in their work day. They focus upon the immediate tasks, and consider the range of possibilities away from the practice situation. Benner et al. (1999) recognize that in practice there is engaged thinking-in-action and active participation in the ongoing clinical situations. This is realized through a narrative understanding of the situation, with reflection after the fact (p. 4-9). With reflective caring practices we allow ourselves to step back, observe and reflect upon our acts and actions, to describe and connect with them (Watson, 1998).

"I think it's that there's a different kind of thinking that goes on in your work day. It's more the immediate problem-solving, crisis resolution type of thing in my work day," says Max. The notion of reflection as reviewing, analyzing, assessing and evaluating, was evident with both the individual participants and with the focus group. Miranda reflects "internally, in my mind." Six considers "if you reflect on it, you've got to think more about it or something, put more into it, more angles to it." Max describes reflection thinking.

There seems to be that first of all, whatever point you're about to reflect on jumps into your brain, for whatever reasons. And so it's usually those quiet times I find that it enters my mind, and I usually play it over again in my head, I see the occurrence and then I'll ask myself questions. Why did it happen that way? Why did I react that way. Then I'll think about how that other person might have reacted, if we're talking about a situation with another individual. Why did they react in the way that they reacted for instance. So, then all of those things considered, [I] come to some conclusion. Is there something I could have done differently? Maybe that's just the way it was... Those are the steps. And beyond that, there can be action, what do I take from that? Do I act on it. Approach that person again and say gee, I've been thinking about or reflecting on what went on; or do I just decide that's fine I reflected on it and there's no need to re-approach the situation?

Acting knowledge. These nurses identified an absence of reflection "in the moment" of practice. They do respond to situations appropriately and with great skill, suggesting a highly sophisticated and holistic processing of information (Freshwater, 1998). Perhaps thinking-in-action may not be reflective, but may involve such essentials as pattern recognition and clinical judgement. A complementary perspective to reflection-in-action may be found in the Confucian

notion of *to know is to act knowledge*. Knowledge is the highly sophisticated integration of experience of the moment with the processes of the mind, and this integration is essential to "act knowledge" (Whittmore, 1999). Within nursing, knowledge encompasses personal, aesthetic, empirical, ethical, and socio-political ways of knowing, even unknowing. Whittmore (1999) suggests the result is a marvellous harmony of the person, the environment and the mind in understanding (p. 365). The nurses spoke confidently of their practice, implying confidence in their knowledge and action in practice moments. Perhaps because they were fully engaged in the experience, attentive to cues, and acting knowledge - or refraining from action, the expressive functions of knowledge were realized. The action does not define knowledge, rather the thinking processes behind the action. However, the nurses were unable to articulate the process by which an action was decided. The nurses grasp and interpret the situation, envisioning what is to be achieved, and responding with appropriate action (Johns, 1998). These types of descriptions more closely parallel the nurses' practice reflection or the type of thinking in the moments of practice. "It is only afterwards that you say, that's right, that was something that wasn't quite comfortable or that I found interesting... and then reflection takes place," according to Max.

These nurses describe the intersection of reflection for practice and the practice environment or the impact of the practice environment on their reflective activity. While they labelled the kind of thinking at work, in practice, as problem-solving, this language does not capture the skilled decision-making and nuanced clinical judgement that was evident in their descriptions. A familiar context allows work to unfold and they may thoughtfully act with no need for reflection (van Manen, 1991; 1995). Nurses are familiar with the work setting and circumstances and feel ready for what might transpire as part of the work day. Knowing in

practice is constructed knowledge - a subjective, holistic, contextual knowing appropriately informed by empirical science and theory. This is the knowledge used in practice (Benner, et al., 1999, pp. 7-10). This language more accurately captures and characterizes the nurses' lived experience of reflection.

For these nurses, a consensus in the construction of the thinking dimension of reflection is evident. Reflection "the word itself means looking back" and "thinking back." Thinking in reflection is often described in the literature as conscious, complex, deliberate and purposeful. An underlying principle is that with adequate coaching, nurses will achieve systematic and purposeful reflection (Taylor, 1998, p. 139). In contrast, these nurses describe reflection as natural, automatic, spontaneous, popping into their minds. They are able to identify purposes for reflection, but do not describe reflection as purposeful. This suggests the systematic and purposeful reflection described in the literature is not necessarily second nature.

Thinking is integral to reflection and this thinking is natural. Content rather than process distinguishes the thinking. There is no formula for reflective practice, no difference in the thinking form or process. Reflection for professional purposes is an extension of a life long habit of reflecting. However, reflection is identified with continuous incremental improvement, particularly for practice. In practice, reflection is realized by acting knowledge. The contrast between these nurses' descriptions and those pervading the literature is striking! The construction of thinking as integral to reflection, for these nurses, involves a synthesis of aspects, which in themselves would not be considered specialized. The type of thinking is natural, informal and spontaneous. The content is both personal and professional. The content is frequently related to improvement, and may include problems. For these nurses, reflection involves reviewing the past

and projecting into the future. This is accomplished at a distance from experience or practice.

Benner et al. (1999) propose reflection as connoting a stepping back or being outside the situation (p. 9). While the nurses act knowledge in practice, reflection is accomplished outside practice.

Affective Dimension

Another attribute closely identified with reflection in the orienting framework is the affective dimension. It is generally accepted that feelings influence one's ability to reflect, or that feelings, cognition and perhaps even contexts are closely intertwined. However, this is not well developed in the literature. Two aspects related to the affective domain are explored in this section: experiencing reflection feelings and getting started. These nurses described feelings related to reflection, and clearly the feelings belonged with the situation, not the act of reflecting. Feelings, specifically discomfort may trigger reflection. These nurses describe "getting started."

Max has described reflection as "a method of analyzing what has transpired, how it made me feel, how it might have affected people around me. So it tends to go towards feelings... But reflection in general would be again to analyze feelings on things, how I felt about something." "Peaceful is not the right word. It's just enjoyable." Miranda finds "reflection's kind of nice just to make you feel good, makes you happy inside, feel good reflection." For Edi "I'm sure my blood pressure would be less when I've done a good job on the thing I was reflecting."

An awareness of others is important. Lora has "to be sensitive to other people's feelings... how do you know if you did a good job if you don't know how they felt and you have to know how you feel so you have to be sensitive to people's feelings." Some feelings may be recalled even years later. Lora can "still remember meeting my first 100 year old man, still remember that

feeling, someone being that old and you were so young." The nurses spoke of particularly good feelings going on for a long time, and bad feelings coming back.

Experience Feelings - The Good, and the Bad. An interesting juxtaposition emerged around feelings and reflection. Most often, the feelings "belong" with the experience or situation, rather than reflection itself. Feelings may relate to content as Ruby describes

as you're reviewing each incident in your mind then obviously the feeling of that particular moment... a situation where you were frustrated about the outcome, then that's the feeling that would come through... if it's something that went really well you would feel confident and whatever the feeling was at that particular time that you're referring back to .. recapture that feeling... the same feeling that accompanied the initial situation.

Six asserts "the feeling comes from the content, if it's been a positive experience I feel good, if it's negative then I feel like s**t about it." She adds "sometimes it's nice to hang on to the good little feeling that you get, if it's positive. It's not nice if it's negative." Edi finds "it can be distressing to reflect but not always, not always, could be a pleasure, could be both." She notes that "if you've had a disaster of a day and you're reflecting on it, the distress is not as much as during the happening, the event, but it still is." For Edi, "if it's been total chaos, then when I'm reflecting on it, I'm probably getting all the negative vibes from it too... If it's been a pretty positive happening, then I would probably have a better feeling reflecting." Beth "reflect[s] on some nice things, on pleasant things," reflection "would be more of a foe if I was reflecting on things that were very problematic."

Getting started. "The majority of times, things just come to me," says Beth. As Max has previously described "reflection enters my mind, just creeps in, something twigs in my brain."

She finds "it almost catches me off guard, in a passive way things just flood into my brain... I don't go looking for it." Edi may have one word in her daytimer and wonder why she wrote that. "When I stop and think about that, it all comes together. It's cueing really, a cue." She has also "awakened in the middle of the night with a thought, the thought wakens me up." Lora may "..wake up in the middle of the night and think, gee, that's reflection... something twiggled it usually." Reflection "happens as my physical self decides it needs to reflect... reflection just happens when it happens," for Ruby. Miranda finds "it would start with my walk home... when I'm in the right setting, it just comes to me."

Whittmore (1999) suggests that in acting knowledge, we are fully engaged in the moment, the experience. Clearly these nurses do attend to situations and notice things that may be salient, but are reflected upon away from the actual experience (Moch, 1990). For Six, reflection "starts with a feeling," although, she does not attend to the feeling at that time. "I don't do it right at the time, it's usually after... I might not have time to really go into it till later, I will remember to think about that." The focus group echoes this notion with "it's not until afterwards that the cog wheels are turning." "An unexpected reaction in a certain situation" is one trigger for Max. "It will come to me in a quiet time, that would trigger reflection usually, or if I'm speaking with another individual."

Some authors address how reflection gets started. Atkins and Murphy (1993) suggest reflection is often triggered by awareness of uncomfortable feelings and thoughts. Schon (1983) identified an experience of surprise. Baker (1996) and Boyd and Fales (1983) suggest a sense of inner discomfort. Not all authors consider reflection limited to situations of inner discomfort; some like Kim (1999) see it in relation to any situation of self examination. However, these

nurses describe getting started reflecting in a way that is at odds with the literature.

The affective dimension with reflection was prominent, though not particularly clear. Reflection may start with recognition, awareness, or a feeling but it may not unfold until after the experience, when it is more conducive to reflect. Alternately, reflection most frequently "just comes" to these nurses, in the absence of any particular feeling state, when they are open to it. While reflection feelings themselves are "enjoyable" or "feel good," the feelings related to the content or the situation are recalled along with the content. Positive and negative feelings accompany situations or experiences and are often misidentified as reflection feelings. These notions within the affective dimension are further described in lived body.

Experience-based

The narrative accounts of the nurses' experience of reflection contextualize the experience and provide richer understanding (Sparks-Langer & Colton, 1991, p. 39). These nurses suggest what counts as experience through reflection content. They speak of the breadth of reflection in everyday life, in everyday terms, as personal and professional. As brought out earlier, Beth reflects upon life, family, work, faith, and "how lucky I am... it's the same as reflecting on life." Six has described reflecting about "pretty much everything - personal, professional, spiritual, cultural, not just my life, other people's lives." Other people may be friends, colleagues, residents or even strangers. Miranda reflects "about other than work issues, personal issues, how it makes me a better person, not just my home life... in my personal life, things I hope for, pray for." The focus group echoes this diverse content with "we've been reviewing our whole lives; particular occurrences, life style, raising children, ideas; practice, home life, personal life." Reflection content for Beth is "not necessarily a big major situation or even a minor situation."

These nurses also reflect on a broad range of practice related issues and specific situations that arise within their work days. Ruby, for example, "might reflect on an interaction with a physician, where I advocated really well for my client and everything went really well."

Understanding and interpretation of events, situations, or experience link to facets of background, which includes clinical nursing experience. The nurses expressed that they were more likely to reflect upon negative or problematic things. Lora reflects upon "something pretty good, pretty bad or unusual, not just status quo, anything that pops into my head, the residents... to stick out in my mind, it has to be pretty good, things that haven't gone so well, or palliative care." Edi might reflect upon how she solved a problem, or interactions with residents and their families. In the focus group, Suzie asserts "certainly we are... looking at ourselves and making our goals... how to better improve communications, how we could have dealt with that better."

Edi "learns from experience," so do Max and Ruby. This experience may include issues and ideas that are not necessarily concrete. faith, for example; even thoughts may comprise experience. Lora often reflects on the residents, "for no reason, no big reason but they came to mind that day in the course of the day... how would it be to be that age and have lost all your children... they have had a lot of hardships, you have to admire them, you think of these things."

Clarke, et al. (1996) suggest that nurses might reflect upon the technical or practical aspects of practice, the social, political and economic context of practice or knowledge of self. Carper's (1978) range of categories of knowledge (personal, aesthetic, empiric, and moral/ethical) might also represent the content of reflection. Reflection may extend nurses' personal practical knowledge. Moch (1990) asserts that experience is as an aspect of personal knowing. These nurses did not restrict their reflection to practice related issues or experience.

Experience may be living experience or everyday experience that includes life - family, friends, faith, and practice. Knowles (1980) suggests that mature practitioners build on life experiences to make sense of what happens at work.

Reflection is often portrayed as triggered by experience, or the exploration of an experience to create meaning (Baker, 1996; Boyd & Fales, 1983, Fenwick, 1999). Criticos (1993) maintains that experience must be reflected upon, to have value. Like reflection, experience, the word, contains many ambiguities; it may be a noun, or a verb, and "it is almost impossible to establish a definitive view with which to work" (Boud et al., 1993, p. 6). However, they also assert that we spend most of our time learning from experience, although this aspect of learning is greatly neglected in comparison with what takes place more formally. Learning involves much more than an interaction with an extant body of knowledge, it is "all around us, it shapes and helps create our lives, who we are, what we do" (p. 3). Reflection is crucial to make experience significant, to identify strengths and to establish a meaningful basis for further self and community development (Kenny, Ralph, & Brown, 2000, p. 116). Owen-Mills (1995) suggests that reflection lends meaning to knowledge already gained from experience with life. Pierson (1998) however, proposes that reflection is itself an experience. White (1995) suggests that an experience not be viewed as an isolated moment, but as part of a continuous flow over spatial and temporal time. This way of knowing incorporates past experience and anticipates future experience. Reflection may provide access to past experience in order to develop the reservoir of tacit knowledge (Lumby, 1998). As nurses gain experience, developing an experiential base, they become reflective in ways, and about things that new nurses do not (Brubaker, Case & Reagan, 1994, p. 6). Lambert et al. (1995) note that people bring past

experiences and beliefs, their cultural histories and world views, to the experience. These influence how we interact with and interpret our encounters with new ideas and events.

As the nurses shared perceptions of their reflection experience, they drew upon past experiences to understand and manage current situations. Learning through reflection may be considered as subliminal learning through experience, recognized by looking back over experiences or situations (Moore & Carter, 1998). It was interesting that clinical nursing experience, for example, was described, but not specifically identified as experience. While previous knowledge and experience was in play as the nurses went about their practice and their lives, this did not surface explicitly. Perhaps it was so integral to these nurses' lives, it was simply a given, taken-for-granted.

The breadth of experience for reflection is remarkable. The nurses did not dwell upon experience in detail. It is not possible to ascertain whether reflection is superficial or deep. An alternate continuum, narrow to broad, is evident. Reflection is not limited to the practice arena. It ranges across everyday life, from practice to personal and family life and beyond.

Context-bound

The nature of reflection as context-bound is the final dimension to be addressed. All nursing work is contextual. Nursing takes place within specific situations and always involves human encounter between two or more people (Lumby 1998, p. 13). We are part of our context. Therefore having a disposition to reflection, or contextual sensitivity, is an important consideration. A supportive environment and connectedness characterize the dimension of context.

Reflective disposition. Beth identified herself as a "thoughtful person," a necessary disposition for reflection. "An interest in doing it, reflection," is also necessary. This is similar to van Manen's (1998) description of being mindful, that is, developing the capacity to be actively reflective and thoughtful. Ruby has a "curious" disposition, as do Beth and Max, which they maintain predisposes them to reflection. Mary considers reflection "just part of my being... it's just been a part of life." Suzie speaks for the focus group saying "its just part of us." Beth views reflection as an "innate ability." Boykin (1998) suggests that someone who is naturally reflective, sees and responds to each unfolding moment through a reflective lens. Without exception, these nurses identified themselves as disposed to reflect.

Rose and Webb (1998) suggest that we have certain dispositions, habits of the mind, or more particularly, ways of receiving information that may dispose us to reflect. Nursing as a disposition is suggested by Antrobus (1997). Nursing involves becoming a certain type of person and not merely doing certain things. Calderhead (1989) suggests that the right disposition and sufficient experience are necessary for reflection. Astrom, Furaker and Norberg (1995) describe the importance of contextual sensitivity. They maintain that this requires imagination, understanding of human intentions, and an appreciation of the particulars of time and place (p. 1073). Reflection for practice or in the general sense of appraisal of one's own work, requires possession of certain knowledge, skills, a basic degree of competence and a degree of self confidence (Calderhead, 1989, p. 47). Facione and Facione (1996) assert that a style and set of attitudes define one's personal disposition to apply and value critical thinking. It becomes a habit of the mind. a part of one's character. This may also be said about reflection.

Supportive environment. Certain contexts or conditions are essential for reflection. These nurses welcome reflection in two environments or settings, specifically, at home or in their cars. Striking in its absence, is the work environment as a context for reflection. Max has "to have the right setting and be able to focus myself... a setting that's conducive where I can put all of my energies, cognitive energies, toward the reflective process." Miranda finds "when I'm in the right setting or ambience it just comes to you." For Six, as with each participant, this is "usually not at work."

At work, these nurses juggle complex technical skills and busy unit management, with the awareness of having to complete tasks within allotted time. Pediani (1998) suggests that often residents just want nurses to sit with them and give them some of their time. This is the most difficult thing to do. One basic nursing skill, listening to others, is most difficult to justify in determining health care priorities. Fordham and Dunn (1994) suggest that personal, interactive clinical time spent with a patient, the essence of good nursing care and not an unproductive luxury, should be actively supported. The concept of having time to care is not new. In practice a context for caring, nursing, thinking, reflecting is problematic.

Distraction. Beth needs "a more peaceful atmosphere, less distraction, when there are no other distractions." She reflects "at night, not at work," when there are "less distractions," and when there is the "opportunity." Ruby requires a "quiet time with no distractions. If I'm distracted my reflection becomes very fragmented." Although not constrained by time and space, even home may hold distractions. For Max "what will make it scatter away is if there are other intrusive stimuli. So that, I don't know, suddenly a whole bunch of people come in, or the phone rings, or whatever, that will disperse reflective thoughts," and she may be otherwise attracted to

these competing stimuli.

The focus group participants confirmed that they reflect "away from the situation." Vera wonders if "it's just the situation sometimes, because of what we deal with in our work day. That sometimes just being away, entirely away from the situation." In being at some distance from the situation "you're now concentrating on that one particular thing... rather than thinking of everything else that's been going on in your day. It's a possibility you're away from the situation." For Suzie "it's not until afterwards that .. you know the cog wheels are turning and it's like ohhh."

One characteristic of an environment that attracts reflection is quiet. Lora requires "peace and quiet and time." For Max it will "come to me in a quiet time." Miranda identifies "a quiet place." Privacy is another important characteristic. Edi reflects "usually alone, not always, need a place and privacy." These nurses were clear that there was an absence of privacy within their practice environments.

Miranda describes a different view of distraction in practice. She finds "at work and there's something that just happened about your situation and you know you've left it and you haven't really resolved it." When this occurs, "I find that it'll distract me from everything else and I kinda have to do something about it at the time or it will kinda consume me." While this doesn't happen often, when it does "I might have to go and .. reflect on it find what I'm going to do about it and go and then do it." This illustrates Langer's (1997) notion of being distracted, meaning being otherwise attracted. Distraction may attract Miranda to reflection.

The Buddhist philosophy addresses the need to turn inward, leaving behind the distractions and deceptions of the world of practice. Langer (1997) proposes an interesting reframing of distraction. She suggests that when we are distracted, we are attending to something

else. Being distracted means being otherwise attracted (p. 36). These nurses are attracted to reflection, but often they are attracted to other situations, which require their immediate attention.

Nursing is practised in a social context, ideally in a supportive environment that values life events as legitimate opportunities for growth. Hawks (1992) identifies essential characteristics of a caring supportive environment as trust, honesty, openness, genuineness, open communication, mutual respect, acceptance of people, courtesy and valuing others. Another characteristic of any environment is change; environments are dynamic, not stable. Physical characteristics are important in the environment. The quality of setting is also defined by the availability of knowledge and resources, access to models/nurses, access to others with similar concerns and opportunities to experiment with new modes of behaviour and expression (Ford-Gilboe, 1994, p. 116).

Connectedness. With the personal and shared nature of nursing, nursing is seen as collaborative practice. Reflection is seen by some authors such as Carkhuff (1996) and Noffke and Brennan (1988) not just as an individual process but also a social process, involving individuals or groups of individuals. Belenky et al. (1986) speak to "connected teaching" as a collaborative way of knowing. Here members nurture each other's learning and truth is constructed through self reflection and consensus. While each participant identified reflecting alone, there was also evidence of a relational aspect.

Beth might "discuss with peers, family, share with other people and learn from each other." She also "gain[s] things from other people's reflection. Lora might "get together with a peer," although she would "have to feel comfortable with that person." Max has "almost forged a relationship... a reflective relationship" with carefully selected colleagues. Miranda finds there

are times "I know I have to share it, get it out, get it out verbally; sharing with colleagues, talking with someone," that someone may be her husband. Ruby reflects "sometimes alone, introspectively, other times with my peers, 50/50... alone or with a peer." At work, the focus group participants "discuss how things are going, what could have been done better," and also at home with their spouses.

An awareness of others is important, as is a connection to the residents. Lora needs to know "how the resident feels, or how the family feels. How do you know if you did a good job if you don't know how they felt?" Edi needs "to be connected to the patient to get that satisfaction, meaning the resident, that I've made a difference in their day... I'm not talking about patients patting me on the back and saying you've done a good job, those little things, not major stuff." She nostalgically recalls her early nursing career, when connection with patients was primary, and feels sorry for more contemporary graduates who have not had access to such experience.

Trust and choice are identified as two prerequisites for reflection and this is confirmed by Shapiro and Reiff (1993). Tapp (2000) speaks to the notion of situating ourselves in relation to others. This implies purposefulness or thoughtful choosing. The nurses choose to be in a relational stance with particular people. Situated in their practice communities, they acknowledge the expertise of others and choose colleagues with whom they can pool expertise. Max asserts that with reflection, she is "collaborative by choice." Tapp (2000) describes the importance of questions that invite reflection, as do Friedman (1995) and Wright, Watson and Bell (1996). Max appreciates "getting to pick and choose who I want to reflect with, because people will ask the kinds of questions I like to hear. Why did that happen, do you think you could have done this or..." Most often the dialogue centres around concrete clinical situations, stories or narratives of

clinical practice. Max continues "I choose who I share my reflections with... I would choose very carefully." "There has to be some level of trust... Don't just do it with anybody" says Lora.

McCormack and Hopkins (1995) assert that reflection can be a legitimate tool for increasing one's capacity for experience in clinical leadership. It does, however, require confidentiality, support, challenge, honesty, trust and commitment to the process (p. 167).

The nature of the context in which nursing occurs is intricate and multifaceted. Taylor (1998) describes context as "all the features of time and place in which people find themselves, and in which they locate their descriptions of things and people in their lives... the familiarity of context provides relative security for daily activity (p. 141). Rose and Webb (1998) assert that our understanding and interpretation of information or experience are linked to facets of background. This includes clinical nursing experience and it is important to include it as part of total background or context rather than excluding it. Context may be where we find experience, in practice this would be through the repetitive experiences in long-term care practice (Schon, 1983). However, a disposition toward reflection is crucial for its realization.

These nurses are situated in their practice and connected to their environment. However, the practice environment is not a good context for reflection. As Beth says, "perhaps at work, I push it aside, consider other things that have to be dealt with at the moment, then when there are no other distractions, it just comes back." The nurses are engaged in practice, actively participating in practice. However, they step outside or away from practice into a more attractive context to reflect.

There is no question that reflection requires a conducive, supportive environment, with sufficient resources and supports including close associates (Houston & Clift, 1990; Lauterbach &

Becker, 1996). Freedom to reflect may be limited by time constraints, space constraints, and a distracting atmosphere lacking quiet and privacy. A supportive environment may help to overcome stress and allow nurses to develop a sense of belonging with their environment. This sense of belonging with their environment and colleagues promotes personal involvement where nurses feel themselves to be integral to the system (Winter-Collins & McDaniel, 2000, p. 104). Hagerty and Patusky (1995) found that participants who experienced a valued involvement in their environment, identified a sense of belonging with peer groups in their environment. Connectedness within context includes peers, family and friends, residents and practice and involves choice and trust.

Summation of Interpretation Part One

If you keep working at it, learning from it .. gradually you realize your palate is filling up with colours. You see more shades of meaning. You realize you are well on your way to creating a work of art, maybe even a masterpiece (Mallison, 1987, p. 45).

In this expressive way, Mallison is referring to nurses and nursing. One way of working at it, learning from it, creating this work of art is through reflection. The use of imagery in the nurses' language expresses or describes reflection. The complexity of reflection is captured in the thinking and affect illustrated in watching a movie, putting the pieces together and puzzling through reflection. Experience is the basis of the imagery and it is recalled in a context away from practice.

Imagery is common within the reflection literature, for example Schon's (1983) artistry of practice, Daley's (1997) creating mosaics and Bunkers'(1992) healing web. Even Webster's Thesaurus (Laird, 1974) includes many images such as rays, light, likeness, shadow and mirror (p.

372). Some wonderful imagery pervaded the conversations. The focus group participants referred to reflection positively as "warm fuzzies." With "cog wheels turning," reflection may get started. Six speaks of a way of thinking and being open to reflection as "mulling things over" particularly as reflection is "kind of jumbled most of the time." For Miranda "feel good reflection makes you happy inside." Max finds reflection "almost like breathing to me, I need it to get through my day." When the context for reflection beckons, "I always chose to take the ride," demonstrating an attraction to reflection with Max. Beth and Ruby echo this, describing curiosity as a feeling state related to reflection. The nurses' reflection experience is summarized through three images.

Watching a movie. Max speaks of reflection in the visual imagery of watching a film or movie, as a spectator.

I usually play it over again in my head, I see the occurrence and just kinda play it back and forth. So, that's what often happens. My vivid imagination, but I do have imagery, that goes with it. I get a definite picture. I'm just needing to replay it in my mind, and kinda take a back seat and have it almost like a movie. I'll play through and watch it again. I get a definite picture... play it back for myself.

The notion of reviewing an experience echoes Hewison (1991) who describes reflection as replaying an experience. Schonhammer (1989) using film/movie as metaphor, describes a feeling of being outside reality while being aware of living in this reality (p. 135). With Max, there is a sense of being some distance from the event or experience. The context is present in the picture, but the context for reflection is somewhere away from the experience. She has stepped outside the experience. Imagination is an aspect of a reflective disposition, as this example illustrates. There is a sense of both pleasure and anticipation in this example. While getting a definite picture of the

experience, there is no formula, no "steps" involved. In playing the experience back and forth, or reviewing, different images from different perspectives may be constructed.

Putting the pieces together. The imagery in putting the pieces together includes notions such as patchwork quilts, board games. Max may "have in my mind's eye, my layout or blackboard game plan, the xs and the os and arrows going here and there, like a ball type play board." She identifies that "there's a common thread. But then there are filling in separate patches and pieces and they all come together in a different kind of way, a different significance." Similar to a board game, Shorter (1993) uses the Ouija board as his image. Putting the pieces together creates an openness to experience. These are not reified stages, not a formula, but a variety of possibilities. As in a game, the outcome is not predetermined. It is the result of many factors in play. Edi uses similar imagery when speaking of "a bit of a reflective discussion" with her peers where "we bounce things by... we bounce ideas off each other." This is a playful description, in the affective dimension. Here, experience is in the form of ideas. The relational aspect of reflection is also evident.

For Edi, reflection is "to get rid of thoughts, just to get things out, and sometimes they don't make sense at all." This is similar to Six's description of reflection as "kind of jumbled most of the time." Edi captures the intricacy of reflection in "later they all come together, and of course they make sense, perfect sense. It's like a quilt, pieces - the pieces together and very different, very different but a finished fabric or finished front is very beautiful." Her description of a beautiful finished fabric conveys a sense of pleasure or contentment. Through reflection, Edi can put the pieces of the quilt together in ways that make sense to her. Max, also, will "put the pieces together, [patchwork] quilt." Of course, with a patchwork quilt there is no predetermined pattern

or outcome, no formula, but again a variety of possibilities. Langer (1997) suggests similar images in approaching learning, highlighting novelty in situations. For example, she suggests learning anatomy as if it were a jigsaw puzzle or board game, where one assembles or disassembles familiar people.

Puzzling through reflection. Ruby provides a wonderful description of reflection, and an interesting confirmation of McBride's (2000) assertion that gerontological nursing is a career for those who want to make a difference in people's lives, and those who enjoy solving puzzles.

When I reflect I don't think it usually very concisely. Something pokes at my curiosity, ... sparks my curiosity, going over the situation within my mind, playing it out in my mind, reviewing it, looking at each piece of what happened. I sort of play it over introspectively, play out the scenario, how it unfolded, playing out each incident, reviewing each incident in your mind... I don't take things and put them all in the exact order as they occurred.

Here, the affective dimension is expressed as curiosity, where curiosity is an aspect of reflective disposition, and a trigger for getting started. Like Max, Ruby plays the experience out in her mind, looking back at all the aspects of the situation that she noticed. Her thinking is not concise, and she does not proceed in a linear fashion to think through the experience by ordering the incidents as they occurred. This creates an openness to a variety of possibilities in understanding the situation. Like Max and Edi, an experience has attracted her attention or reflection. Ruby is removed from the actual situation, enjoying a context conducive for reflection. She continues her description.

Sometimes reflection is very clear cut and only one topic goes through at a time, then it is more concrete. Other moments, I've got six or seven issues I'm reflecting about all at the

same time, doesn't play out quite as easily, more fragmented, pops into your mind. It's almost like a hindsight, play out whatever the scenario is, trying to figure out what little pieces of the puzzle need to go in there, just mulling over and enjoying the moment. Just sort of take bits and pieces of whatever the event may be that I'm reflecting over. And then, I take one little piece of it, and ponder that and then take another little piece of it and ponder that and then take another little piece of it and ponder ... and then I think about the whole situation as it unfolded. I guess you sort of dissect each little piece of what has transpired, like a puzzle with all the little pieces which finally get together... A peer would be able to provide that [missing] piece in the puzzle.

The nature of reflection varies from being clear and focused upon one topic, to more likely being attracted by many possibilities, the challenge being to choose among possibilities. Clearly, there is a sense of pleasure or enjoyment in this description of a reflection moment. Ruby moves back and forth between the parts and the whole, taking bits and pieces and then thinking about the whole situation. MacLeod (1995) describes this as "doing a hermeneutic," reviewing the experience holistically. As Ruby puzzles through or reflects upon the situation there is no predetermined outcome. While there may not be an infinite number of configurations, there are many alternatives but not "one right one." Another time, Ruby might use different pieces or configurations and come to different understandings.

These metaphors parallel the conceptualization of knowledge presented by Bevis (1993). Knowledge is composed of patterns, insights and the building of cognitive structures. The conceptual system is always growing, developing, expanding and being revised. This enables us to take an idea, concept, experience or thought and elaborate upon it. We can analyze it, take bits

and pieces and reconstitute them until the results are substantially different from the one that triggered the process. Through reflection this involvement with information is transformed into knowledge (p. 103).

Four Fundamental Lifeworld Themes

In the first part of this interpretation chapter, the nurses have described their experience of reflection through imagery and excerpts from the reflection narratives. The imagery captures reflection thinking, the affective dimension, and the experience-based and context-bound nature of reflection. In this second part, reflection emerged from the data in relation to the four fundamental lifeworld themes. Meaning is constructed in its embodied, relational, temporal and spatial situatedness. Within the structure of these lifeworld themes, the description and interpretation address the second research question, where, when and how reflection enters the nurses' experience. Experiencing reflection feelings, reflection awareness, reflection relation, and embodied knowing emerged within the lived body theme. Lived human relation involves reflection relationships, sharing reflection, and reflection conversations. Encountering reflection - initial encounter, reflection in everyday life, in-between time, work time, taking time making time, looking back and looking forward, and time as development, describe lived time. Lived space encompasses home - a reflecting place, work space, in-between space, and space experience.

Lived Body (Corporeality)

van Manen (1990) asserts that we are always bodily in the world and that we meet people first through the body, in a corporeal way, being physically present. In our unique bodies we are in the world, and through them we affect the world and are affected by it (Paterson & Zderad,

1988). We experience others as separate yet physically or emotionally close or far. The body is experienced as an aspect of the world in a variety of modalities (van Manen, 1998, p. 8). The meaning of body is limited in English because there is only one word to describe its different realities. Lived body, in a phenomenological sense, becomes the centre for all experience, the source of all motivation, and the means by which consciousness experiences the world (Emden, 1991, p. 19). In this section, the theme of lived body or corporeality is explored in relation to how reflection enters the experience of practising nurses. Lived body is characterized by the participants experiencing reflection feelings and their awareness of reflecting. The nurses experience reflection corporeally in a relational context, and through embodied knowing.

We are "in the world embodied, practising and living in an embodied way" (Wilson & Hutchison, 1991, p. 268). Our fundamental life feelings are intertwined with our body experience. Benner, et al. (1999) describe embodiment as the ways in which meanings, expectations, skillfulness, styles, and habits are expressed and experienced through comportment. Comportment refers to style and manner of acting and interacting, including gestures, posture, and stance (p. 567). Nurses are embodied people whose habitual bodily patterns and routines cause them to act in particular ways. The body learns to act automatically, to carry out actions within particular time frames and within particular spaces (Street, 1992). This bodily way of knowing, thinking through the body, is one way of approaching reflection. Our emotional and physical being may inform our knowledge of both ourselves and others. It may comprise patterns of knowing identified as personal knowing or aesthetic knowing (Carper, 1978). Benner et al. (1999) suggest that emotions are moments of connectedness to ourselves and the world. They provide important evidence or knowledge about the world. As emotional and physical responses are valid and "no more or less

infallible than any other form of knowledge, they at times indicate perceptions that are *less* distorted than those available to the cognitive mind" (Michelson, 1996, p. 450).

Experiencing Reflection Feelings

In asking the nurses what it was like to reflect, I was also asking about the "body of the self as *self*-observed" (van Manen, 1998). Interestingly, these selves were embodied through emotion more than corporeal presence, for the most part. Max, Miranda and Six experienced reflection incarnate as comfortable, "I get comfort from reflecting," "I am comfortable reflecting," which could refer to either a physical or affective state. When negative feelings surrounded an experience, these nurses found that they experienced frustration, and other negative feelings. When conditions for reflection were not right, they pushed reflection away. They were bodily aware. Max finds reflection "can be draining, takes a lot of energy, again it's something I can't brush aside, can't put aside because it will still be there." She experiences reflection in a corporeal way. Max continues "it takes energy, but then I know the payoff is once I get through it, process it, I will feel again at peace and resolve." However, "if that need to reflect tries to creep in when I'm in the middle of my work day for instance, I find that frustrating... So those times I have to push it away."

"I don't think I could reflect and have no feelings... I don't think it's a grey area, nothing. I don't think you reflect and not have any feeling - something, not nothing, but not zero feelings, got to be something" says Edi. "I do think there's an emotion involved with it, passively, after the fact or before the fact... With the act of reflection, I would say there is less feeling - I don't think, I don't really know." It was difficult to articulate the role or relationship of feelings with reflection. This may be due in part, to the tendency in everyday language to use the word feel as a synonym

for think.

Six considers "it's a comfortable feeling, for me it is." She does not "find it difficult to actually do the headwork." Reflection is "usually more relaxed," for Lora. As Max previously described "it tends to go towards feelings... a thought will come flooding in and I actually enjoy having these thoughts, because I enjoy the whole process of reflecting." She just "enjoys that reflection... It doesn't cause you turmoil... I knew it made me feel better."

Miranda understands reflection as "how things made me feel." She may "get comfort" in reflection, a positive feeling. Again, comfort may be a physical or emotional feeling. This contrasts when on occasion "if it's something that's really eating me up" or some "unresolved situation... (it) will consume me... could be stressful," experienced as *dis*-comfort. Miranda finds reflection "almost a way of getting in tune with yourself... reflection's kind of nice just to make you feel good," and it "kind of makes you happy inside." Another time, Miranda expressed that "reflection is more positive and relaxed. a good feeling." She has described situations where she will "thank God I have this and I have that, and I am grateful for this and I wish I had that... comfortable." Generally, feelings in relation to reflection are positive. Beth finds it's "not a chore." She also describes reflection in relation to curiosity. For Max "peaceful is not the right word, it's just enjoyable and it's just a thing I needed to do, yah, like it's just a need." Max considers that an absence of reflection would be distressing. "I would have a really hard time if suddenly I stopped reflecting, I think I would just explode, I don't know what I would do, because again, it just comes naturally and it's almost like breathing to me, it's what I need to get through my day." She describes

I have to get through the feelings, being able to identify, okay, those feelings of frustration

are related to the incident, not the fact that my brain is telling me I have to look at this. I am quite happy to look at it, but first I have to say, okay I was frustrated about that and it caused me some turmoil, that's okay. It'll be even better once I get to think about it. And it is. I get past the emotions, put them aside and I enjoy the reflective experience.

The body is usually experienced as "passed-over-in-silence (Sartre, 1956 cited in van Manen, 1998) or as "near self-forgetfulness." Usually, we tend not to take much notice of our bodies. We go about our movement through the day on "automatic pilot," or what van Manen (1998) calls a sort of "unaware awareness." Miranda describes reflecting while walking. "When I walk, I reflect all the time, it would start with my walk home." She is not preoccupied with the act of walking itself, but the meaning of walking home from work is in reflecting. A difference in destination or location may imbue walking with a different meaning. For example, when walking along the canal on a summer's day with her husband, Miranda might be reflecting upon their life or their relationship.

When our sense of self and body is "unencumbered," we tend not to take notice of our physical selves, the body is experienced as "passed-over-in-silence." These nurses also spoke of reflecting while driving their cars, doing the ironing, making the beds, even in the bathtub, that is, in relation to physical activity. However, while they are engaged in these normal, familiar, every day practised activities, they do not need to attend to the activity and are able reflect alongside it. van Manen (1998) suggests our "primary occupation is in the world and with the world, with our projects, purposes, relations with others, and the places we travel or inhabit" (p. 11). While our bodies are central in our existence and the source of our activities, they are taken-for-granted. We function in a mode of unawareness for we may not have any reason to take notice of our corporeal

being. To be attentive to the things of the world in which we are involved in everyday life, we must be able to forget our bodies. "We are able to move around in the everyday world because our understanding is always situated and our actions are typically only as orderly as the situation demands" (Benner & Wrubbel, 1989, p. 83). In caring for residents, the nurses live out embodied knowledge in practice. They have no need to take notice of their physical being, but they are concentrated upon the resident, in all his or her dimensions. Our experience of ourselves as embodied is generally passed-over-in-silence; our experience of others is not.

Feelings may be emotional, physical or corporeal, or knowing, an aesthetic pattern of knowing which some call intuition. Heron (1992) suggests that 'feeling' is the most inclusive of all mental words. This is because feeling may refer to physical touch and bodily sensations, general states of being, emotions, moods, thoughts, beliefs, aesthetic experiences, hunches and intuitions, to name a few. Feeling is involved in each everyday experience. While feeling may be a modality of consciousness, it manifests through the body.

These nurses expressed an overwhelmingly positive experience of reflection feelings, "comfort," "pleasure," and "enjoyment," for example. Situations may have negative or uncomfortable aspects, creating sensations such as "eating me up," and "consume me," and "frustration," although these did not transfer to reflection feelings. Much of the time, while reflecting, the body was passed-over-in silence, taken-for-granted. However, the feeling of comfort, bodily and emotionally was easily recalled and was common within the group.

Reflection Awareness

Is reflection a deliberative, purposeful activity? Can one reflect and not be aware of reflecting? Awareness is identified by Atkins and Murphy (1993) as the first stage in reflection.

Others, such as Mezirow (1981; 1990) and Ross (1990) highlight the importance of awareness to reflection. Awareness of reflecting is recalled by the participants. For Ruby, "reflection may be subconscious, I notice it retrospectively." Then again, "thinking about things that occurred during the day would be conscious, not a dreamlike state... I would have to be aware that I'm reflecting." Ruby describes an outcome for reflection as "increased awareness." She does find that "probably the self-awareness component in reflection, that's most difficult part of it."

Lora is "more aware of it, but," as previously mentioned "I don't think I have ever sat down and consciously thought I am going to reflect." She continues "I don't know if it's conscious... I don't think it's conscious for me... subconsciously, it has gotta be easy." This may be because "it's automatic, so automatic." Max notes that reflection "enters my mind... probably subconsciously at the time." However "it is conscious once the reflection starts... The process is conscious. Once the thought pops in, conscious." She considers that reflection brings "just a greater awareness or consciousness I suppose, of everything all around." Miranda describes reflecting spontaneously, however, "maybe not consciously, but certainly subconsciously" She considers "I'm usually aware... subconsciously... I think I'm aware when reflecting... I am usually aware when I'm reflecting." Edi expresses her uncertainty with "there is some awareness of self... I honestly don't know - maybe I will from now on, be more aware... I am conscious of thinking back over the events... probably unaware I do it most times." Whereas Six relates "despite how I come across, I am very self-aware... most of the time, for me, it's conscious... usually I write it out, then, if I'm going to think really hard on it - tear it up right away, but nevertheless... I can identify it in myself, what I'm actually doing."

In the nurses' descriptions, there was a strong sense of reflection being spontaneous and

automatic, a natural process of everyday life. The response with respect to awareness, was tentative. Some nurses were aware of reflecting, and some were not sure about awareness. Perhaps this illustrates a continuum of awareness, with different nurses occupying different positions along the continuum. Reflection was also described as both conscious and subconscious, but not unconscious, indicating some level of awareness of reflecting.

Reflection Relation

Another modality of the body is established in a relational climate and intersubjectivity may be experienced as relational subjectivity (van Manen, 1998). How we are with others characterizes this strand. Heron (1992) notes that interpersonal life is rhythmic, with comings and goings, togetherness and separation (p. 98). The nurses mainly identified their peers in the reflecting relation. Max would "choose carefully... individual or individuals I would share it [reflection] with ... so that I don't feel further frustrated." Nurses working together have some continuity in daily interpersonal relationships and events, a sense of familiarity. Nurses and residents make sense of their situations "in terms of their own personal concerns, background meanings, temporality, habitual, cultural bodies, emotions and reflective thought" ((Benner and Wrubbel, 1989, p. 82).

Speaking and hearing. Reflection relation suggests dialogue and interaction, where speaking, hearing and listening are the predominant perceptual modes. Ruby finds "being on the listening end of someone else reflecting, that's the easy part... When I share with my peers it's usually verbally and ... we'll just play out the scenario for each other through discussion, and then just talk with each other." Max describes reflection relation as conversation and "being able to bounce it off someone else." Bouncing ideas off others was a description used by Lora, Edi, Max

and the focus group. This action description suggests a back and forth activity, speaking and listening and physical positioning in reflection relation. Within the conversation Max notes that "both parties are comfortable." Reflection relation is an interpersonal interaction, a conversation. Friedman (1995) considers conversation to include, in addition to what is said and can be heard, ones' position in relation to those who are in the environment. Shorter (1993) speaks of the importance of "positioning oneself" in relation to those who see and hear the person's utterances. Utterance is how Andersen (1995) describes all the activity that occurs when the spoken word is uttered. This activity includes the physical movements and the breathing, the interplay between creating a muscular tension and letting it go (p.30).

For Miranda "I guess it's still part of reflection to be able to say this outside of myself, to hear it outside of myself." The notion of hearing her own thoughts expressed verbally is important to Miranda. In addition "I guess in a way, it's wanting the other person's opinion, but probably at the same time it's just to want to hear it out loud. What these are and once again confirm what I was feeling or what I was thinking." For Max, "talking with someone, it's as much as getting it out there and hearing it for myself." When we listen, we don't dwell upon the pronunciation of words but rather their meaning (Arndt, 1992). Hearing is a synthesizing sense. There is distance between people and a definite direction which delimits the interpersonal space. Schonhammer (1989) suggests that sound "fills up the space... does away with locational differentials, and homogenizes space." (p. 132). The sound in conversation arises, persists, fades and has its own rhythm. "It is a creature of time, it dispenses the flow of time with its own becoming" (Schonhammer, 1989, p. 133). Lived common presence in the world is experienced in hearing. The reflection relation within the lived body theme is intersubjective though primarily corporeal. It is interpersonal in a

physical sense, where interaction is exchange through speaking, hearing and bodily positioning.

Embodied Knowing

We lack a rich language for skilled know-how and for the skilled social body which are operative in practice (Benner et al., 1996, p. 215). These nurses, in talking about their involvement in practice, did not articulate, as such, the skilled know-how and embodied knowing, developed over time through experience. It was evident in their descriptions. This supports that notion that the knowing embodied within the practitioner is difficult to articulate, and this taken-for-granted knowledge characterizes the very nature of tacit knowing. Reflection for clinical practice requires, in part, the embodied skills of noticing and attending. These two aspects of embodied knowledge, pattern recognition and noticing, paying attention or attending to patients and situations, were evident in the nurses' accounts of practice. Benner (1991) suggests that narrative memory actively engages the nurse's embodied skilful know-how, complete with feelings that allow her to recognize similar situations. These feelings allow for the perception or recognition of similar situations without necessarily allowing for the ability to articulate why one recognizes or notices the situation (p. 7).

Noticing. Noticing, attending and paying attention is evident in the nurses' descriptions, as is their confidence in clinical judgements and their skilled know-how. Max "may recognize it at the time" but she "puts it on the back burner, the day goes on, and it's not necessarily a priority at the time." This may be "a reaction you notice of another person that caught you off guard" or "maybe something I've done or an action I've taken that's not sitting right with me." When she reflects upon it later, Max "often times I'll go back and say, yup, that's what I should have done, that's what I'll do the next time, or if I could do it again that's what I would do." Lora notes that "if

everything is going smoothly, the way it's supposed to, I wouldn't reflect on it." However, if she notices something unusual, it draws her attention and she would engage in reflection. She finds this is "so automatic, maybe because of your years you've done this."

In the focus group, Mary says "you may not realize it at the time, may feel okay, but later..." Or "I might notice it at the time but the day must go on, and knowing it will come back to me later." These nurses pay attention in practice to the residents and the situations as they unfold. They notice and prioritize their responses. Often, when they notice, they make a mental note to themselves to "give it some thought later." When an immediate response is required, they respond immediately, and may still reflect upon the situation later.

The knowledge for practice is worked out and largely maintained within daily practice of nurses caring for patients, families and communities. Lora's reference to her years of experience as a reservoir of clinical experiences highlights her clinical knowledge developed through "reading" residents and situations over time. These nurses are open to learn from questions about clinical situations, and even mistakes. Alex, for example, recounts attending to situations and recognizing "I really blew that one, now how can I approach that differently so I don't blow it again." Prerequisite skills for reflection for clinical practice include noticing and attending to situations in practice, seeing when things go awry, paying attention to those gnawing feelings that things didn't go quite as expected, and sorting out the relevant dimensions of those events (Benner, 1996, p. 327).

Pattern recognition. Patterns and trends are developed over time and with experience. Past clinical experience provides memories that enable pattern recognition, and inform responses in the present. This is enhanced through comparison with other residents and situations and through

dialogue over time and practice with patients, families and colleagues. These nurses recognize patterns and respond to situations appropriately and with great skill (Freshwater, 1998). Taylor (1998) suggests that with embodied knowing is sophistication in rapid thinking and acting. This is possible from being the inhabitant of a physical body with all its past, present and future potential. Narrative memory can evoke perceptual or sensory memories that enhance pattern recognition (Benner et al., 1996, p. 207).

One particularly interesting situation of pattern recognition shared among long-term care nurses is that of palliative care. It was common among the group, from their stories and anecdotes, they recognize when a resident is dying and they change their approach to one of providing palliative care. Yet they are unable to articulate exactly how they know this. In addition to clinical knowledge of physiology, personhood and such, the nurses recognize something inexplicable in a situation, which triggers memories of past clinical experiences with similar other situations.

Edi describes how she uses particular language to share this information with families. "I said, your father is going downhill, which was a gutless way of saying your father is dying." She knew this because "the signs were there." Edi noticed a "decline, deterioration... his refusal to eat, and we think he kind of gave up." Edi expresses a value held by the nurses, "we are all working toward the same end, a comfortable, dignified death with family and loved ones and pain free, if possible." Perhaps this strongly held value contributes to the nurses' ability to recognize when someone is "actively" dying. Edi also notes that "sometimes, we are wrong." Timing is involved with the transition to a palliative care approach, "we don't try to do it too soon... not too late either." Something in their embodied knowing allows them to recognize a pattern and make the change at the right time.

Embodiment provides a common human circumstance that allows for understanding (Benner, 1991). Benner and Wrubbe (1989) speak of embodied intelligence where understanding is grounded in mind-body unity; persons are in situations in meaningful ways. The nurses go about their world without considering the everydayness of their practice, and embodied intelligence is working well. However, practice is informed and nurses are comfortable. Reflection gives access to past experience in order to develop a reservoir of tacit knowledge (Visinstainer, 1986). Embodied knowing may be characterized as tacit, unformulated, or even ungraspable (MacKinnon, 1996). Practical knowledge, the knowledge in practice, resides in lived embodied everyday understandings and meanings. Knowledge or knowing in practice is constructed knowledge - a subjective, holistic, contextual knowing that has been appropriately informed by empirical science and theory (Taylor, 1998). This resembles a pattern of knowing identified as aesthetic knowing (Carper, 1978). Johns (1995) suggests that the empiric, ethical and personal ways of knowing converge upon the aesthetic response where reflection leads to the knowing embedded within the self. It is a holistic knowing that is able to grasp the meaning of the whole situation in a moment and respond appropriately.

We live in the world in an embodied way. Thoughts and feelings are manifest through the body. For these nurses, the body was passed-over-in silence while reflecting. It was only through recall that they constructed the reflection experience as comfortable. Comfort may be a physical and/or emotional feeling. The nurses described reflection as conscious, subconscious, and automatic, although they had some awareness of themselves reflecting. Within the theme of lived body, reflection is both corporeal and affective. In social exchange, reflection is through speaking, listening and positioning oneself to enhance the process. Knowing in practice is embodied as lived

everyday understandings. It is constructed and socially embedded in practice and develops through a process of membership and participation. It may be expressed through ways of behaving and interacting. This includes gestures, posture, and stance (Benner et al., 1996). Embodied knowing comprises a dimension of reflection.

Lived Human Relation (Relationality)

In this section, the nurses describe the intersubjective nature of nursing. A sense of informality pervades the theme of lived human relation. Reflection in relation is primarily through verbal language and face-to-face or in physical presence, except when recalling interactions. These nurses might observe another's readiness to engage in reflection relation. Max observes someone deep in thought, not ready to be interrupted and engage in dialogue. The nurses, at home in their language, engage in dialogue amongst themselves or with others, generally verbally or in word pictures. Language is their house of being (Heidegger, 1962). The strands within this theme include reflection relationships, with peers and others. Sharing creates a bridge between reflection relationships and reflection conversations. An element of feedback is often constructed within reflective conversations or dialogue. The social embeddedness of knowledge is evident through dialogue or reflective conversations; and in this way reflection enters the experience of practising nurses.

Reflection Relationships

These nurses find that reflection is in relation with self, or in relation with others. Max describes reflecting "with myself or with one other person usually... then again, with myself is another level altogether." She notes "it might be something I want to think about more myself and then discuss with that one other person, if I'm seriously wanting to reflect on it, and see what their

opinion is on it and to help me reflect more deeply." As Ruby has described, she reflects "sometimes alone, introspectively, other times with my peers, 50/50."

Max eloquently describes reflective relationships, "it's usually a mutual person, the same person I feel I can go to with these reflective thoughts, that same person is likely to come to me as well. We've almost forged a relationship that way." Reciprocity, trust, and ease with the selected, "mutual" other is evident in a reflecting partner relationship. This other is "someone I know I can talk to and I think they likewise feel, so, all we want to do is reflect... I'm actually quite interested to know what they are reflecting on anyway... It would be that mutuality." As Max has described, she appreciates "getting to pick and choose who I want to reflect with, because people will ask the kinds of questions I like to hear."

Lora has previously described a bond or closeness necessary for reflection in relation. "You'd have to have a friend, pretty much. Because you wouldn't want to do it with someone who wasn't friendly, because you don't need criticism from someone you don't like to begin with." She continues "there has to be some level of trust. The people that you do it with that are not out to hurt you. Don't just do it with anybody."

Current discussions of reflection most often portray it as a personal and isolated act that typically occurs while engaged in practice, a very individualistic notion of reflection. This is unlike Noffke and Brennan (1988) who describe reflection as both an individual and a social process, and as group oriented. The social and collegial nature of reflection presented in the literature is often related to formalized, structured, reflective learning groups (Carkhuff, 1996; Johns, 1998). This contrasts sharply with the collaborative, spontaneous, informal, non structured flavour of reflection in relation which these nurses describe. For them, reflection is structured only

to the extent that conversation may be considered to be structured. Collegial dialogue enhances the development of a reflective stance among these nurses in practice. Through reflection in relation, nurses develop new patterns of thinking with which to approach the complex practice environment (Pugach & Johnson 1990, p. 186).

Collaboration and partnership characterize the new movement or climate within health care. This is echoed in the reflection relationships these nurses build with family, colleagues and residents. Communication is collaborative. Within the nurse-patient relationship, empathy, warmth, caring, and connectedness predominate. This parallels the relationships the nurses build with friends, family and colleagues. Reflection in relation is about mutuality, trust, familiarity and choice. The nurses choose "reflection partners" with whom they have a close emotional bond and who share their interest in exploring practice issues, or with family, life issues.

Reflection relationships with peers. Not surprisingly, reflection in relation is primarily with peers. The nurses reflect with or "discuss with your peers," "we can get together with a peer." Reflecting with peers is pretty much exclusively in relation to practice. "I reflect with my peers," says Ruby. She previously described being "inclined to seek out and compare what I think about things with somebody else, like to bounce different ideas off, inclined to review, reflect with somebody else." Lora finds "you have a peer that you can do that with, reflect with your peer is important... I think probably a lot of nurses don't have a chance to reflect with their peers very much." Beth expresses concern that nurses on nights have fewer opportunities to reflect with peers. "Through a conversation with a co-worker, we might discuss an experience that we've had, talk about it... So that would be the part where I'm more likely to want to speak with a co-worker" says Max.

Edi and Lora describe reflective relationships with peers at weekly coffee breaks. "The full time day nurses have coffee together one day a week... trying to support each other is really what we're trying to do. It does help, we bounce things by and we have ideas on how we're going to start new things, that type of thing." These encounters are referred to as reflective discussions or support groups; they are also forums for the nurses to consult with each other about their judgements and practice. As such, they are potentially powerful strategies for maximizing the clinical knowledge of the group, based upon personal experiences and the collective experiences of the group (Banks Wallace, 2000).

One opposing view with respect to reflecting within a group is expressed by Max. "If I'm talking with a group, I'm not usually as reflective as I would be one-on-one because there is more time for ponderance and thinking and for reflection... there's more information coming and going." However, "if it's just myself and another person or just myself I am able to think out step by step what has happened and what I would do in the future and so-forth, how I feel about it."

Six was the exception to reflecting with peers at work. "I don't discuss with somebody else what I did or said or. I tend to make my own decision what I did, whether it was a good thing or not. I think it's mostly a personal kind of thing, to me, reflecting." However, she does talk with her colleagues at work. "I've sort of said to other people, there must be a better way we can do this. So that's reflecting, I guess." She does reflect off site "a lot" with a friend, a close and trusted colleague from a different facility, about work and her practice. She remains in the work, in relation, while not at work.

Development of clinical know-how is refined by comparison of assessments, clinical and leadership situations, difficult or interesting encounters and unusual events, among peers (Benner

et al., 1996). Ruby provides a comprehensive description of the content of her reflection in relation with peers. They might reflect about specific approaches or specific assessments. "How a colleague might have addressed something versus how I addressed something." Different leadership experiences as well as "how I've handled certain confrontations or conflicts... physiological changes that I've noticed... how I intervened, how I might intervene differently in future." For Ruby, and for the other nurses, collaborative reflection is a form of learning and support. These examples illustrate a distinction between patient-related encounters, reflection on practice and other situations, for example leadership experiences, reflection for practice.

At work, the focus group "always discuss how things are going and what could have been done better." Or they might reflect collaboratively on conversations. "Well, when we talk about for instance at work - gee that conversation didn't go very well, and I wonder what I can do in the future," says Suzie. Pia recalls "maybe you have a care plan discussion or something, and say, well I notice or we notice, when we tried this or when this particular one tried this, we had that problem or we didn't have." Collaboration and pooling of expertise create a climate of support and possibility.

Both Pia and Edi spoke specifically about reflecting upon how things might go well or not so well with different constellations of staff, different relations among the group, or on different days. Pia says "you look at the staff you had, and you try to find out how different they did things... You just don't know what makes that big difference." Or "sometimes you go home I think you had a real bad day with somebody in particular. You try and find out why was it so bad." Later "you come back the next week, and it was a lot better. And you wonder, well who was there and what did they do different. So you reflect on that too, on an everyday basis."

There was a striking in denial of reflecting at work, with "no time," "no place," "too busy." At the same time, the nurses spoke spontaneously and eloquently of reflection in relation, often with colleagues and at work. They seemed not to notice this discrepancy, and it may be that they took reflection for granted in at least two modes. In the intrapersonal mode, reflection is personal, individual, in relation with self. Reflection in relation with others, interpersonal reflection was constructed within the conversations. Somehow, somewhere the nurses created opportunities to reflect in relation with peers! Naturally occurring, unstructured and informal, these reflection conversations in relation with colleagues exemplify what Michelson (1996) refers to as indigenous reflective thinking. Such collectives and indigenous reflective thinking is not well represented in the reflection literature, and this perspective expands our understanding of reflection.

Yinger (1990) suggests that to practice a particular occupation or art, one must enter into a relationship with participants and place, a community. Community "consists of the shifting, face-to-face group of persons each of us travels with, like a school of fish, which maintains and shapes who we think we are. Polarity between environment and person has dropped away, and we are now concerned with the type of communicational event," (Friedman, 1995), a community of perception. Benner et al. (1996) consider that practice within a community of nurses is based upon socially embedded knowledge, and not the product of insular disconnected individuals. These communities are the expression and living out in context of their members' cultural traditions, shared narratives, habits, practices, and concerns. Practice is defined by Benner et al. (1996) as a coherent, socially organized activity that has embedded a notion of good, and common meanings; this is internal to the practice. A practice is located within a tradition and is continually being

worked out in history and through the ongoing development of the practice. Reflection within such practice communities helps "to limit snap judgements and tunnel vision" (pp. 252, 205).

Reflection in relation with others. Reflection is part of everyday life and reflection in relation is not exclusive to peers at work. The nurses spoke of reflecting in relation with their spouses and family. In the focus group, Mary speaks of transferring knowledge gained at work, to her home situation. "I think, too, many of the things that we learn at work... We take that home with us and we use it with our spouse and with our children, and it becomes part of life again." Miranda notes "I see myself right in there sharing it with whoever it is that is there, or is important at the time." Max finds "if I'm speaking with another individual, sometimes I just can't keep it to myself. I'll have to turn, if there's someone else in the household, and say to them: you know what I was thinking about was such and such." So reflection is ".. again in conversation, with just having a conversation with my spouse."

Max introduces the notion of reflection increasing her understanding of and responsiveness to others. "How I relate to strangers probably, or I see a stranger, someone who I met for the first time and if I see that they are having a difficulty in a certain experience, [reflection] may help me better understand that person." The knowledge gained through reflecting with others enhances Max's understanding of and interaction with strangers.

Palliative care is a component or dimension of long-term care and the nurses share palliative care as a focus in practice. Encounters involving palliative care were used as examples of reflection opportunities. In the homes, at least quarterly, a memorial service, attended by staff, residents and families provide a formal opportunity for reflection. Edi describes an example of collaborative reflection, with staff and the family of a resident for whom palliative care was

required and who subsequently died. During this ongoing encounter, the nurses collaborated with the family, so that they could also care for their loved one. These events over time are spoken of, by the nurses, as very rewarding experiences. Lora describes attempts at work, particularly around the death of residents, to acknowledge and work collaboratively with unit staff around the grief related to residents' passing, a perfect opportunity for collaborative reflection. However she found "no time to grieve or time to acknowledge... and you have to have the right kind of people to interact in that kind of a situation, we didn't really have either." Lora is speaking specifically about her home unit, where she would be the only registered nurse. While Lora was unable to engage in collaborative reflection around encounters and endings while on her unit, she is able, as are the other nurses, to enjoy this opportunity with her peers, in reflection conversations off the unit.

Others in reflection relation include the residents in long-term care. Lora, for example, speaks of reflecting in relation with the residents, who are "the greatest reflectors." The focus group spoke optimistically of continuing to reflect well into old age (85), as in practice they see this and engage in this with their residents. Edi and Lora also speak of reflecting with and upon the families of the residents. The nurses speak warmly of the residents and experience a close bond with them, which is not surprising given the intimate nature of their relationships. Lora noted that she had a number of "old nurses" on her unit and considered that "you should interview them!" While this was said in jest, Lora is aware of and shares my intense personal and professional interest in the lives of nurses in old age. She is quite correct, it would be a wonderful study that perhaps we could do together.

In lived relation, we are present with each other. We maintain with others the interpersonal

space we share with them. We develop a conversational relation (van Manen, 1990; 1998).

Michelson (1996) notes "the emotional and sensate mediate our social and moral selfhood, and our lived physicality binds us to a planet in which all life is social and relational, not autonomous and self-enclosed" (p. 446). Interaction, shared language in dialogue, suggests exchange and discourse. Nursing knowledge, caring knowledge requires community and occurs in dialogue and relationship with the other (Benner, et al., 1996, p. 193). Reflection may be in relation with self, others and surroundings. Reflective relationships are accomplished at a distance from the experience and through conversation with trusted, chosen others. Reflection partners were most often identified as peers. Peers, family and friends may be reflection resources.

Sharing Reflection

Not surprisingly, there is a strong sense of sharing with reflection in relation and this was primarily described with respect to practice. Sharing is illustrated in the language the nurses use to describe reflection. "Sometimes I share with my peers. When I share with my peers it's usually verbally," for Ruby. It was common for the nurses to consult between themselves and compare around assessments, clinical decisions, judgements and encounters. This is taken for granted to the extent that it is expressed but not recognized as sharing reflection. Beth "certainly can share with other people and gain from other people's reflection as well." Sharing involves the relation between our own actions and the responses of others to them. Max sometimes finds "I have a need to express what I've been reflecting on and sharing." She does, however, "choose carefully who I share my reflections with," and she would choose someone "who is not going to judge me in any way." Miranda has described

professionally, it's either more of a sharing that I might do with colleagues. If it's

something that's really bothering me... then I know I have to share it and get it out verbally. Like my husband, he gets a lot of it back to reflect back. I guess if it's a reflection you want to share ... then I see myself right in there sharing it with whoever it is that is there or is important at the time... Certainly if it's a reflection that's been very positive or ... made someone else feel whatever, then I certainly want to share it and probably share it if it was bothering me .. that's when I find I share things too.

Beth notes "you can discuss it with your peers or you can discuss it with your family, depending what you're reflecting upon." There are, however, boundaries and not everything is open to sharing. "I think there are some very personal parts of it, but I think it certainly is something you can share with other people and gain things from other people's reflection as well."

Within the communities of practice, the nurses share background habits, skills, practices, and language. They hold practical and theoretical knowledge and clinical experience in common, although specifics and perspectives differ. Sharing knowledge is important, in part to ensure that the individual's knowledge is valid or well founded. In sharing is a process of exchanging knowledge and enabling greater understanding. Through sharing or communication, knowledge may be reformulated and made accessible, and it is through dialogue or discussion that meanings become clear (Clarke, et al., 1996). Dialogue is a way of sharing experiential knowledge with other nurses. In conversation, the nurses talk openly about practice, they share what worked and what didn't work. They may talk about moving or ambiguous encounters, or unusual events. They pool memories, past clinical examples and clinical expertise. Through sharing they build and nurture connections and create and maintain a sense of community. Sharing is expressed by Margretta Styles (1982) as collegiality.

Collegiality is the actual sharing of that innermost core identity with our colleagues... True professionhood, perhaps above all else, means that we are bonded to our associates... through conviction and calling, through social contract, through professional thought and conscience, as we are bonded to our natural sisters through blood... This professional bond causes pride when a colleague triumphs and pain when she fails. It causes loyalty that does not blind us to her faults but opens our eyes to her virtues. It causes us to confront her in disagreement, disappointment, and disapproval and to stand beside her in determination.

Collegiality is as sacred as a vow, it is a solemn promise whereby we bind ourselves to those who share our cause, our convictions, our identity, our destiny. (p. 143).

The nurses choose reflection relationships with trusted others in the commonality of experience. This is characterized by openness, willingness to share and readiness to accept new ideas. The emotional bond includes a sense of trust and reciprocity, which enhance the shared language in conversation. The shared language shapes the conversation and contributes to a collaborative, relational stance (Gilson, 1991). Sharing characterizes the relational context the nurses create. Receptivity, reciprocity, relatedness and responsiveness characterize the reflective stance.

Reflection Conversations

Reflection may begin within the person and move to engaging in dialogue with a particular other or others. Max describes entering into an ongoing reflection conversation. "I might sit next to them and say do you mind if I sit with you, I was just thinking about such and such and... Usually that will be that mutual person or persons, there may be two or three, that I can reflect with." Max positions herself in relation to her reflection partner, so she can see and

hear the reflection partner, and so that they are both comfortable. Timing is also an element in reflection conversations. It might be that "they may not be quite ready to talk right now, but I know that probably down the line, we'll talk with each other about what that issue was." The conversational relation or process might continue with

I'll probably go back to that person in a couple of days and say, I've been thinking about what you said, and you know that was a good point. And again that person will probably say, you know what I was thinking about it too. So we've probably done it at different times in our day, whenever it's most conducive for our own personal reflection. But lo and behold, we've both been reflecting on that initial conversation, come back and have a secondary conversation... So usually it can be maybe two or three conversations on a similar topic before we kind of feel settled about it.

The description offered by Max illustrates the ongoing nature of reflection conversations. These reflection conversations take place within a relationship, not discrete events but ongoing processes (Walsh, 1997).

Conversation with others is one level or "layer." Max describes "another layer" as conversation with oneself. Beth, for example, talks about reflection in relation to herself, considering "how lucky I am. I look around and take stock and say compared to other people, we're doing very nicely in our life." Max extends this with "its almost, I would say, to me as another step in the process, because then I will go further and I would reflect on a reflective conversation I have had with others." Within conversations there are shifts between talking and listening. Friedman (1995) suggests that talking to other(s) may be described as "outer talk." While we listen to others talk, with ourselves it is "inner talk." Within a conversation with

another, we are also in conversation with ourselves. Through these conversations which include various perspectives, inner and outer talk, we might come to understand an issue within the conversation in a different way.

Knowledge may be constructed in dialogue with others who have different perspectives. The possibility of dialogue, inner and outer talk, correction through multiple perspectives and memory of experiential learning from the past is found within communities of practitioners (Benner et al., 1996). How we talk depends on the context in which we talk (Freidman, 1995). Bjornsdottir (1998) in studying nurses' communication patterns in their work, found that their public (interdisciplinary) conversation differed markedly from their private (intradisciplinary) conversation. Amongst themselves, the nurses' conversations focused mainly on the human experiences of the patients and their attitudes and feelings about what was happening to them.

Feedback. In relation with peers, a feedback aspect of reflection is important. Unlike the "give and take" of conversation or dialogue, feedback is a more specific. It is evident that this feedback element is valued. Ruby describes receiving "feedback from a peer on how they might have handled a certain situation... my peer will give me feedback on whether they felt that was handled appropriately or how they might have handled it a bit differently." With her peers, Ruby will "seek out and compare, to get feedback *about* my reflection." Max considers feedback an aspect of reflection in that "what the other person might say back to you and what happens with that, I think that's part of it." For Miranda "it's wanting the other person's opinion." Edi describes feedback, although she does not identify it as such. "You can discuss things" with a colleague and each of you reflect your day... and the follow-up, whether it's comments, input or whatever." Six notes that "it hasn't happened to me too much that somebody's come back to me and said 'well, I

didn't like that' or whatever." Should this occur, Six will "think about that and then think, well, maybe I was a little or whatever. On the other hand I might think, no."

Lora appreciates "feedback from anyone, I don't care if it is the cleaning lady or if it comes from the DON, it all makes a difference." Feedback is "often is feedback of how you are doing your job," although this was not in the sense of performance appraisal. She continues, the feedback "often is negative at all levels, should be positive more often... probably should have more feedback... Probably don't have enough, could make the job nicer, better communication."

The notion of feedback suggests a purposeful aspect to reflection in relation. Feedback is purposefully sought and provided, within a nonjudgmental atmosphere of trust and choice. As Marge Piercy (1973) writes her introduction/dedication in To be of use,

For the give and take
for the feedback between us
for all the times I have tried in saying these poems
to give back some of the energy we create together
from all the women who could never make themselves heard
the women no one would listen to
to all the women who are unlearning to not speak
and growing through listening to each other.

Voice reflects the particular social context in which practice occurs, and voice was expressed by these nurses in our conversations around reflection. Noddings (1984) suggest that voice can only be created by reflection on experience and as such it is a necessary condition for relation and community. Reflection in relation encourages voice by supporting the integration of

knowledge the nurses hold or feel intuitively with knowledge they learn from others, and from hearing each other. Within their practice communities, these nurses make an effort to develop relationships and bring their voices into communal hearing. Gibson (1999) asserts that one indicator of participatory competence is being heard and that being heard reflects the relational aspects of empowerment. Tanner (1993) suggests that having a dialogue about nursing as part of day-to-day practice lives could be revolutionary, both in the act of doing it and the effect it might have (p. 291). These nurses appreciated the opportunity for their voices to be heard about their experience of reflection. In speaking aloud they both heard themselves, and were heard. In hearing themselves, they also corrected and /or clarified their perception of reflection. They expressed that through reflection in relation they both listen and are heard.

Lived Time (Temporality)

Thomas Philipott expressed in *On the Sight of a Clock*,

How fruitless our designes would prove, if we should be possett with so much vanitie,

As with our fraile endeavours to assay to stop the winged houres in their way?

Or fondly seek to chaine up Time, and try to make him with our wild desires comply,

Since leaden plummets hung upon his feet, not clog we see, but make his pace more fleet.

(1646, Cited by Martin, 1950, p.2)

What are the temporal dimensions of reflection? In this section, the theme of lived time, our temporal way of being in the world, is explored. Within this theme are the strands of encountering reflection - the initial encounter. In everyday life when do these nurses reflect? They reflect during in-between time, work time, taking time and making time. Reflection time is characterized by looking forward, looking back. Reflection is ted

related to development, another aspect of time.

Time is too slow for those who wait

Too swift for those who fear

Too long for those who grieve

Too short for those who rejoice

But for those who love

Time is eternity.

This poem by Henry Van Dyke runs through my mind, as I consider the theme of lived time or temporality and it captures the relativity of time. Lived time (temporality) is subjective as opposed to linear, although we live in a world where time is both linear and relative. Time dominates our lives (Williams, 1991) and presents us with a paradox for we may have no time, too much time, enough time. We start and finish our work day at a certain time, on certain dates, indeed we are paid for linear time. But, time may also speed up with enjoyment "time flies when we are having fun;" or it may seem to pass more quickly when cramming for an examination where we "run out of time." We may also "run out of time" when doing a presentation, too much to cover in too little time. Time may slow down when we are anticipating a pleasurable event or when we are bored. Time may be cyclical as in the passing of seasons.

Taylor (1998) suggests that people live their daily lives in the moment, yet remain connected to their past and hopeful of their future. Being human and living suggests some passage of time and some continuity in daily relationships and events (p. 141). Relationships, by their very nature are also linked to the experience of time. Lived experiences accumulate and gather interpretive significance as they are remembered. This is reminiscent of Heidegger (1962) who

believed that the past, the present and the future are intricately linked. What we have already experienced, what we are experiencing, and the anticipation of experience is essential for interpreting our world and the world of others. It is not surprising that time was a theme which emerged from the data. This addresses the study question, when does reflection enter the nurses' experience of reflection?

Encountering Reflection - Initial Encounter

I was curious as to when these nurses came to know about reflection because reflection is such a familiar word. Most of the nurses identified reflection coming to their attention recently. While these nurses had certainly heard the word reflection and were familiar with it, indeed used it often in conversation, its use in practice or for practice was relatively recent. Lora speaks of her first encounter with reflection. "I hadn't really had *time* to think about it. I don't think I started hearing about it until the College... three years ago? I don't think I heard much about it before then." Beth echoes this stating that "I never heard of it relating to nursing, until quality assurance came out." Edi also identified being introduced to the term through the College of Nurses, noting "it's a new buzz word, the buzz word of the particular decade." The perception was unanimous that these nurses had come to know about reflection as a term for use in practice, through the College of Nurses quality assurance program. Lora asserts that we "always had it [reflective practice] in that you renewed your registration, but we never called it reflective."

The notion that reflection was both a familiar, everyday term and new use of terminology within nursing was unanimously supported within the focus group. For Suzie, "we have been reflecting all of our lives, but I think it's just that now the College has established this program of reflection and this is your documentation that you have to do for it. We think it's something new."

She has described "I think we've always done it, it's just new terminology now... Not even the terminology because I think we're all familiar with the word reflection."

Annual reflection exercise. There was a strong sense that as a College requirement, reflection was an annual exercise or assignment. This is perceived as an annual cycle in time, with an interval of a year where there is the opportunity to review the intervening activities and events. Time is both linear and cyclical. Like Max and Ruby, Pia speaks to annual reflection. "Now we have to have a plan every year... in writing like everything else." Max supports this as it's "simply an annual assignment... you must put something down on paper that is pretty reflective." The notion that these nurses engage in reflection far beyond an annual exercise is represented by Suzie. "Certainly we are doing what they ask as far as looking at ourselves and making our goals, but the amount of work that we do throughout the whole year doesn't encompass what we're writing on the papers... It's all the time." Mary supports this with "I don't think we are catching a lot of the things we are doing."

For this group of nurses, their formal encounter with reflection is recent, in last few years as proposed by the College of Nurses of Ontario. This recent, initial encounter was actually the naming of a longstanding activity as reflection. Their perception of reflection as a College requirement is that of an annual exercise for re-registration. At this time, the registrants look back over the year, recall specific incidents of reflection and develop learning plans for the following year. As the years pass, they will focus on their previous learning plans for the previous year, whether they met their goals, and plan for the coming year, looking back and looking forward.

This locates the notion of the history of reflection for nursing with this group of nurses. Reflection per se is not something new but the use of reflection for practice is new terminology

within nursing, recent in historical or chronological terms. While they were not sure when they initially encountered the notion of reflection, a lay or everyday conception of reflection existed long before it was mandated, or named, by the College. In retrospect, these nurses were able to trace the actual activity of reflection back in time and asserted that they had been "doing it all our lives." This was simply a new use of terminology.

Reflection In Everyday Life

When does reflection enter the experience of practising nurses? These nurses identified one understanding of reflection as an annual exercise in which they participated in order to renew their registration with the College of Nurses. However, they reflect often, throughout the day, every day, or perhaps more specifically during the evening! and throughout the year. For Lora the frequency is expressed as "I think that probably without putting a word on it we reflect almost daily," for example, "did you feel you did a good job?" She asserts that "we've - I've always done it... just never thought of as reflection... it is every time you go home and you think about the day." There is an absence of reflection while sleeping, although Lora may "wake up in the middle of the night and think, gee. I guess that's reflection." This is echoed by Edi who has also awakened with a thought. Reflection could be any time or as the focus group expressed "its all the time." While Beth doesn't find reflection a chore, Lora often reflects while doing her household chores. The nurses reflect while listening to music, talking with spouses about child rearing, driving to and from work. Perhaps time finds them, as Ruby says "it just happens... when time allows for it." For Max, "my day is just full of reflection."

Reflection is part of the nurses' everyday patterns of home and work or patterns of daily activities, and all tasks and activities take time. There is a rhythm in the day and this rhythm may

be cyclical. Cycles of repetitive and recurring activities may occur daily, weekly, monthly, annually or in some regular fashion, going to work for example. The nurses are required to "connect up" for particular periods of time, in particular places. The nurses live out relationships with people and places, not as discrete events but as ongoing processes which may span months, even years. In part, the richness of the lived experience of reflection time is found in the relationships these nurses have among each other and among residents, when viewed in a nonlinear sense. The present, away from practice, carries the past, influences the present and engages the nurses in future possibilities. Encounters with others, as ongoing processes, live with us as we ponder past situations (Walsh 1997).

While these nurses work permanent shifts, their work cycle or routine varies from the typical Monday to Friday, and from the norm. Nevertheless, there is a rhythm in daily activities or practices and there is in the biweekly work cycle, a pattern in time, a rhythm in everyday life. The rhythms, patterns and cycles, of everyday life repeated over time become so familiar that they are taken for granted. Personal activities, patterns and cycles, time, characterizes our everyday life and provides a context for reflection.

The nurses are immersed the tradition of their own life histories. They have identified reflection as an aspect of their life histories "we've been doing it all our lives." We define ourselves in terms of accumulated history and the anticipated future. Memories accumulate and there is continuity across past, present and future. Thoughts, feelings and reflection may be directed toward past, present and future. Bell (1988) suggests that taking time to reflect "can enable me to recall myself to myself and myself to others and others to me" (p. xix). Aoki (1990) acknowledges the grace by which we are allowed to dwell in the present that embraces the past

but is open to the possibilities yet to be (p. 42). Gadow (1986) suggests there may be a certain temporal limbo with reflection as time consists of only the present. Past and future matter little beside the fullness of the moment. The present is boundless immediacy without markers, direction, or movement (p. 2). Max describes reflection as "a fleeting moment" on occasion, perhaps a jiffy which Davies (1988) describes as the smallest unit of time, the time it would take for a beam of light to travel one million-billion-billion-billionth of a centimetre.

There is no sense of the time it takes to reflect, but reflection is in the present moment, the fleeting present. The nurses go over situations, reflect upon them, explore them, become aware of what now seems salient but then did not. These situations have an effect and live on as they are projected into the future. As an ontological experience, the nurses dwell in reflection moments, they are in time.

In-Between Time

A particularly striking and unexpected notion was that of reflecting while commuting to and from work, travelling with reflection. With two exceptions, all the nurses drove to and from work. They spontaneously identified transit time as reflection time. Ruby notes that reflection "has to be when I'm commuting to and from work and I have that quiet time with no distraction." Bevis (1993) echoes this notion. For her, reflection time has become even more restricted, and has been reduced to driving back and forth from the airport. Distance is measured in time. Edi notes "mostly it's driving to work... it's that we all have a distance to go and it gives us time to sort things out." Max finds that "I am fortunate now to have a twenty-five minute drive home so it gives me enough *time* to reflect." She "looks forward" to the commute, "by the time I get home, I've gone through some of the layers, so I'm not coming straight through the threshold with these

things still immediate, in your face." For Max "the next time I'm driving in my car" will be a good time for reflection.

Time as commodity. The idea of using time expands the notion of time as distance, and the use of discretionary time. For Vera "that's where I use my driving time, I have a good time to drive to work and I have used that for further reflection." There was unanimous agreement with this all around the focus group. Suzie expanded this idea. "I use my driving time, unwinding in that drive, reflecting." These nurses identified reflecting in their cars, in transit, but this was specific to commuting to and from work. There was no suggestion that they might reflect when they were driving or going other places. While privacy and lack of distraction are important, it is not necessarily solitary. This is also time for reflecting with peers. Edi finds that "if you're with somebody else like driving in to work... each of you reflect your day, and then bounce it off each other."

Miranda often walks to and from work and speaks of this as a time for reflection, and a "cool down time." Only Six did not identify her commuting time as reflecting time for practice. She travels on the bus, by public transit, and finds herself "too busy watching and wondering about the people on the bus," to reflect. Six specifically identified reflecting about other people and other people's lives. Perhaps, reflection may be in this watching and wondering. Since reflection was named by the College of Nurses, these nurses recognize it as pervasive in their lives. A particular in-between time, while commuting, is a fruitful reflection time. These nurses use this in-between time as an opportunity to reflect.

Work Time

Max states emphatically that time for reflection is "not at work, it's not at coffee time, it's not at lunch time, it's not in the middle of the day." She reflects "when I'm physically away from work I would say... almost exclusively." However, these nurses do pay attention, attend to situations in practice or notice things which are then reflected upon at another time. They don't have "much time inside of work," to reflect. Max doesn't "get to sit and ponder on it... I might put that on the back burner because the day has to go on." She continues, "its not necessarily a priority either at that time, but it's important enough that it does come back to me later, once I can relax and be with my thoughts. It seems to come to the forefront." Beth is "sure I do some reflecting at work. But I probably identify things that I and *then* give it the time it deserves when I get home... at work that's very difficult to find the time to do that." At work, "I don't think I'm doing it right away... it's usually after... I think about it, depending on what I am doing at the time - I might not have time to really go into it till later." says Six. Ruby also reflects "after hours, from the experiences that have happened to me during a specific day."

Lora does not find reflection at work, "There's too many things that go on in a day, just it's multi multi fast." During a regular work day, finding even a short period of time, is uncommon. As Lora says "need a time out, so ten fifteen minutes, would be a godsend really. There's no time... there really isn't a time to ... go and reflect for ten or fifteen minutes." Ruby finds "well work definitely doesn't allow for it, workload. You're too busy to have a time where you can actually - reflect." "I can honestly say I don't (reflect at work). I don't have the opportunity," says Edi, "rarely do I sit in the office and reflect." For Max "there's really no point to me in reflecting at work, during my practice time."

The notion of such a fast paced work environment in LTC this is surprising. Temporal pace refers to the relative rapidity or density of experiences, meanings, perceptions, and activities, whether ongoing, recollected, or anticipated (Werner et al., 1985, p. 14). While pace may be rapid or slow, these nurses describe the pace in practice as "fast, multi fast." However, this is understandable, given that each nurse is responsible for a minimum of 36 residents, for the supervision of both the living environment and the non-registered staff. Included in the nurses' practice time are care conferences for residents, organizational meetings, mandatory inservices. In the ordering of work time and shifts, the nurses rapidly learn that they have limited time within any shift to accomplish all their activities and deal with emergencies, and relate with residents or connect with the temporality of the residents and families. The residents may have unexpected health crises, or families may be in distress. Regular staff who know the unit and the residents may be away and replaced with staff who require closer supervision and support. There are more activities in the work day, than time.

Shapiro and Reiff (1993) suggest that reflection during the practice day is difficult due to multiple demands and "if anything an overload of professional knowledge" (p. 1380). It takes time to reflect on the complexity of the situation and to formulate ideas (Houston & Clift, 1990). Reflection is implicit in the idea of interacting with practice to create meaning (Williams, 1991). At work, these nurses describe being restricted to the task at hand rather than consideration of the full range of possibilities of interpreting what is going on, understanding the various modalities, considering alternate courses of action, weighing their consequences, deciding what must be done and doing it. There is a quality of immediacy in practice, at work. Williams (1991) suggests that "we have almost totally eliminated from our professional lives time for reflection" (p. 13).

Thinking time may be perceived as wasted time. However, nurses need to process practice experience. For these nurses, this is accomplished later, outside of practice. There is a close relationship to practice, and recollective reflection may be a way of being in the work even when the work is not being performed (Yinger, 1990).

Time with colleagues. Although the workplace is not an environment for personal or individual reflection, collegial reflection does occur to a limited extent during the practice day. There was an interesting juxtaposition of no time during practice to reflect and descriptions of collegial reflection with peers during infrequent coffee breaks, at lunch, or when the nurses "snatch" a few moments. At these times "we might discuss an experience that we've had, talk about it. I might take that information, reflect on it and then see how it would affect my practice in the future," says Max. Lora thinks "in a lot of settings it is hard for nurses to (reflect), it's even a time thing. Like I could reflect with my nurse manager but it's a time thing ... I think probably a lot more of it would be beneficial .. but the health system the way it is, who has got time to come and discuss?"

Work time or practice time does not encourage reflection. There is an immediacy in practice which excludes reflection. The work place is fast-paced and busy. Occasionally, the nurses are able to snatch time to engage in collegial reflection. However, while they remain connected to practice, the nurses generally reflect at a distance, where distance is measured as time.

Taking Time, Making Time

These nurses find time to reflect at home, or perhaps this is when reflection finds them. It may be while they are involved in what Lora describes as "mindless little activities" such as

doing the dishes. "At night before going to bed" is a time for Miranda. Ruby finds "after hours, after work, my brain is still going. I'm still thinking... I'm reflecting on what has already occurred and I'm still working at it. " Suzie finds "sometimes it takes a while to think, for that to be processed." She continues "depending on the situation... it's not until afterwards that you know the cog wheels are turning." Beth describes the quandary of reflection on practice

I think most of the nurses here that I work with reflect, take a lot of their work home mentally, because you don't have time to think about your work, so when you're at home that's when I find myself thinking about work. And I perhaps think to myself, now leave it there a little, but because probably we don't have the time here.

Beth describes taking the time to reflect at home, when "I do say occasionally to the children... I have some things I have to think about... and I don't want anybody to interrupt me." Like Lora and Edi, "when I wake up in the night I do a lot of reflecting then. No, but night time is usually when I have the opportunity to think deeper thoughts than others." Beth was quite emphatic that "you have to take the time to do it." She continues "how that works I'm not quite sure, but I don't come home and say now at seven o'clock I'm going to sit down and think about, reflect, I don't do it that way." Ruby echoes this with "I don't sort of set fifteen minutes a day to quietly meditate and reflect."

A quiet time is a right time for each of the nurses. Max says "it will come to me in a quiet time... usually it will be at home or at the end of my day." For Beth, "if I'm going to reflect about things at work and I don't do it here," but rather, "when I have time that is quiet, I'm not as distracted." The right time for Ruby, as with others, "has to be when I am commuting to and from work and I have that quiet time with no distraction." Vera speaks for the group with "just being

away, entirely, from the situation (practice), gives you that time." Or as Max notes "once I'm removed from the immediate circumstance." Quiet time, with no distractions is home time or in-between time. These nurses are committed to reflection. They create the right time, a quiet time for reflection. This is outside of work.

Looking Back and Looking Forward

The notion of looking forward and looking back is expressed by Suzie. "I use my driving time, unwinding in that drive, reflecting on what decisions have been made. That is a bonus, when I am going home. You reflect to work the next morning. You're reflecting on what's going to happen." Ruby describes reflection as "a time to stop and *think* about the experiences that I've had and draw upon those experiences." Lora wonders "isn't it (CNO) asking you to look forward and back? ... Look back over things that were good, that were bad .. helping you reflect." Mary reviews "things that I do in my practice/job everyday and looking back... and trying to find ways of improving areas I feel I could do better."

The notion of improvement incorporates looking back and looking forward. Max considers "how that will affect my practice and the future. So it's an opportunity to review something that has happened, and to make improvements in the future, that's what reflection is to me." Beth identifies a goal focus with reflection, where "you identify things that you would like changed or I would like changed... in order to improve what I'm doing."

Miranda will "think back, what's gone on in the past or in my day... how I would do things differently... if there's something I'm thinking about or worried about or looking forward to or something that's going to happen." In the focus group, Mary "felt that reflection was reviewing things that we have done every day, whether it's at work, at home... and if there are ways that we

can improve on it." Like Suzie, Mary might also "reflect to work the next morning, you're reflecting on what's going to happen." Suzie's understanding of reflection is "reflecting on the past in my nursing career, the knowledge I've gained and how I have applied it, and also reflecting into the future, what is expected of me in the ever changing health care system and the facility where I work."

van Manen (1991, 1995) proposes slightly different terminology for the temporal dimensions of reflection. Retrospective reflection is on past experiences and anticipatory reflection on future experiences. Wolf (1996) suggests that past encounters stick as memories or as (near) forgotten experiences that somehow leave their traces on our being. The present may influence the past through reinterpretation. The past changes itself because we live toward a future which we already see taking shape (p. 3). Reflection is identified as both looking forward and looking back, anticipatory and retrospective. The notion of improvement incorporates both perspectives and as illustrated earlier. It is a frequent description.

Time as Development

The focus group participants, unlike the individual nurses, in an exchange addressed the possibility that even young children can and do reflect. In doing so they also imply a looking forward, anticipatory perspective. Alex states "even a two year old or three year old they'll say okay I got this by doing this so maybe I'll try that again and I'll get the same results. I mean they're constantly reflecting." Suzie, in speaking of her daughter, continues, "so she was reflecting upon it, anticipating the visit to Grammy's the next day, and wondering if she was going to feel that same way she did way back... So, three and four year olds are even doing it." A chorus of agreement from the focus group surrounded this exchange.

Notions of a developmental aspect to reflection also surfaced with the individual nurses. Miranda expressed that reflection is "more like learning about your profession or about what you do or like growing in your profession." With reflection, she wonders if "we grow up with this, is this something we develop as we grow up, don't think anyone ever taught me." Lora regretted that she didn't write down her reflections "which is probably something if I was younger starting over again, maybe that's something that I would do, write down things, have a journal." She would "probably suggest that to someone younger."

Reflection is a normal activity, often mentioned as one form of meta-cognition (thinking about thinking) that occurs both spontaneously and deliberately in adults and children (Houston & Clift, 1990, p. 209). Most authors implicitly or explicitly allude to reflection in adulthood, or at least late adolescence. King and Kitchener (1994) in studies of reflective judgement identify that this develops through maturity but is present in childhood. Reflection is described from a lifespan perspective, beginning in childhood by Houston and Clift (1990). However, Mezirow, (1990) for example, proposes that for the most part, significant learning experiences in adulthood involve critical reflection, reassessing the way we have posed problems and reassessing our own orientation (p. 13). It may be that the quality and character of reflection changes, varying with age and the maturity of individuals. A level of maturity is also suggested by Knowles (1980), in that mature practitioners would be expected to build on life experiences to make sense of what happens at work. The notion of maturity in reflection eases the linear flavour of any developmental perspective, as maturity is not necessarily chronological or linear. Movement, change and action are implied in the notion of continuing to change throughout the lifecycle. Change may also be in response to the environment or biological events. Heron (1992) describes

personal development as rhythmic, with oscillating phases of new learning and consolidation, that wax and wane. Such development has its own cycles and periodic recurrences for learning, growth and change (p. 98).

Others reflecting. These nurses did briefly address the issue of others reflecting, whether all people can and do reflect. Max believes that "different people might do it to different degrees or levels. Some people more likely, maybe even the questions they ask... some couldn't care less." Six considers that everyone may be able to reflect "maybe to a degree, to a certain degree, to a point." However, she is not convinced. "Not everybody does, like self-awareness. There's a lot of people completely unaware of themselves. I just think some people you see their behaviour and they just appear to be totally unaware - I don't know how you get these people to [reflect]." Miranda considers that "probably everybody does it differently." Edi notes that "sometimes we see the results of their [others] reflecting in their comments and their suggestions."

Lora provides an interesting lifespan perspective on the residents with whom these nurses work. The average age of residents in long-term care is 85. "Residents, like the old folks, they have lots of reflections. They reflect all the time... every time they tell you a story, it's their reflection, of what went on before, how they feel about it. And they're the greatest reflectors." She often reflects about the residents "especially when you've worked with them for such a long time." This implies longevity in resident-nurse relationships as well, demonstrating a difference between acute and long-term care. These, as all relationships, involve change and stability, recurrence and rhythm as relationships have histories as well as futures. The nurses also develop relationships with families of residents. Lora notes, at care conferences, for example, the families of residents also reflect. While these reflections may be related to the care the resident is receiving or the

quality of everyday life, the families also reflect upon the nurses, "whether the family thinks you're doing a good or bad job. They're reflecting on what I'm doing."

Heron (1992) describes persons as "distinct centres of consciousness with an unlimited capacity to feel the world through continuous empathic resonance." As such, persons are capable of continuous development, through interaction with the world, where feeling is the grounding capacity which makes growth and learning possible (p. 94). Reflection may be an innate ability, but it is not necessarily realized among all people. However, age per se certainly does not inhibit reflection. We live experiences, participate in interactions between the present and the past, experience and memory. Experiences preserve, evoke and even revise memories. Through experiences, there is connectedness to the past and this also extends connectedness with the future. Growth or development requires interaction between the present and the future, between our experiences and our dreams. Reflection extends across the lifespan, into very old age.

In this theme of lived time the nurses identified their initial encounter with the naming of reflection as recent, within the last three years. However, in naming reflection, they had the opportunity to understand that they had been engaging in reflective activity "for a long, long, time." The nurses found time to reflect, frequently. Sometimes, this time was alongside activities of daily living. Sometimes, they created time, space and an environment for reflecting, protected time; or reflection just came "when the time is right." There was no resentment of using their time or time off for reflection. Naturally occurring time, in-between time while commuting was an opportunity for reflecting. This time was described as distance. Indeed, there was no expression of linear time in reflection.

Work time was essentially not a time for reflection. The nurses do not reflect in the

moments of practice. The nurses distance themselves in time from practice as practice time is "too busy" and fast paced. However, they willingly made time, at a distance, for reflecting upon practice. Reflection was described as looking forward and looking back, and this was linked to improvement.

Lived Space (Spatiality)

Alden Nowlan (1971) describes *The traveller*

It was not the weight
of my feet that tired me,
nor the steepness
of the hill,
but thinking too hard
on how much further
I had to walk.

You may have seen me
unstrap from my back
that trunk, half as long as a coffin,
and drop it in the ditch.

It was my destination.

Reflection has its own modality of lived space and may be understood by exploring the various qualities and aspects of lived space. Lived space addresses the question where does reflection enter the experience of practising nurses? This section addresses the theme of lived space which is felt space and "refers us to the world or landscape in which humans move and find

themselves at home" (van Manen, 1990, p. 102). The language these nurses used was rich in spatial descriptions demonstrating the importance of space to everyday life, practice, and reflection. Within this theme are two conventional, concrete, familiar and particular spaces of home and work. These are more than particular arrangements of space. They are also symbolic constructions, centres of felt value. They remind us of our connection to others, to the natural world and to projects. Spaces give meaning to our lives, we are linked to spaces through emotional and affective bonds, suggesting that lived space also has a certain relational dimension (Liaschenko, 1994). Commuting or transit creates a bridge between home and work, an in-between space. Constructing the "in-between" space of transit or commuting, a bridge between home and work, was an "ah ha" experience. Although frequently surfacing in the conversations, it was in thinking about this in relation to other descriptions of home and work, as destinations, that travelling with reflection took shape. Distance is an aspect of the in-between space of reflection. A more ephemeral space, where the actual lived space is not geographical or concrete, was described as requiring a positive environment of quiet with few distractions, or as described by Miranda, "a nice place to be." Phenomenologically, the structure of the reflection experience asks for a certain space experience; reflection requires its own space.

These nurses are situated in and share the practice setting of long term care. They share certain cultural, historical and social conventions related to the practice setting. There is a spacial organization of nursing in relation to the work that they do, that is, in practice. There are similarities in clientele, roles and responsibilities, and their place within the setting. The geography differs among the nurses with respect to rural/urban, the size of the facility, and the location of the facility within the city or town. While there are architectural differences among the

long term care facilities, the nurses share public space, perhaps an office or a nursing station. The nurses do not have private offices and they do not have access to the private offices of the managers. Staff lounges and the cafeteria are public spaces. Resident rooms are private spaces, to which the nurses have access. All the nurses share a peopled space and a position within an administrative hierarchy (pecking order). Each shift they enter in to and they exist in this practice world physically. They may also be "in this world" of practice while reflecting in transit or at home.

Home - A Reflecting Space

Max usually reflects "at home... the tub... any quiet spots," where she will "talk about or work through some of the home stuff and reflect on the home stuff." Lora reflects alongside housework "doing the ironing or making beds or something like that." At home, the bedroom is frequently mentioned in relation to reflection. Ruby is "more inclined to reflect, once I hit the pillow or bed." Edi has "awakened in the middle of the night... and I'll just get up for a minute and stop and think and then - either read or go up to the bathroom, have a drink and go back to bed," moving from place to place with ease, navigating in a familiar environment. Miranda reflects "in a quiet place, even at night before going to bed or something." The focus group participants echoed "its not until you're going home and sort of relaxed and sitting there."

Home may be described as connectedness, a series of connections between persons and the world. Home as a reflection space invites connectedness with people, place, past or future. Home is a bonding of person and space, "a set of connections between the experience of dwelling and the wider spatial, temporal, and sociocultural context within which it emerges. It orients and connects us with the past, the future, the physical environment and our social world" (Dovey,

1985, p. 44).

Quiet characterizes home. However, even at home there may be distractions. Activities may accompany reflection, such as reading, listening to music, or housework but these are not considered distractions. Beth takes active measures to create a reflecting space at home. She creates a haven for reflection. She finds herself unable to reflect amid distraction.

Not with things that are very distracting, no, you can't... I use a lot of strategies that I use here [at work] in my own home though. There is no television allowed when my children come in at the end of the day, those kind of things at my house... because I live with distraction all day and I don't think it's good for anybody. So I encourage them to... give thoughts to what they are doing instead of just all this excessive stimuli coming at them... I do say occasionally to the children, I'm going into my room for a while I have some things I have to think about... I think that's a very important part of it, you do need the peace.

These nurses, without exception, experienced home as a good space for reflecting. Home is a special space experience. Liaschenko (1994) suggests that home is a private space and that to be home is also to be the agent of your own life, in contrast to the bureaucracy of the workplace. Home is a haven. It separates inside from outside, private from public. It is demarcated territory with both physical and symbolic boundaries that insure that dwellers can control access and behaviour within (p. 23). "Home is a sacred place in a profane world. It is a place of autonomy and power in an increasingly heteronomous world where others make the rules" (Altman & Werner, 1985, p. 46). Dovey (1985) describes being at home as a mode of being where we are oriented within a spatial, temporal and sociocultural order that we understand. To be at home is to

know where you are, to inhabit a secure centre and to be oriented in space (p. 35). Home is a special reflecting space. While at home, these nurses create a safe haven for reflection, private with an atmosphere of peace and quiet. This is in marked contrast to work space.

Work Space

There is a special tension within the work space in long-term care. An interesting juxtaposition of private and public space exists within these facilities. Practice space is not home to nurses, although it is familiar and comfortable and the nurses clearly feel "at home" in the familiarity of their work. The residents claim these environments as home, or at least where they live, although they may not feel "at home." It is the rare resident who truly wishes to be living in a long-term care facility! Private spaces exist within the long-term care facilities, the residents' rooms. Residents live particular lives, in particular places. For this group of people, their entire life long belongings are located in one room. Sometimes, the room is shared. Interestingly, these are referred to as the residents' rooms or bedrooms. Really this is the residents' "living" space. Privacy is relative. In providing care, a very intimate activity, the nurses enter residents' space, and are physically close. Dining and other activities of daily living are accomplished in public spaces. The nurses have knowledge of resident space, it is familiar to them, this is a unique domain of nursing knowledge. Nurses are charged with the responsibility of helping residents maintain connections to a life across space and time that has been disrupted by relocation to long-term care. This influence of space in everyday life also comprises an aspect of context for nursing practice in long-term care.

Interesting, given the volume of literature devoted to reflection-in-action and the many efforts and strategies presumed to promote reflection-in-action/practice, work is not a good place

or space for reflecting. These nurses describe their work world as busy, fast paced, full of many distractions. These nurses think-in-action at work, but the content or process is focused upon more immediate concerns. Reflection is a luxury not afforded them at work. Max reflects "when I'm physically away from work I would say... almost exclusively physically away from the site." Beth reflects "about my life and work, not necessarily when I'm at work because I think you need a more peaceful atmosphere to do that in." Ruby notes that "work definitely doesn't allow for it."

The nurses enjoy their work, but within their work, they are concerned with the immediacy of the moment. Although they described reflection conversations with peers at work, they also described reflecting at or during work as outside their experience. Some were more emphatic than others. Max notes that "if the need to reflect tries to creep in" at work "I think, just go away thoughts until I can deal with you." Beth provides a moderate view with "I am sure I do some reflecting at work but I give it the time it deserves when I get home." Vera wonders "because of what we have to deal with in our work day. That sometimes just being away, entirely away from the situation... you're not in the immediate area. It's a possibility you're away from the situation."

Lora speaks persuasively for a "reflection room" at work. This resonates with the longstanding issue of nurses having no place of their own. No place to think. No space. While they may feel ownership of their unit and be perfectly comfortable in that respect, there is no private space to do the kind of "head work" needed for reflection. Lora asserts "I would love a place to go for a time out - just a room with nothing, I don't even care if I'm having a drink - just nothing, but there's no there's no time, and there's no place."

These nurses have learned the social character of place, the conventional space of

workplace, as well as the cultural and social conventions associated with that space. The workplace is a particular place, an identifiable world made up of specific patterns, structures, substance, and meanings (Yinger, 1990). All space is coded with a function so nurses entering that space learn to act in predetermined ways. The use of space intersects with position and status (Street, 1992). There is no space for nurses' reflection within the workplace. The resident library where this conversation was taking place with Lora is a lovely room "but we're not supposed to be in here, this is residents' space. We never come in here during the day and sit down and just think. There's lots of really nice rooms but they are all residents' space." Many of the homes have small lounges, sitting rooms, country kitchens and the like, which tend to be little used. The space for staff is striking in its lack of welcome, generally bleak and dingy. Most homes and indeed many facilities have not created space for nurses to escape to, from the chaos. "There is no space for staff to have a time out to reflect." Lora describes a lounge type area for all staff in which they could sleep, watch television, eat. The space for staff is public space such as the lounge or staff dining room. Lora recaps

There really isn't a time out place where you can go and reflect for ten or fifteen minutes and go back. It's really probably very important for a lot of people to have that kind of space... I mean, it's not a rest staying in your office either, but going to the dining room and listening to people complain. We need a reflection room... but you need to have the time and the place, which is the hardest thing to find time *and* place, both. The car is about the only place we have left.

Liaschenko (1994) suggests one understanding of space as that of locale. Locale is that of "a physically bounded area that provides a setting for institutionally embedded social encounters

and practices (p. 21)." Institutional structures and practices intersect in locales. Such places also organize social space, which includes social relations and power, practices, resources, and knowledge. They lend authority to some agents and constrain others. Within the practice locale, these nurses have social and institutional authority to perform certain actions, that is, to practise.

In Between Space

These nurses with only one exception talked about travelling with reflection. The destination was either home or work and this travel was exclusively commuting. There was no mention of travelling with reflection while going other than to or from work. Travelling to the grocery store, trips to visit friends or family did not figure in the conversations. This travelling is like a bridge or transition between work and home, an in-between space, where reflection is a travel companion. Marge Piercy (1973) describes *Bridging*.

Nobody can live on a bridge
or plant potatoes
but it is fine for comings and goings,
meetings and partings and long views
and a real connection to someplace else
where you may
in the crazy weathers of struggle
now and again want to be (p. 51).

Six was one exception. She commutes to work by public transit. She tends not to reflect on the bus because she is too busy looking at, wondering about and eavesdropping on the people on the bus. However, on occasion, she interrupts her trip, gets off the bus, sits in a park and

reflects about a particular experience. Miranda walks to and from work, except when she gets a lift with a peer, and they may reflect in transit. However, she reflects "all the time when I am walking," traversing space.

Transit, commuting or travelling provided privacy, though not necessarily solitude as many talked of commuting alone or with a peer who was usually also a friend. However, while travelling they were removed from the distractions of people and place. van Manen (1990) suggests that roads have a certain quality. They are not places where one can feel at rest, they are no place to *be*, rather they are a means of travelling from one place to another. It is true that these nurses use the roads as a means of getting from one place to another, the destination being either work or home, but they also use the distance to be with reflection. As Max says "I talk about conditions that are conducive, so in the car is one of those places... So it's rather convenient to have that drive home, get to reflect."

Lora concurs. "Because you leave here and you get into something else, so probably a lot of my reflection is done in the car because by the time I get home I'm into the next life here. A transition. Thank God for the car." Beth reflects "often in the car, because that's the first peace I've had since seven o'clock in the morning when I get in the car." In this in-between space, Beth enhances reflection space by decreasing stimuli, for example "not having the radio on and those kinds of things as well in the car. Because I don't want more distraction, I want peace and I can think about what I need to do and be reflecting." Ruby describes "I reflect in the *car* on the way home. So it has to be when I'm commuting to and from work and I have that quiet time with no distraction." Or as Max says "the next time I'm driving in my car for instance is a good place for that (reflection). So it's just me and the steering wheel and my reflective thoughts and so that

would be another place."

The focus group nurses, being rural, all commute to and from work by car, and this is a space "for further reflection," says Vera. "But that is a bonus, I look for the good thing about having the distance to drive to work." Mary added "that's when you're going home, you reflect to work the next morning." Connie summed up with "its that we all have a distance to go." Dovey (1985) describes a spatial dialectic deriving from the opposition of home and journey. Home is described as a place of rest from which we move outward and return, a place of nurture where our energies and spirits are regenerated before the next journey. "Lived reciprocity describes this dialectic, like breathing in and out, most life forms need a home and horizons of reach outward" (p. 45). These nurses engage in a rhythmic, cyclical pattern of journeying to and from home and work.

Distance. Distance, in transit or commuting, was not so much in a concrete or geographical sense, in miles/kilometres, but was described as time. Distance is also the sense of being removed from the immediacy of the moment and was a strand throughout the conversations. This echoes Yinger (1990) where thought and attention about past and future performance are conducted apart from the immediacy and demands of actual performance. Yinger (1990) also proposes that consideration is conducted at a distance from the phenomenon of interest. Unlike this perspective, reflection being the phenomenon of interest, reflection came to these nurses at a distance from the actual experience. There was distance from the experience, but not from reflection.

Distance is a dimension in reflecting in relation, and this may be physical/geographical or emotional. These nurses are separated in space while doing their work, that is, they work on

separate units within the facility. None of the nurses work together on the same unit as there is only at most one registered nurse working on a unit at a time. So, while they may work within the same facility, they must create a physical and relational space to engage in reflection conversations.

Space Experience

These nurses created a space for reflection or once removed from the immediate circumstance, at a distance, quietly reflection comes to them, finds them in that space. They look for a certain space that is good for reflecting. As Miranda has previously described "I'm in a quiet place... or when I'm alone and listening to music... When I'm in the right setting or whatever the ambiance is... When you're in the right setting it (reflection) kinda just comes to you... now I'm in the right place to ... reflect on it." Max describes reflection space as "more the setting, the environment. It's primarily to have the proper environment ... usually, when I'm physically away from work, for sure." Intrusive stimuli will "make it scatter away." For Max "I wouldn't say a place where I go to reflect necessarily. I find when reflection comes to me because I don't necessarily go to reflection... it will be just a quiet place... I have to have the right setting... So as long as I have a setting that's conducive," she can engage in her reflective process. At home during a quiet time "a quiet environment, not necessarily solitary, I find that conducive to reflection."

Reflection space is "a nice place to be" according to Miranda. Reflection space is comfortable, peaceful and quiet. Ruby speaks for the group when she says "it can't be any time when you're distracted." Unlike the other nurses, who describe reflection space as peaceful, Max describes it as "peaceful is not the right word, it's just enjoyable." Privacy is another critical

characteristic of reflection space. It is in this space that reflection comes to these nurses.

Reflection is not in the space but comes with them in the space. Clearly, for these nurses, reflection requires a particular space.

Reflection as an individual activity was actually absent in work space. These nurses had learned the meaning of place with respect to practice. They had learned their place within the organization and culture. The nurses knew how and where they were situated within the long term care hierarchy. They were familiar with having responsibility for unit, and for nonprofessional staff, with no line authority, an uncomfortable space! They were familiar with working alongside residents, in space denoted as the residents homes, but definitely not home for nurses. So, they practise in someone else's home, which is also an institution. This is a place apart from their own homes, at a distance. It is a peopled place, with staff and residents and families. This space is crowded, noisy and has many distractions. It is not a reflecting space.

Reflection may be accomplished by interacting in a participatory mode with another set of actors, in a particular, practical place (Yinger, 1990). This interaction always takes place in a particular place, which for these nurses may be at home, at work or in-between. These places possess traditions grounded in history, knowledge, and beliefs and the participants share the traditions, which may be related to family or work life. At work, within the privacy of their conversations, the nurses create collaborative space and time for sharing stories of practice among themselves.

Certain spaces were specifically and exclusively identified as reflecting spaces; these are home and in-between space. No other spaces for reflection were identified. Reflection was limited to private spaces and excluded public space. Reflection space was quiet and comfortable. In these

reflection spaces, the nurses are open to the world, and also insulated from the world, enabling reflection.

Interpretation Chapter Summary

Body, relation, time, and space, are important to reflection, as well as essential themes in everyday life. For the nurses in this study, reflection is located in the multiple layers of everyday life, of which practice is a part. Everyday life is both context and experience, providing fodder for thought, which may be expressed as embodied knowing, and eliciting an affective response. Through a human geography of everyday life, we may construct the context in which experience happens. We think about and we have an affective response to our everyday experience, in which reflection is intertwined. As the persons who construct and act in everyday life, we are bodily present. Part of our identity, our self, is in relation to the presence of others. Gregory and Walford (1989) liken the human geography of everyday life to a kaleidoscope in that its component parts can build an infinite number of different but often equally satisfying patterns (p xiv). Reflection in the human geography of everyday life, within the essential themes of time, space, relation and body, constructed throughout this study, is one such pattern. "Everyday life has a temporal mobility. It is a project with a past, a fleeting present and ... future. It also exists in the reality of space ... localized at the most basic level in relation to self to others" (Eyles, 1989, p. 115).

CHAPTER 5

Discussion

The purpose of this hermeneutic phenomenological study was to describe, interpret and build new knowledge about nurses' experience of reflection. It is retrospective or recollective in consideration of experiences that are already past or lived through. Two central phenomenological questions guided the study. They enabled description and interpretation of the meaning of reflection from the perspective of registered nurses engaged in active practice.

How do practising nurses experience reflection? Where, when, and how does reflection enter the experience of practising nurses?

In the previous chapter, I described and interpreted the nurses' experience of reflection. A brief summary highlights the nurses' experience of reflection. Then, I shall share my personal learning gained through the hermeneutic phenomenological tradition. I take the images that emerged in the interpretation to a higher level of abstraction. They are more deeply and broadly interpreted in this chapter. They illustrate my learning and they contribute to new scholarly knowledge. My learning as it contributes to scholarly knowledge through practical theorizing, in nursing and education lies in three core areas: reflection and the geography of everyday life, reflection in the between, and reflection *is* relation. In the next section, accepting the challenge from the College of Nurses, reflective inquiry culture and reflection for practice comprise the implications for nursing practice. Implications for educational practice found in the core areas of reification and the language of reflection follow. Finally, I suggest areas for further study.

How do practising nurses experience reflection? The language of the everyday characterizes reflection. Two modes, annual and everyday illustrate the reflection experience. As

a requirement for the College of Nurses, reflection is "simply an annual exercise." Reflection is "just part of us, part of our lives." It is a natural process of everyday life occurring alongside activities of everyday living and as such it is informal and unstructured. "Reflection comes to you," "it pops into your mind," or "something sparks my curiosity."

The experience of reflection is comfortable, positive and relaxed. It is also natural, spontaneous, automatic and enjoyable. Mindful reflection is a completely natural activity and reflection is the experience (Varela, Thompson & Rosch, 1991, p. 29). It is both solitary and relational, collaborative by choice. Reflection is iterative, generative, fragmented and not concise. It is nonlinear with an absence of steps or stages. There are no predetermined answers or outcomes. Reflection has much to do continuous incremental improvement, kaizen.

Where, when, and how does reflection enter the experience of practising nurses? Certain conditions are necessary for reflection, quiet, privacy and an absence of distractions. A supportive environment, a sense of connectedness and a disposition to reflect are also important. Space and time intersect at home and during the work commute. At home, reflection comes to the nurses alongside normal, familiar, routine everyday physical activities. While driving along the way to and from work or commuting, the nurses welcome reflection. The nurses denied reflection in practice. In practice, thinking is noticing and pattern recognition, thinking-in-action and acting knowledge. However, at work they create opportunities for collaborative reflection with chosen, trusted peers.

Three images summarize the nurses' experience of reflection. Watching a movie, putting the pieces together, and puzzling through reflection, capture the complexity, thinking and context involved in reflection.

Personal Learning Through the Hermeneutic Phenomenological Tradition

Phenomenology is a method without techniques. It requires a dialectic going back and forth among various levels of questioning and thinking, and between the parts and the whole. Writing becomes a complex process of rewriting, re-thinking, re-flecting, re-cognizing (van Manen, 1990, p. 131). To make the experience of reflection as an aspect of lived experience understandable and intelligible required a commitment to write. Writing creates patterns of meaningful relations. These condense into a discursive whole, a finely crafted piece, which we may call theory, the theory of the unique (van Manen, 1990, p. 131).

Hermeneutic Phenomenological Tradition

The hermeneutic phenomenological approach used in this study enabled descriptions of long-term care nurses' experience of reflection. Interpretation was a way to uncover meanings, understand and construct or reconstruct these experiences. As a hermeneutic researcher I sought commonalities in meanings, situations, practices and bodily experiences in the depiction of the lived experience. These commonalities were evident in the texts (Benner, 1985; Rather, 1992)

Using a hermeneutic and dialectic method, through interaction between and among myself, the nurses, and the text, I elicited and refined individual descriptions. There are no formulae for description and interpretation. There is no single, correct interpretation of the whole and the parts of the text. However, my constant reference to the text ensures grounded and focused interpretations. As well member checks produced a phenomenological nod from the participants that enhances confidence in the interpretations. I do not assume a single, correct meaning, and I am aware of possible alternate interpretations.

van Manen (1990) asserts that hermeneutic phenomenology is a writing activity, research

and writing are aspects of one process. I had not appreciated that research does not merely involve writing, research is the work of writing, writing is its essence. Writing is the method. Writing is an interpretive act, a creative act, a personal act. Lu Ji (261-303) describes writing.

Writing is a joy -- so saints and scholars all pursue it.

A writer makes a new life in the void, knocks on silence to make a sound,
binds space and time on a sheet of silk and pours out a river from an inch-sized heart.
As words give birth to words and thoughts arouse deeper thoughts,
they smell like flowers giving off scent, spread like green leaves in spring,
a long wind comes, whirls into a tornado of ideas, and
clouds rise from the writing-brush forest. (cited in Barnstone & Ping, 1996, p. 10)

As previously noted, there was some interpretation verbally, during the conversations. However, the interpretation in the writing is the interpretation. The eloquence of the text contrasts with the scattered thinking, the paths not taken, the paths taken then discarded in the research/writing process. This process took place as I contemplated, pondered, imagined, mulled over, brooded, intuited, and fussed with the data. I chose the nurses' easy, everyday, English words to describe their experience. I was concerned with writing in a way that captured these nurses' experience, being true to my experience and to their experience.

Hermeneutic Phenomenological Inquiry

The research question came from my own lived experience. I shared the College of Nurses of Ontario (CNO) requirement to reflect and engage in reflective practice with all Ontario nurses. I wondered, what is reflection? How do other nurses experience and understand reflection? To undertake this journey of exploration, I had to make decisions about appropriate

ways to create meaning and understanding from the research questions. I chose to engage in a hermeneutic phenomenological study. This study was designed to describe and interpret the experience of reflection among long-term care nurses. We did this through a process of conversations oriented toward reflection. My interest was to bring insights nested in profound respect for nurses participating in this study, not speaking for them but with them.

I accomplished the process of access and entry with relative ease in this study. It might not be so smooth in different settings with different participants. I had observed these nurses in practice and they had demonstrated significant clinical nursing knowledge. In their nursing practice they recognized residents as people, not diseases, tasks and techniques. These long-term care nurses live nursing and every nursing act has to do with the quality of a person's living and dying (Paterson & Zderad, 1988). My sample may have been biased in this particular respect. This group of nurses also differs from the norm in their educational preparation. Three of the seven nurses were baccalaureate prepared and two were progressing through a post basic nursing degree program.

Following our conversations and the subsequent transcription, I realized I had too much data; they were unwieldy. I had noted common descriptions and intriguing notions in my study journal. As the study progressed, I decided to construct narratives to represent the reflection story for each nurse and to manage the data. The process of winnowing required decisions about what to include and what to exclude, and resulted in the essence of each nurse's description. I did not realize at the time that the use of narratives in phenomenological writing is merely not literary embellishment. The narratives are examples of practical theorizing and they function as experiential material upon which analysis and interpretation is possible (van Manen, 1990).

The themes and patterns emerged from the conversations, transcripts, narratives, and my study journal notes where I continued to draw in perspectives from the literature. Polkinghorne (1988) describes the process of understanding. It is a movement from the pre-judgemental notion of the meaning of the whole to a change in the meaning of the whole because of the confrontation with the detailed parts of the text. The linking of the data to reflection dimensions and fundamental lifeworld themes evolved from being immersed in the data. The data spoke to me, and I drew the nurses' experiences into the larger context. Some structure always must be imposed upon the data. The resulting structure is my structure, embedded in my relevance scheme, though true to the lives of participants.

Over time and through further levels of interpretation, I tried different images for description, such as webs and rainbows. These failed to capture the essence of the reflection experience. I work in long-term care, in nursing homes, and the notion of home is omnipresent. In pursuing the notion of home, for practice purposes, I found myself in the human geography literature. As I ventured further into human geography, I found discussions of home, space, time, relation and self. I was even more surprised to find this literature framed within a phenomenological perspective. While always keeping the participants' descriptions at the forefront, I came to realize that I could draw the nurses' experiences into this literature and perspective. I chose this human geography frame instead of other possibilities.

Living Hermeneutic Phenomenology

I required passion, interest, commitment, stamina, creativity, imagination and insight as I was immersed in this study. Bergin (1991) describes a dialectic tension between inner commitment (the interest and the passion) and outer activities (stating the question, establishing

the approach, writing and re-writing). Retas (1996) speaks to the evolution of the method debate in the 1980s. One expression of the perceived or interpretive view of nursing is hermeneutic phenomenology. This approach to studying, describing, interpreting and developing knowledge has been described as an attitude. I found the use of self as research instrument congruent with the therapeutic use of self, self awareness, and working through relationships. These are tools of the trade for psychiatric and mental health nurses. Some notions I encountered during the study, such as Langer's mindfulness and the power of mindful learning have been incorporated into my practice. I know I have changed and grown and I know myself capable of becoming more. I am my choices, both in terms of my past and my future. My possibilities as a person are necessarily related to others in time, space and relation. I learned that I live hermeneutic phenomenology, just as I live nursing and education! This study is my work of art, my creation; others might come to different understandings based upon same material.

As a nurse I am interested in exploring more fully front-line nurses' knowledge of the world, and as a carer the views of the cared for. As a researcher I am interested in the practical knowledge that nurses have and use in clinical nursing practice. Knowledge is subjective, value-laden, traditionally formed and contextually embedded in the practices of clinical nurses. Nurses are eager to talk about their experiences and to be heard. They are thoughtful about their practice with a view to continuing incremental improvement. Hermeneutic phenomenology retains its appeal, although I still feel the pull of other frames such as critical theory. I wonder about action research for addressing nursing issues. There is more to learn. I shall continue searching for other views of the complex reality of living which may open further depths of questioning and understanding.

Contributions to Scholarly Knowledge in Nursing and Education

Throughout the description and interpretation in Chapter Four, the everydayness of reflection descriptions surprised me. The emerging notions of time, space, and the strong sense of relation interwoven with reflection intrigued me. I chose to take these constructions to a further level of interpretation, through practical theorising. My contribution to scholarly knowledge is in the construction of practising nurses' experience of reflection as: reflection in the geography of everyday life; reflection in the between; and reflection *is* relation. These three constructions comprise original and innovative understandings of the experience of reflection, and they contribute to scholarly knowledge. They demonstrate understanding from the ground up, rather than from the top down, and address an absence in the extant literature of actual practising nurses' experiences. These constructions, created from nurses' experiences have heuristic value. The study and description of nursing phenomena will affect the quality of nursing situations, and the development and form of evolving theory and practice. The constructions expand and clarify our understanding of nurses' experience of reflection and stimulate further exploration. Nurses have encountered the term reflection and created their own understandings. These constructions illustrate their understanding and experience. They highlight the incongruence between these constructions and those found in the extant literature. They expand nursing and educational knowledge.

Reflection in the Geography of Everyday Life

Body, relation, time and space are integral to the reflection experience. These essential themes are constructed in the human geography of everyday life and elucidated through the multiple layers of a landscape metaphor. Landscape is a repository of meanings including our

beliefs, feelings and the essential lifeworld themes (Cosgrove, 1989; Gregory & Walford, 1988). In speaking of virtues Roberts (1988) says "no virtue is an island. Each virtue gets its character from the surrounding geography of concepts and practice - what I have called the virtues system to which it belongs" (p. xxi). Like virtues, our understanding of reflection is located in the geography of these long-term care nurses' everyday life.

Everyday life is the *plausible social context* and *believable personal world* within which we reside. Highly textured with multiple layers of meaning, its features change over time and between places (Cosgrove, 1989; Eyles, 1989). In reflecting on everyday life we may construct the significance of everyday life itself (Eyles, 1989, p. 103). The geography of everyday life is dynamic. For nurses the textures change as people live and die, come and go, within their personal and professional lives. Ideas change the geography of everyday life as they are introduced, removed, transformed. The introduction of reflection and reflective practice significantly impacts upon the everyday life of Ontario nurses.

Everyday life is a series of social interactions between ourselves and others that provide the context for our meanings and behaviour in our lived experiences. We construct our sense of self, our identity through the experience of everyday life. It is the societal contexts of everyday life that may shape and constrain our experiences. In a study of place, Eyles (1989) reports that most people had a sense of place that was a foundation of identity. It was everyday activities and notions that gave shape to this sense of place. Some defined place in terms of intense social relations, others as the arena or stage for conventional social ties, still others as opportunities (p. 110). In part, the nurses in this study construct their identities in relation to the workplace and their position within it. The participants are in the world as nurses. Their practices are bound up

in what it is to be in the world as a nurse. Their practices become part of everydayness and reflection is embedded in practice (Arndt, 1992).

One way we express ourselves is through patterns of daily activities. Everyday life tends to be considered mundane with many typical but unrelated routines. We tend not to think about our everyday life or acknowledge its complexity. Although it is the background of meaning in our lives, it is also taken-for-granted. Everyday life includes aspects such as family, work and leisure. Other features include time, space, self, other, interaction, biography, situation, power and structure. However, once these enter our consciousness they take on a distinctive and special meaning, and become removed from everyday life. Reflection was part of the nurses' everyday lived experience and as such was ordinary, unrecognized, its meaning lost (Rather, 1992). However, as reflection was the focus of our conversations, it was highlighted, removed from the everyday, or taken out of that context for consideration.

With the nurses in this study, "reflection is just part of us," or "part of our lives," not something apart from everyday life. Reflection occurs naturally alongside activities of everyday living such as commuting, household chores and personal activities. The content of reflection is remarkable in its breadth and it pervades the landscape. The content of reflection is incorporated with the everyday where practice is one of many foci. These nurses reflect on their home life, families, relationships, faith, and spirituality, culture, life goals, events, and practice. Space/time is created for reflection, not as a reified activity but as a part of life. There is no duality between reflection on and for practice and everyday reflection. It is distinguished only by content and context. Reflection "comes to" the nurses at home or along the paths traced through the landscape while commuting to and from work.

A geography representation creates ties between life and feeling with the invariant rhythms of the natural world. It reminds us of our position in the scheme of nature. It reminds us that only through human consciousness and reason is that scheme known to us (Cosgrove, 1989, p. 122). Our days have a familiar and taken-for-granted rhythm in which time and space are intertwined. The nurses describe familiar rhythms in their days, and rhythmic fluctuations of their life process. There is a rhythmic repetition around such things as eating, sleeping, and waking. In the 24 hour day, patterns include awakening time, meal time, family time, sleep time or bed time, work time, sun up, and sun down. We each embody a distinct personal rhythm, through patterns of heartbeats, breathing, movement and speech, for example. There is rhythm in our interpersonal lives (Heron, 1992). In the rhythm of their discretionary time, often in the evening at bedtime and even when they awaken through the night, reflection is with the nurses. They reflect alongside their routine and mundane activities of daily living, for example while doing the dishes, making the beds, or even when bathing. Participation in these mindless, routine, mundane activities, frees the nurses to pursue their attraction to reflection. The nurses trace paths through time and space, and they move rhythmically and embodied through the landscape.

The nurses describe reflection accompanying the familiar rhythm of commuting to and from work. They engage in rhythmic, cyclical patterns of journeying to and from home and work. Along these paths these nurses may encounter each another. Ruby, for example, car pools with "one of the other nurses who work here and we reflect to and from work about different issues." Movement through the landscape is evident as the nurses connect up, interact with and part from their peers and their residents. In practice, comings and goings characterize interpersonal rhythms. The residents come to, are admitted to the facilities, live, and they go

from the homes, usually through death. The rhythm or pace of practice itself is accelerated, "multi fast," The nurses inhabit time and space and embody their own life rhythm. Similarly, the landscape is an unending process of movement with rhythmical patterns. It is never static or complete.

Reflection landscape. The notion of landscapes lies within the larger core area of reflection in the geography of everyday life. Landscapes carry symbolic meaning because they are products of our making. They are a "way of seeing, a way of composing and harmonizing the external world into a scene of visual unity" (Cosgrove, 1989, p. 121). We have a reciprocal relationship with landscapes as they shape and are shaped by us. Landscape constitutes and reconstitutes particular social relations. Identified meaning shapes and structures everyday experience. This includes activities of particular locales and groups, in this study long-term care nurses and their practice settings.

Schon (1983; 1987) and others (eg. Davis, 1998; Watson, 1997) have used descriptions of fens and marshes, highlands and swampy lowlands to describe reflection. In the topography of professional practice, there is a high, hard ground of abstract theory overlooking a swamp, or the lowlands of the day to day world. On the high ground, manageable problems lend themselves to solutions through application of research based theory and technique. In the swampy lowland, messy confusing problems defy technical solution. Watson (1998) maintains that we uncover new meanings from the ground up through the lens of discipline defining theory, rather than from the top down. Most, who use the topography description, identify the irony where the problems of the high ground tend to be relatively unimportant to individuals or society at large. The problems of greatest nursing and human concern lie in the swamps or lowlands. It is in practice

that nurses experience with others peak life events related to health, episodic and chronic illness, death and dying. Theory is viewed as developed by a relatively small and elite group of non practising academics (Burton, 2000, p. 1011). The grand theory from the mountain may obscure other ways of seeing from the marsh. This creates a dissonance between the reflective practice movement in nursing and the movement to theory guided and evidence based practice (Davis, 1998; Schon, 1987; Watson, 1997; 1998). In this topography, highlands represent the formal, the theoretical and academe, the swampy lowlands are "the stuff of practice," and there is a great divide.

Reflection is already implicated as integral to professional development, however, in North America, critical thinking is highlighted over reflection. Nevertheless, reflection does have a place in the conversation. Scanlon and Chernomas (1997) identify reflection as an important aspect of critical thinking. Burrows (1995), Glen (1995), Andrew (1996) and Durgahee (1996) for example, claim that reflective activity encourages critical thinking ability. Reflection is integral to critical thinking.

Davis (1998) notes that the reflective practice movement in the UK and to a lesser extent in Australia and New Zealand, represents the marsh end of the spectrum. This is in respect to nursing science, nursing theory, uncovering new knowledge of practice, and knowledge development. This is evident in the United Kingdom, where requisite skills for all pre- and post-registration nurses include "effective reflection and reflective practice" (Burton, 2000). Reflective practice is also a prerequisite competency for nurses in Australia and New Zealand. Watson (1998) asserts the US and Canada represent the mountain end of the debate with respect to nursing knowledge development. Cody (2000) identifies nursing theory as most influential in

Canada and the US. He confirms that theory is a lesser concern for nursing throughout the rest of the world. Most of the writing explicitly about reflection and reflective practice is from outside the US and Canada.

In this topography at the level of nursing practice, long-term care nurses in Ontario would be located in the swampy lowlands, between the peaks and valleys. Perhaps nurses live and work in the between. The topography description of highlands and lowlands may reinforce the notion of a theory-practice gap. Simply considering theory and practice as separate entities continues the view of nursing as an applied science. Rather than separating theory and practice, or disciplinary and practice concerns, creating a dialogue with one another brings the peaks and valleys into focus from a different perspective. It eliminates the extremes in the topography. Along with the move to reflection and reflective practice is a move toward practical theory or practice theory. There is a place in many models for the identification and development of theories in use or practice theories (eg. Calderhead, 1989; Jarvis, 1992). Capasso (1998) asserts the theory is the practice. The nurses in this study are engaged in the world of everyday practice, and attuned to practice theory. They did not identify a gap. While they described acting knowledge, notions of theory and academia were absent in our conversations. Perhaps, the theory-practice gap is a concern to academics, but it is simply not an issue to practising nurses.

A human geography of everyday life metaphor is useful for locating these nurses' descriptions of reflection, and has heuristic value in describing and explaining the nurses' experience of reflection. However, the contrast between highlands and swampy lowlands suggested by Schon and elaborated in nursing is not a good fit with the nurses' descriptions of reflection. Geography changes when, by virtue of its location and nature as the central business

of nursing, the practice of nursing informs the discipline of nursing (Lumby, 1991; Visinstainer, 1986). Although the language is culturally specific, the nurses in this study think and talk in everyday language. The language of academia, or the highlands, is remote from their experience (Cox, Hickson & Taylor, 1991, p. 373). Removing reflection from the topography of highlands and lowlands shifts its location to the geography of everyday life. This enhances the discourse, and contributes to the advancement of nursing knowledge. Language is important to the practice of nursing and the everyday language of reflection provides the opportunity for the inclusion of practising nurses in the reflection discourse. Reflection in the geography of everyday life is a faithful representation of the reflection experience for these long-term care nurses.

Reflection In The Between

Body, relation, time and space are useful focal points or commonalities of experience around which phenomenological interpretation occurs (Morse, 1991). Although these themes were separated for ease of discussion, the construction of reflection in the between illustrates interconnections among the themes. These themes highlight both the complexity and the everydayness of reflection. This is the second core contribution to the advancement of scholarly knowledge in nursing and education.

The human geography of everyday life incorporates the concepts of place, space, and landscape, time, relation and body. There is a considerable overlap or intersection among the four fundamental lifeworld themes. Descriptions for one domain repeat in other domains, illustrating these interconnections. The lived body is the centre of all experience. The body first grasps the world and moves with intention through that meaningful world, with bodily intelligence. Viewed as intentionality, bodily functioning can express affective and cognitive experiences. Subjectivity

is always corporally expressed as we navigate our world, travel through space (Benner, 1994, p. 52). Corporeality assumes qualities of spatiality and temporality and it is directional. Merleau-Ponty (1995) suggests that the human body can never be understood as a thing, as an object, "we must avoid saying that our body is in space, or in time, it inhabits space and time" (p. 139). There is a dialectic relationship between ourselves and society as our selves are constructed in relation to others (Eyles, 1989). Spatial analysis parallels social analysis and vice-versa. Gregory (1989) describes the annihilation of space by time in everyday life (p. 84). Space and time intersect. In this study the sections on lived time and lived space illustrate the intersection of time and space. Reflection, time, space, self and relation are constructed in the between.

In everyday life, relation depends upon the binding of time and space into the conduct of social life. The continuity of day-to-day life depends on routinized interactions between people who are present in time and space, that is, in the company of others. Each day we meet other people and part from them at particular times and at particular places to fulfil particular purposes. In doing so we trace out paths in time and space, where "a flickering and fleeting time-space coherence can be discerned" (Gregory, 1989, p. 80). Along these paths, social or professional practices intersect. This creates "bundles" or knots of social activity in time and space. These are tied and retied over and over (Gregory, 1989, p. 82). The nurses meet each other, and the residents in the particular space of the long-term care facilities, during their particular shifts. Throughout the shift there are patterns of daily living for the residents and practice patterns with the nurses. Within these everyday patterns there are bundles or knots of activity, where, for example, reflection conversations take place among nurses, in the between.

Nursing is lived by human persons and is always an interhuman or intersubjective event

that takes place whenever two or more people are related in a shared situation. Nursing involves nurturing, being nurtured and relation, the between in which and through which nursing occurs (Paterson & Zderad, 1988, p. 22). Nursing is a quality of being experienced in the doing or being in shared situations. Nursing, being nursed, and the process or interaction that is nursing occurs in the between. The meaning of nursing is in the between.

Social and professional practices are shaped by and influence the wider social systems in which they are located. These systems define what connections are made, when and for how long. The nurses practice in their long term care facilities, within the Ontario system of Health and Long Term Care. In the current climate there is a tension between an espoused commitment to resident-centred care and a need for fiscal restraint. The College of Nurses requirement for reflective practice also influences nurses. Practices tend to be routinized and although they grow, evolve and change they are recognizable over varying spans of time and space. Nursing practice is evolving to incorporate reflection, reflective practice and patient-focused care. Gregory (1989) suggests that interactions within our social or professional practices reach beyond the here and now. In the between professional practice may transcend or stretch across time and space to include others who may be absent. Yinger's (1990) notion of being in the work while not at work has illustrated the in between way in which the nurses are engaged in everyday practice. The nurses describe being in the world of practice while reflecting in transit or at home, stretching out across time and space, or pulling in time, space and relation.

These nurses construct an informal culture of reflective inquiry and discovery with their peers. Informality and sharing characterize in the between. There is a notion of inclusion and exclusion in a hierarchical sense. This particular subculture does not include those in positions

above these nurses and non registered staff. The in between culture of reflective inquiry constructed by these nurses from their positions in the facilities, suggests a different experience and consciousness.

We live experiences, participate in interactions between the present and the past, between experience and memory of experience. Experiences preserve, evoke and even revise memories. In this way, time may be seen as connectedness. Through experiences, there is connectedness to the past and this also extends to connectedness with the future, in the between. We live in the present moment, reflection is in the present moment, what Gadow (1986) has called temporal limbo, although the perspective may be past or future. Moments of reflection exist in the present, between the past and the future. Growth or development requires interaction between the present and the future, between our experiences and our dreams. Recollective reflection is a way of being in the work while not at work (Yinger, 1990). In reflecting on experience in the present, the nurses remain connected to their practice through memory or recollection. They are connected to the future through anticipation of experiences and possibilities, an interaction between past, present and future, in the between.

The nurses engage in a rhythmic, cyclical pattern of journeying to and from home and work, tracing particular space and time paths through the landscape. This temporal rhythm for reflecting between time and space, between work and returning to work, was spontaneously described as "good for reflection." The journey was exclusively commuting and the destination was either home or work. Commuting is like a bridge or transition between work and home, between space and time. Commuting or travelling provided privacy, though not necessarily solitude as many talked of commuting either alone or with a peer who was usually also a friend.

There is a social dialectic in the idea of privacy. Privacy is in the between, a dialectical process of being in contact and out of contact with others (Dovey, 1985, p. 47). However, while commuting the nurses were out-of-contact with the distractions of time, people and place.

There is a spatial dialectic between home and journey. Home is a place of rest, a safe haven, from which we move outward and return. There is a sense of connectedness at home, a series of connections between ourselves and the world. Home is a bonding of person and space "a set of connections between the experience of dwelling and the wider spatial, temporal and sociocultural context within which it emerges. It orients and connects us with the past, the future, the physical environment and our social world" (Dovey, 1985, p. 44). These nurses use the roads to get from one place to another, work or home. They also use the distance, the time, to be with reflection. Distance is between past and future, between practice and home and between people, in the between.

Reflection *Is* Relation

The reflection experience for these nurses is striking in its relational aspect, as a collaborative, collegial activity. Perhaps this should not surprising given the intersubjective nature of nursing. Initially, most nurses described reflection as solitary and individual, in relation with self. However, as our conversations progressed this expanded to reflection in relation with others. At the time we were unaware of the strong relational dimension expressed during our conversations. It was through thinking, reading, writing, re-reading and re-writing that the strong relational element showed itself or was coaxed out of the data. Reflection *is* relation is the third core contribution to scholarly knowledge.

Reflection is not only a solitary, individual activity but also collaborative, relational. We

live in a permanent web of relationships with one another in every domain of human life (Echeverria, 1999). In Teaching from the heart, Moore (1991) writes that one way we know ourselves is as social beings. The web of social relationships within which we are connected includes all the elements of the world as part of the social matrix (p. 185). Eyles (1989) describes a dialectical relationship between ourselves and society, where our selves are constructed in relation to others. Grudin (1996) suggests that "any interaction that is reciprocal and open ended should be viewed as dialogic... Evolution, ecosystems, the human body, the living cell, these are best understood as dialogic entities, self regulating interactions of multiple forces" (pp. 12-13). Reflection is an ongoing process of our everyday lifeworld emphasized explicitly through dialogue. It is an inherent and explicit linguistic event. Reflection is interactional, an instance of social action grounded in the everyday world (Cinnamond and Zimpher 1990).

The social embeddedness of knowledge is evident through dialogue or reflective conversations. Trust and choice are necessary for reflection *is* relation. Choices determine our relational stance (Tapp, 2000), and these nurses enter reflection exclusively with those they experience as close. Max describes forging "reflective relationships" characterized by "mutuality." She will "pick and choose who I want to reflect with." Reflection is relation, predominantly with peers, colleagues. Not surprisingly in this context, the focus is on practice. These nurses choose reflection relationships with trusted others in their community of experience. The nurses share background habits, skills, practices, and language. Through sharing they build and nurture connections and create a sense of community, a culture of reflective inquiry.

Nursing is a dialogue over time. It unfolds over time, from moments to months in

measured time. Conversation involves entering and living with a context and its participants. There is a rhythm of talking and listening in conversation. Reflection in relation with peers through informal reflection conversations is naturally occurring, informal and unstructured. The nurses support each other in reflective dialogue. This contrasts with the notion that reflection might be enhanced by a reflective coach, mentor or supervisor, although this notion is prevalent in the literature. The coach would assist others to reflect in a number of ways, ask open-ended questions, and develop a safe and nurturing environment (eg. Schon, 1987, Snowball, Ross & Murphy, 1994).

There was silence in our conversations around any suggestion that a mentor, model, or coach could encourage or facilitate reflection. Schon (1987) argued that practitioners need coaching to deal with practice problems and to enhance reflection. Coaching is necessary to promote collaborative knowing and encourage cooperative communication among people (Belenky et al., 1986; Conway, 1996; Johns, 1998). Not only is coaching necessary, but to help others with reflective skills and abilities, these mentors and coaches would also need time in training and support themselves (Newell, 1992). Despite calls for supervisory structures and strategies for promoting reflection within initial professional education programs, none of these nurses had enjoyed such opportunities. There was no one in their environments who embodied reflection for them to emulate. Williams (1998) suggests that we have modelled behaviour that does not include reflection. Reflection time as integral to the learning process, has not been valued, at least not in any visible ways (p. 17). There was no sense of time to learn reflection in our conversations, perhaps because the nurses did not identify learning or being taught to reflect.

Practice is a coherent, socially organized activity, located within a tradition. It is

continually being worked out in history and through ongoing development (Benner et al., 1996, p. 252). Practice is shaped by the communities of practice in which we participate. Stockhausen (1994) suggests that reflection is a new order that may emerge within a conversation. Yinger (1990) advances the metaphor of conversation for practical action or practice. Conversation refers to the means by which social practices are conducted. It is relational. Practice is grounded in a close relationship, a conversation, between the practitioner and her own place. It is carried out in a cultural context defined by a rich tradition of practice and local knowledge. The nurses' descriptions illustrate this. A language of practice frames the practitioner's interaction with materials, people and places. Conversation involves an entering into and living with a context and its participants. It is not only a means of interaction and a way of thinking but also a relationship with one's surroundings (p. 82).

Yinger (1990) developed propositions related to the conversation of practice. These include: being suited to situations that discourage or prevent deliberative processes; the compositional process uses the building blocks of situationally (contextually) grounded patterns for thought and action; holistic configuration of embodied thought; primarily retrospective using patterns from past action to further future action; based upon incorporation of patterns and pathways continually responsive to changing exigencies and purposes; structured by action and including embodied knowledge, beliefs, and goals; and primarily relational, it is directed toward the establishment and maintenance of relationships. Within these propositions, action is improvisational, thought and action are adapted to the dynamics of social interaction and conversation (p. 84-86). The nurses create conversations with their practice, in the work place, at home and while commuting, when they are attracted to reflection.

Knowledge is constructed in dialogue with others who have different perspectives. The possibility of dialogue, inner and outer talk, correction through multiple perspectives and memory of experiential learning from the past is found within communities of practitioners and their conversations (Benner et al., 1996). Among themselves, there is a give and take in reflection conversation or dialogue. In practice the focus of the nurses' conversations is mainly on the human experiences of the patients, their attitudes and feelings about what was happening to them. The nurses experience close bonds with the residents, which is not surprising given the intimate nature of their relationships. Lora speaks of reflecting in relation with the residents, who are "the greatest reflectors." Paying attention to the lived reality of residents, their understanding of life situations and outlook on life is central to the way we understand nursing practice (Bjornsdottir 1998). This echoes the new movement in health care, connection and partnership.

Reflection in relation encourages voice by supporting the integration of knowledge the nurses hold or feel intuitively with knowledge they learn from others, and from hearing both themselves and each other. Within their practice communities, these nurses make an effort to develop relationships and bring their voices into communal hearing. The informal structures created by the nurses provide opportunities for nurturing professional relationships and enhancing reflection. These nurses choose community, dialogue and reflection in relation with others. Support and connection characterize peer alliances. Markus and Kitayama (1991) argue that a sense of belonging and collaboration could become so strong that relationships, rather than individual functioning, might become the primary unit for reflecting.

While we are unique beings, we are interdependent and related to others in time and space. Reflection requires an appreciation of the particulars of time and space, that is, contextual

sensitivity. Lived space and lived time are intertwined. Familiarity through time with practice settings leads to feelings of reciprocal belonging. We belong in the place and place belongs to us. Within these places of belonging are the intersubjective transactions that characterize nursing and reflection.

For the nurses in this study, reflection is constructed in the geography of everyday life. Reflection is removed from the highlands of academia and located in the everyday reflection landscape. Rather than forcing a fit with these nurses' experience and extant models or frameworks, the nurses' experience is honoured in the everyday. The language in the reflection landscape is not reified but that of the everyday. We inhabit body, relation, time and space along with the reflection experience. These essential lifeworld themes converge upon the construction of reflection in the between. Reflection is embodied and lived between people, time, and space. True to the intersubjective nature of nursing, reflection *is* relation.

Implications For Nursing Practice

The implications for nursing practice are found in the core areas of accepting the challenge, reflective inquiry culture and reflection for practice. Accepting the challenge to reflect is a requirement for re-registration with the College of Nurses of Ontario (CNO). Clearly, nurses have accepted the challenge. They identify two modes of reflection, annual and everyday. In practice, a culture of reflective inquiry parallels peer review. There is a curious absence of reflection in action/practice, and an environment unsympathetic to reflection and reflective practice.

Accepting the Challenge

There was no doubt that a call to reflection from the College of Nurses was instrumental in introducing reflection and the reflective practice framework. For Ontario nurses these terms are now used within nursing. Had the College not selected this framework, it is unlikely, despite the prevalence in the literature, in academe, that reflective terminology would have formally entered the nurses' consciousness as expressed through their language.

A consensus was evident among the nurses around two separate understandings or modes of reflection, annual and everyday. Reflection is understood as an annual exercise required by the College of Nurses for re-registration, "simply an annual assignment." In this context, Edi states "reflection is a very new word to me," and as previously described "it's the new buzz word of the decade." The second mode incorporates recognition and labelling of already existing practices or behaviours. Reflection in everyday life includes practice. In this "new use of terminology," the familiar word, reflection, or the language of reflective practice is imbued with fresh meaning.

The language of reflection has infiltrated the nurses' everyday life and practice. Does this represent a change in nursing practice in Ontario? Perhaps it is more accurately a change in the language of practice versus a fundamental shift. Gregory (1989) describes change as "a transitory stage that has to be passed through in order to alter one state into another" (p. 10). A temporal aspect with change is the rate of change. The rate of change is a particular time perspective. Reflection and reflective practice were "introduced by CNO about three years ago" according to Lora. Reflection was defined as "the process of reviewing experiences to gain insight and learning to help prepare for future experiences and learning" (CNO, 1996, p. 107). Although the nurses' understanding goes beyond that defined by the CNO, as a College requirement, the

nurses' descriptions of reflection parallel the College definition. Ruby, for example, has described reflection as having "a *huge* purpose... gaining knowledge, learning and improvement." Max finds reflection "an opportunity to review something that has happened and make improvements for the future." In the focus group, Mary describes reflection as "reviewing things we have done every day... and if there are ways we can improve on it."

The language of reflection or reflective terminology has clearly been incorporated into practice, in the space of a few short years. Further evidence of its incorporation, is the nurses' description of the reflective practice framework. They readily describe the quality assurance program or the various components as comprising self-assessment, peer review and learning plans.

Reflective Inquiry Culture

One component in the annual requirement of the College of Nurses is peer review. Nurses are directed to seek constructive feedback regarding their own practice and role performance from peers, professional colleagues, clients, and others. These nurses considered peer review also an annual requirement, more formal or structured and outside the everyday practice experience. While the nurses described informal reflection conversations among peers, these everyday activities were not identified as peer review. In our hours of conversation, the nurses never located their reflection conversations within the formal peer review component of the quality assurance program.

Within their informal reflection conversations the nurses discuss their clinical nursing practice, often with a view to improving resident care. This dialogue also enhances support and belonging. Peer feedback is important. The nurses specifically note that they like the questions

asked by their peers and value their opinions and feedback. This figures in their choice of reflection partners. They engage in sharing experiences and insights, which contribute to feelings of professional belonging or connectedness. Communities of reflective inquiry are created, where peer supervision/feedback is a mode of reflection among nurses of the same rank or status (McCormack & Hopkins, 1995). These nurses describe opportunities for what might be regarded as, but were not identified, as peer review or supervision. Perhaps this was informal or taken-for-granted. Their informal, private conversations at work among themselves were valued for professional growth, mutual support, and feedback. However, these were not recognized as meeting the College requirement for peer review.

These nurses create a culture of reflective inquiry and discovery with their peers. This almost submerged culture may not be immediately evident within their facilities, although it was common across facilities. This reflective climate, replete with indigenous reflective thinking, is found exclusively among the front-line registered nurses. Cosgrove (1989) suggests that alternate cultures are less visible in the landscape than dominant ones. Each facility is seen as a single community, not a collection of interacting communities, which might be a more accurate description. Each unit has a distinct personality as well as being part of the whole. The nurses are a part of the organization, their unit, and the naturally occurring communities of reflective inquiry.

Astrom, Furaker, and Norberg (1995) illustrate the strength of climates of reflective inquiry. If nurses have a group of co-workers to share their thoughts with, and to gain support from, that is, people listened to them and cared, they could act according to their own ethical reasoning and feelings. In situations where the nurses did not have any support from their co-

workers, they did not view others as unique and valuable people (p. 1074). In this study, the nurses convey a very strong sense of peer interaction and support, a valuing of others. They describe a culture of reflective inquiry.

Reflection For Practice

The nurses understand they must be reflective practitioners. This is realized through reflection on their own and other's practice. They are exhorted to live up to the expectation that good practitioners are reflective practitioners (van Manen, 1995). However, reflection on practice, for practice is but one dimension or focus of reflection in everyday life.

The notion of reflection in the moments of practice was absent from the nurses' conversations. They are unencumbered by this notion. Unfamiliar with the concept of reflection-in-action, and having not received any strong message to do so, they do not experience any need to reflect in action. Reflection in action would be difficult, as the nurses describe their practice day as "fast, multi fast." In practice there is a sense of temporal immediacy with no opportunity to reflect, "too many things happening" at any given time. However, the nurses spoke confidently of their practice, implying confidence in their knowledge and action in practice moments, thinking-in-action. In practice, these nurses describe active participation and engagement (Benner et al., 1999). This has been described as thinking-in-action and acting knowledge.

The nurses' construction of reflection related to practice is at odds with the concept of practice as deliberative reflection-in-action. Yinger (1990) proposes an alternative view as intelligence of practice. Careful thought and attention are directed toward past and future performance, conducted apart from the immediacy and demands of actual performance (p. 83). In this way, reflection as thinking for action, whether before, during or after action may be realized

(Teekman, 2000). These nurses are situated in their practice and connected to their environment. However, the practice context is not good for reflection. They are actively engaged in the everyday world of practice but they step aside or away from practice to reflect in a more attractive context. The nurses have constructed their own understandings of reflection. They have no sense of deficiency, no sense that they could or should reflect better or different.

A temporal dimension in reflection was introduced by Schon (1983; 1987) as reflection during action, recollective reflection on action, but not reflection before action. Most writers have expanded the temporal dimension to include looking forward, before action, anticipatory reflection (eg. Fitzgerald, 1991; 1994; Greenwood, 1998; van Manen, 1991; 1995). This was clearly the case in this study. The nurses described reflection as both "looking forward and looking back." The notion of reflection for improvement also suggests both recollective and anticipatory dimensions. Suzie describes thinking back on "particular occurrences, practices, problems, ideas and put them to use in the future or change them to make improvements." With reflection, the nurses are connected to past experiences, and connected with the future.

The time required to reflect, represents one prominent criticism in the literature (Burton, 2000; Heath, 1998; Snowball et al., 1994). This is evident in the juxtaposition of time to reflect and current health care environments or climates that leave no time or space to reflect. Practice situations are complex and require respect of time for practitioners to think these things through (Houston & Clift, 1990). Thinking time is often perceived as wasted time. Williams (1991) suggests that reflection time, time for processing experiences, has fallen prey to benign neglect. Perhaps this is too kind. It may be not benign neglect but active discouragement of reflection time, or at least not active encouragement of this in practice. These nurses describe heavy

workloads, fast paced environments, temporal immediacy in practice and the absence of reflection in practice.

The nurses were emphatic that they reflect exclusively when physically away from work, but that practice is often the focus of their reflection. They step out of practice, take time and make time before and after work for reflection. They carry with them images of residents and practice that change with each interaction. In reflecting on experience in the present, the nurses remain connected to their practice, through memory or recollection, and connected to the future through anticipation of experiences. This is an interaction between past and present and future.

These nurses described reflection thinking as natural, automatic, spontaneous, popping into their minds. Everyday reflection is both personal and professional in content. Reflection is important for improvement, in the sense of continuous incremental improvement or kaizen. Reflection thinking is individual. Max has "my own style of reflection and I assume others have theirs." She describes her style as questioning: "why did it happen that way, why did I react that way, how did the other person react, why did they react in the way they reacted?" She also wonders "is there something I could have done differently, do I act on it or do I decide that's fine, I reflected on it and there is no need to re-approach the situation." Reflection for professional purposes is an extension of a life-long habit of reflecting.

Clearly these nurses are attracted to reflection. Despite attending the CNO presentations about reflection and reflective practice, these nurses assert that the sessions never really addressed what reflection was, or how to reflect. They understand, from the College perspective, reflection is to be on or for practice. They have developed their own meanings for reflection and reflective practice which include learning and improvement. The nurses in this study locate

reflection in the everyday, not in the extant stage models of reflection. The nurses describe practice environments that do not support or encourage reflection, so they develop their own. Higgins (1998) suggests we must address the complexities of practice environments, and the broader context, not just simply exhort nurses to reflect. DeMarco, Horowitz, and McLeod (2000) assert that "our health care and academic institutions generally fail to provide the type of support system needed to promote the nurses' interactional expertise, self-reflection, and collegiality" (p. 173). Where or when did we learn to reflect or did we learn this? How are we expected to go about it? How do we support reflection? In what way is the enactment of reflection assured? Where is the environment that supports reflection?

Implications for Educational Practice

Two main implications for educational practice emerge from this study. These are found in the notion of reflection as reified or everyday, and the language of reflection. The construction of reflection in the geography of everyday life is a remarkable contrast to the almost reified conceptions of or formulae for reflection found in the extant literature. Our practice context is too complex for any single theory or set of principles. The application or reach of theories is too limited, too universal, too partial and too general to be of immediate practical use (Benner, 1994). However, reflection in the geography of everyday illustrates the situated practical knowledge of this group of nurses. The language of the everyday represents these nurses' constructions of reflection. For example, reflection had much to do with improvement, although there is no notion that reflection or reflective activity itself could be or needed to be improved. We practice a language and grammar. Descriptions of language and practice provide insights into how reflection may be learned through language and conversation. The language and grammar of

reflection, while represented by nurses in this study, could nevertheless provide a frame for other professions such as teaching.

Reflection: Reified or Everyday

Tremmell (1992) expresses concern that the notions of reflection and reflective practice are in danger of becoming reified or reduced to a formula. Benhabib (1986) echoes this concern. She asserts that "reflection as an approved, sanctioned (and assessed) approach within a university education program can become a reified object" (p. 282). Tremmell (1992) cites examples where "the broad range of cognitive, affective, and linguistic abilities that define thoughts are expressed in the shape of formulas for critical thinking or problem solving" (p. 221). The prescriptive language of rational, analytical thought is evident in many models of reflection. Formula or stage-oriented models are likely to be interpreted as having universal applicability. They can be applied at any time, in any situation, with same degree of certainty each time, and context does not matter at all.

Consider, for example, the definition and mnemonic for reflection, provided by the College of Nurses (1996). Reflection is the "process of reviewing experiences to gain insight and learning to help prepare for future experiences and learning" (p. 107). Reflection "involves the LEARN steps: Looking back, Elaborate and describe experience, Analyze outcome, Revise approach and plan New trial" (p. 107). This description bears a striking resemblance to the nursing process, where the mnemonic "a pie" - assess, plan, intervene and evaluate also directs the nursing problem-solving process. This is unquestionably linear and as a prescriptive formula, stripped of context and affect. In our conversations none of the nurses was familiar with this mnemonic, and their understanding went beyond this restricted view of reflection. Edi

specifically noted "I don't do the steps, *the* steps."

Within these formulations, logic, linearity and analytic predictability are valued. This constricted focus ignores the wide range of thought and language that lies outside such boundaries. It does not account for the interactive reality of practice. Kitson (1999) in writing of scholarship in nursing, noted that one role of university education is to "equip students with the skills of problem-solving, reflection and decision-making" (p. 773). Burton (2000) identifies essential skills as critical analysis, self-awareness, synthesis, evaluation, which also form the basis of degree level study (p. 1013). Clearly, both problem-solving and decision-making are addressed in the current nursing literature and curricula, and to a lesser degree, if at all, reflection. The participants were unable to identify having encountered the term reflection in their basic nursing education programs. They were familiar with problem-solving and the nursing process which is a problem solving method, decision-making, and even critical thinking. They were unfamiliar with other ways of knowing which more closely approximate their understanding of reflection.

The nurses in this study understand reflection in a way that contrasts with the current literature, and clearly there is not a shared common understanding of the phenomenon. Burton (2000) and Scanlon and Chernomas (1997), for example, assert that there is conceptual muddle about other cognitive processes associated with reflection, such as considering or pondering. This could lead nurses to believe they are reflecting, when in fact they are not, at least not in a nursing context. Burton (2000) claims that to make reflective activity productive, requires synthesis, analysis, critical thinking and evaluation, rather than merely pontificating or ruminating over an experience. She calls for nurses to distinguish between what she determines

as real reflection and mulling over an event in an nonpurposeful fashion. Of course, this represents a particular, analytic, linear view where reflection can even be described as effective (p. 1012). This bias toward an a priori and reified understanding of reflection is evident and there is a devaluing of or at least a neglect of other ways of knowing. Alternate views of thinking such as mindfulness, Gestalt or holistic are excluded in such formulations. Practising nurses' experience of reflection is excluded or disconfirmed.

However, the nurses in this study have escaped the danger of reduction and linearity, and expanded the possibilities, in large part by locating reflection in the everyday. Despite describing reflection as watching a movie, playing a game, making a quilt or putting a puzzle together, the nurses do not treat reflection lightly. Max, for example, considers "its almost like breathing to me, I need it to get through the day." Beth would "rather reflect than do other things."

The importance of reflection for improvement, for learning, in the sense of continuous incremental improvement or kaizen, pervaded the conversations. Improvement might be around learning gaps identified or "trying to find ways of improving areas I feel I could do better with," or about improving self. The nurses described thinking back on their practice with a view to improving upon their actions in subsequent interactions. There was no sense that reflection could or should be improved, no-one mentioned improving reflection. Improvement is tied in to learning and experienced as comfortable. Horizons include everything that can be seen from a particular vantage point. They are temporal and always in motion. Landscape and geography are dynamic and change with improvement. Improvement is just over the horizon.

Pleasure is a state of being
brought about by what you learn.

Learning is the process of
entering into the experience of this
kind of pleasure.

No pleasure, no learning.

No learning, no pleasure.

(WANG KEN Song of Joy)

Reflection and reflective practice are required for pre- and post-registration nurses in the UK, Australia and New Zealand. Ontario nurses share the post-registration, re-registration requirement. However, there is a marked contrast in the support for reflection and reflective practice. In the other countries reflection is framed within the critical theory tradition and there are supports in practice for nurses to realize reflection and reflective practice. These concepts are specifically emphasized in initial educational preparation and continuing education. Despite the lack of institutional support for reflection, the nurses in this study create an informal culture of reflective inquiry and discovery with their peers. They create their own indigenous support for reflection and reflective practice, in the social web in which experience and reflection are grounded.

Language of Reflection

The use of reflective terminology requires exploration of the meaning and implications of participants' descriptions. The language and grammar of reflection, while represented by nurses in this study, could nevertheless provide a frame other professions. Language is a way of being, a social practice in a social context. Language speaks us (Allen, 1996). Patterns of language and

human existence have a logic to them. This logic stems from our emotions and takes its shape from communication in ordinary activities of daily life. The language of nursing practice includes patterned ways of meaning and acting that are uniquely suitable and effective for accomplishing nursing. This language of practice and reflection is found in nurses' actions and speech, where it is heard, seen and felt. The body is a medium of culture, or a metaphor for culture. We are people who inhabit real bodies, which are constructed and constrained by our history and embedded in a specific culture (Street, 1992). Nurses assimilate the culture of nursing, components of which, for example language, have a strong influence over us. By practising nursing, we contribute to its continuation as a part of the socialization environment. By using a language we reproduce it. We may alter it slightly by the creation of new words, new meanings for old words, and by making others obsolete (Gregory & Walford, 1989, p. 58).

In this study the nurses identified the use of reflection and reflective practice not as the creation of new words, but as new meanings for old words. Vera identified reflective terminology as "something new, can be challenging." Although Max agreed with the intent, she questioned the use of such terms as "I don't think the term is really applicable or fair term to use, I'm sure there is a better term." However, the nurses in this study accepted and were committed to the use of the term reflection and reflective practice as advanced by the College of Nurses. The new reflective terminology influences the nurses' everyday life of which practice is part.

Taylor (1998) frames reflection from a phenomenological research tradition as a link between the interpretive and critical paradigm. She maintains that Mezirow (1981; 1990), van Manen (1977; 1995) and Kemmis (1985), for example, help practitioners cross the critical boundary to understand the conditions under which practitioners practice. Generally these

conditions are perceived as oppressive in nature. The language of reflection used by the nurses in this study is the language of the everyday, there was an absence of this critical turn. Gavin (1998) identifies some rhetoric within nursing as implying a certain level of expertise, a quality of education that supports that expertise and control over the application of that expertise in practice. Empowerment and disenfranchisement are related in the extent to which a nurse has any influence over how she carries out her role. Within the critical paradigm, nurses are exhorted to understand, expose, and confront contradictions within practice, and to take action to resolve contradictions, to question the taken-for-granted (Johns, 1996). Of course, critical reflection would be supported in education and practice. Durgahee (1996) recommends concentrating, for now, on using reflection to develop practical skills, not to worry about emancipation or developing critical theory. This is congruent with Ontario nurses' current education and practice contexts. In this study, the nurses use everyday language with reflection. They speak in the optimistic language of possibilities, imagining how things could be different. They describe reflection being like watching a movie, constructing a quilt, putting puzzle pieces together. It is a language of cooperation and collaboration, but not the language of academia or critical theory.

Grammar of reflection. Just as having a grammar in our language helps us make sense with our words, so, too, having a grammar of practice helps us make sense of our lives (Bell, 1988, p. xvii). Holmer (1988) describes one way of learning English grammar. We learn the rules, typically "by heart." As we acquire a mastery of the language, we do not speak the grammar itself, but we speak in accord with the rules we have already learned. The more skilled we become in writing and speaking, the more our knowledge of grammar informs everything we say and write. After a while we speak more or less grammatically without remembering the

grammar at all, it becomes intrinsic. The subject matter is no longer separate and "it is as if the rules have become embedded in the speech" (p.4). Everyday speech and practice support the exercise of grammatical rules. In the same way, we learn the grammar of nursing practice in which reflection is embedded and embodied.

The language of practice includes logic or grammar for thought and action, a system of meaning, criteria and guidelines for effective practice. Practice language comprises words, phrases, and modes of thinking and acting. There are typical patterns of action, emotion, and motivation in the grammar of reflection. There are circumstances in which actions and emotions exemplify reflection. These connections constitute part of the grammar of reflection and the context in which it is embedded. Roberts (1988) refers to the context as systems of thought and practice.

Initially, reflection was "a scary thought" to Vera, although it provided "some sort of structure," for Max. However, the nurses describe reflection words and phrases as "a natural thing for me to do," "need it to get through my day," "make myself better and improve on things," "learn more, try new things, develop skill, knowledge," "personal growth," and "feel good." The modes of thinking were described as natural and spontaneous, everyday, including personal and professional, and related to improvement. Reflection is thinking for action, whether before, during or after (Teekman, 2000). The modes or patterns of action are thinking-in-action and acting knowledge, pattern recognition and noticing. There is an absence of reflection in the moments of practice. In the affective dimension, reflection "can be draining," but the "payoff is peace." The emotion is described as a "comfortable feeling," "enjoyment," and "positive and relaxed." Miranda describes motivation as "get in tune with yourself." Beth describes it as "to

know where I am in the scheme of things." The context for reflection is outside of practice, although practice is often the content. The nurses have learned the rules for reflection on practice, but they do not describe rules for reflection in practice.

Language is a way of being, a social practice in a social context. As we acquire language in practice, we learn to give voice or meaning to our experience and to understand it according to particular ways of thinking. The intersubjective nature of language and understanding means that knowledge is both generalizable and historical; generalizable because language and institutions are continually reproduced through linguistic practice. We must celebrate that nurses do reflect as evident in the everyday language of practice. We need to highlight the positive experience that reflection is for these nurse and support their commitment to reflection, without imposing arbitrary ideas and expectations or suggesting that their experience, outside the critical paradigm for example, is deficient.

Durgahee (1996) suggests concentrating on using reflection to develop meanings, understandings and practical knowledge, not on emancipation or developing critical theory. This is congruent with the nurses' current practice contexts. Would it be desirable for nurses to demonstrate critical reflection in systems which provide little support for change based upon critical reflection or "perspective transformation?" Might this increase not disenchantment, decrease satisfaction and engender a sense of powerlessness?

As a teacher, I need to bring this study of reflection, represent these everyday notions, into teaching, perhaps using it to build curriculum. The legitimacy of these constructions of reflection needs to be acknowledged and built into curricula. With this comes a call for models other than linear, rational problem-solving. This means exploring and valuing ways of knowing

other than empiric, throughout the curriculum.

Perhaps, even before this, there is a need to represent reflection, explicitly, in curricula. There is a discontinuity between the College of Nurses requirement for reflection and its explicit absence in curricula, at least as these nurses recount. A dialogue between the College of Nurses and educational facilities could happen, where the notion of reflection is addressed; where expectations for practice could be supported and enhanced through educational practice.

Areas For Further Study

In the absence of understanding the reflection experience of practising nurses, it is difficult to assess what proponents of reflection claim it can do. Reflection and reflective practice are advanced as leading to improved patient care, although there is little empirical support for this. In practice, these nurses describe active participation and engagement in the context of practice moments (Benner et al., 1999). The nurses in this study identified reflection as having much to do with improvement, helping them not to make mistakes in the future, benefiting the whole health care team. These nurses did not focus specifically upon either their mistakes, improvements in practice, how reflection helps them not to make mistakes in the future or how reflection helps to improve practice. There is an assumption that reflection leads to improved practice, but no evidence of this (not that it doesn't, but evidence is absent). Do reflection and reflective practice contribute to the improvement of nursing practice and patient outcomes? Explicit exploration of this question would seem reasonable and critical particularly for nursing in Ontario. This needs to be prefaced by an appropriate description of reflection, what is it we are calling reflection, followed by how we would go about investigating this, and what would count as evidence of improvement.

In this study the nurses described reflection within the context of their own lives. Several aspects such as age and expertise emerge as salient both in the study of reflection and the context of the study. Reflection has a lifespan dimension and most authors implicitly or explicitly allude to reflection in adulthood, or at least late adolescence. The nurses in this study are all over 25 years of age. Burrows (1995) notes that people under the age of 25 may lack both the cognitive readiness and skill and experience required for critical reflection. Burton (2000) suggests reflection as part of a developmental cycle where new knowledge is integrated with old. Similarly, Heron (1992) describes personal development as rhythmic, with oscillating phases of new learning and consolidation, cycles and periodic recurrences for learning, growth and change. Knowles (1980) suggests that practitioners would be expected to build on life experiences to make sense of what happens at work. The long-term care nurses in this study are mature and expert practitioners in an area which is high touch as opposed to high tech. I had encouraged nurses with whom I work closely to participate in the study, precisely because I had observed their considerable expertise in practice and their commitment to lifelong learning. This study represents the constructions/voices of this particular group of nurses, at this particular time. Are most nurses already thoughtful and reflective, or were the nurses in this study exceptional? The voices of nurses in other specialities, even different long-term care nurses, younger nurses or nursing students would enrich our understanding of nurses' experience of reflection. Are nursing students being introduced to the notion of reflection, how do they understand reflection and reflective practice? It would be useful with a similar design to explore with different samples, different groups of nurses in different specialties, how they experience reflection. This could enhance and expand our understanding.

Are nurses placed in an untenable situation where reflection is required in an unsympathetic environment, or context, and might this engender frustration and dissatisfaction? Could the environment, one of the four factors in nursing's meta-paradigm, be brought into the discussion, not as an entity to be acted upon, but as something to be interacted with? This could be addressed through the lens of critical or feminist methods along with those particular techniques.

Nursing is shaped by the ideology that the work nurses do relating to patients as persons, attending to patients' lived reality, is invisible. The historically developed tradition in nursing of emphasizing efficiency and getting the work done undermines the value placed on human relations, among nurses and among patients. Language speaks us. We need to pay attention to ways in which we may be able to enhance discourses that speak to the knowledge and work embedded in nursing. Framing reflection in everyday language could help to surface nurses' practice theories and contribute to making nurses' work accessible and visible. The language used to represent nursing, persons and reflection is an important aspect of nursing practice that needs to be further explored, perhaps through narrative inquiry and discourse analysis.

The degree of intersubjectivity involved in nursing, and in reflection, warrants recognition and study. Markus and Kitayama (1991) have argued that a sense of belonging and collaboration could become so strong that relationships, rather than individual functioning, might become the primary unit for reflecting. This notion finds support with reflection *is* relation. Should we, could we, would we expand our framing of the reflection experience to value it as both an individual and a collaborative activity? Symbolic interaction would be an appropriate frame for such a study. As an interpersonal experience, rather than asking "what did you do in

the interaction," the question would be "what happened between you." The study of informal collaborative structures and relationships could yield some intriguing results. Action research addresses practice knowledge and theory and it is a collaborative process. It would be an appropriate method for inquiry. What is the potential influence of this different, intersubjective understanding of reflection on the future of nursing practice?

Endnote

This study has demonstrated that phenomenology is respectful of persons and honours their lived experience. Phenomenology takes into account life experiences within the everyday. It has been useful in understanding the nurses' experience of reflection and their practice, making the invisible visible. Practising nurses are ignored in most of the existing literature, and have been excluded from other studies. Hermeneutic phenomenology fits well in the current health care environment, where partnerships are promoted. While practising nurses have not participated in the creation of the institutional discourse around reflection or contributed to its formation, they appreciated the opportunity to contribute to this formulation of reflection among practising long-term care nurses. The resulting constructions are just outside the accepted discourses, but there is heuristic value in understanding reflection in the geography of everyday life. The aim of the study was to give voice to practising long-term care nurses, and to celebrate their insights. This study shows how reflection in the geography of everyday life differs from other reflection frameworks.

Reflection is constructed in the geography of everyday life and reflection landscape. This moves reflection from mountain tops into the everyday and creates the potential to develop a new and potentially different reflection discourse. The understanding of reflection among practising

long-term care nurses developed from the nurses' direct experiences, in the language of the everyday. Reflection as everydayness is the lived experience. The language of practising nurses has its roots in the everyday. Reflection as everyday provides a direction for developing new ways of speaking in and about nursing practice.



REFLECTION

Puzzles, fragments

In everyday geography

In the between

Time, space, persons, self

Alone, together

Connected

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Appendix A

Selected Definitions/Descriptions of Reflection

Source	Description/Definition
Atkins & Murphy, 1994	Reflection: complex & deliberate process of thinking about & interpreting experience to learn from it; conscious process not occurring automatically; response to experience & with definite purpose; can take place in isolation or with others; highly personal process, outcome is changed perspective, or learning (p. 50).
Baker, 1996	Reflection: exploration of experience to create meaning, with potential of generating new knowledge. Reflective learning: process whereby individual responds to lived experience & cognitively reviews & explores experience to create & clarify meaning for self (pp. 19-20).
Benhabib, 1986	Reflection: not abstracting away from a given content, but ability to communicate & to engage in dialogue; linguistic access to inner nature is both distancing & coming closer; in naming what drives & motivates us, we are closer to freeing ourselves of its power over us; & in the very process of being able to say what we mean, we come one step closer to the harmony or friendship of the soul within itself (pp. 333-334).
Benner, Hooper-Kyriakidis, & Stannard, 1999	Reflection: based upon narrative understanding of situation; allows clinician to keep means & ends in relation to one another & tied to understanding the situation; aspects of clinical judgement & expert comportment guide active reflection; connotes a stepping back or being outside the situation (pp. 8-11).
Bevis & Watson, 1989	Incubation, discussion, dialogue & debate; fantasizing, imaging

Boud, Keogh & Walker, 1985	Reflection: process of reviewing an experience of practice to describe, analyze, evaluate & so inform learning about practice; begins with description of experience from which key issues within experience can be focused on for reflection; involves connecting ideas from experience to existing knowledge & the new subject matter (association phase); can repeatedly go back to original experience, re-evaluate it & then associate it to theoretical principles.
Boud & Walker, 1991	Reflection: normal ongoing process which can, if desired, be made more explicit & more ordered; activity pursued with intent, a purposive action directed towards a goal; complex process in which both feelings & cognition are closely interrelated & interactive; active process of exploration & discovery, often leads to unexpected outcomes. Three important elements: returning to the experience, attending to feelings, & re-evaluating the experience. (p. 19).
Boyd & Fales, 1983	Reflection: process of internally examining & exploring issue of concern triggered by experience, creates & clarifies meaning in terms of self & results in changed conceptual perspective (p. 113).
Brookfield, 1991	Reflection: 4 conceptual clusters central to critically reflective learning in adulthood: praxis of action, reflection on action, further action, reflection on the further action - a continuous cyclic loop.
Caffarella & Barnett, 1994	Reflective Practice: process of bringing past events to conscious level & determining appropriate ways to think, feel, & behave in future (p. 38).
Calderhead, 1989	Reflection: in general sense of appraisal of one's own work requires possession of certain knowledge, critical skills, & a way of conceptualizing one's own learning as a reflective process, plus basic practical competence together with some degree of self-confidence (p. 47).

Carkhuff, 1996	Reflective learning: process of looking into reasons for & exploration of meaning about issues, concerns or problems that involve individuals or groups of individuals to come to a new appreciation, understanding, awareness, or conceptualization of ideas (p. 210).
Cinnamond & Zimpher, 1990	Reflection: ongoing process of everyday lifeworld emphasized explicitly through dialogue; inherently & explicitly linguistic event; interactional; not separate action for instrumental use in particular instances; not skill taught for use in certain instances (p.64). Power of reflection: instance of social action, grounded in everyday world (p. 70).
CNO, 1996	Reflection: process of reviewing experiences to gain insight & learning to help prepare for future experiences & learning; involves the LEARN steps: Look back, Elaborate & describe experience, Analyze outcome, Revise approach &, plan New trial (p. 107). Reflective practice: the habit of applying reflection to continuously improve one's practice through self-assessing for the purpose of ongoing learning (p. 107).
Cranton, 1996	Reflection: requires moving beyond acquisition of new knowledge & understanding, into questioning of existing assumptions, values, perspectives (p. 76).
Dewey, 1933	Reflection: active, persistent & careful consideration of any belief or supposed form of knowledge in light of the grounds that support it & further conclusions to which it tends (p. 10); process of reflection not merely method of problem-solving but a way of thinking or being; "not the thing done, but the quality of mind that goes into the doing, settles what is utilitarian & what is unconstrained & creative" (p. 215).
Durgahee, 1996	Reflection: process used to analyze nursing situations to raise levels of awareness & insights into them; reflection both in & on action legitimate tool for increasing capacity for experience in clinical leadership (p. 419).

Fitzgerald, 1994	Reflection: retrospective contemplation of practice undertaken to uncover knowledge used in particular situation, by analyzing & interpreting information recalled; reflective practitioner may speculate how situation might have been handled differently & what other knowledge would have been helpful.
Funk and Wagnalls, 1989	Reflection: act of reflecting or state of being reflected; the result of reflecting; meditation, careful consideration, thought (p. 1120).
Gibson, 1999	Reflection: maternal thinking is disciplined reflection; maternal work demands that mothers think, like a scientist writing up experiment; engages in a discipline; asks certain questions - those relevant to aims - rather than others; accepts certain criteria for the truth, adequacy, & relevance of proposed answers, & cares about the findings she makes & can act upon; maternal work demands that mothers think (pp. 305-312).
Goodman, 1984	Reflective thinking: occurs with integration of intuitive & rational thought processes; reflective people are rational & intuitive, childlike & mature, humorous & serious; able to blend rational & intuitive modes of thinking in one dynamic thought process (p. 20).
Hewison, 1991	Reflection: replaying performances/experiences to articulate what is or was happening & making normally tacit knowledge more explicit (pp. 227-231).
Houston & Clift, 1990	Reflection: normal activity often mentioned as a form of metacognition that occurs spontaneously & deliberately in adults & children (p. 209).
Jarvis, 1987	Reflecting: personal process, people reflect in different ways & bring their own personal accumulated knowledge to experiences. Reflection may be cursory & superficial or deep, searching & profound (pp. 164-172).

Johns, 1995	Reflection: method to access, make sense of & learn through experience; in process of reflection, personal knowledge becomes visible & communicable. Unlike the universal, static, & context-free nature of positivist or instrumental knowledge, the knowledge that results from reflection - reflective knowledge - is particular, dynamic, & context-bound, also of immediate & valuable use to other practitioners; Must be consciously activated (p. 25).
Johns, 1996	Reflection: on experience - window for practitioners to look inside & know who they are as they strive towards understanding & realizing meaning of desirable work in everyday practices; practitioner must expose, confront & understand contradictions, within practice, between what is practised & what is desirable; conflict of contradiction, & the commitment to achieve desirable work empowers practitioner to take action to appropriately resolve contradictions; reflective practitioner always needs to interpret extant theory for relevance & usefulness within particular situation (pp. 1135-1143).
Kemmis, 1985	Reflection: not purely internal psychological process, but action oriented & historically embedded; like language, a social process & political & shaped by ideology; political act, which either hastens or defers realization of more rational, just & fulfilling society (p. 140).
Kenny, Ralph, & Brown. 2000	Reflection: crucial to make experience significant, to identify strengths & development of learning needs; & establish meaningful basis for further self &/or community development (p. 116).
Killon & Todnem, 1991	Reflection: for practice the desired outcome of both reflection-in-practice & reflection-on-practice; undertake reflection not to revisit the past or become aware of metacognitive process one is experiencing, but to guide future action (the more practical purpose); reflection-for-practice an ongoing spiral in which each of elements of reflective practice constantly involved in interactive process of change & development (p. 15).

Kim, 1999	Reflection: process of consciously examining what has occurred in terms of thoughts, feelings & actions against underlying beliefs, assumptions & knowledge as well as against the backdrop (ie. context or stage) in which specific practice has occurred; not limited to situations of inner disturbance but to any situation of self-examination (p. 1207).
Korthagen, 1993	Reflection: integration of rational analysis & process of becoming aware of one's guiding gestalts (p. 324).
Kotthamp, 1990	Reflection: cycle of paying deliberate, analytical attention to one's own actions in relation to intentions - as if from an external observer's perspective - for the purpose of expanding one's options & making decisions about improved ways of acting in the future, or in the midst of the action itself; "bending or folding back" as ray of light; metaphor of reflecting light & focus involving the bending back of attention to focus on self, experienced as validation for pulling back & taking time out for self (p. 183).
Laird, 1974	Reflection: Webster's Thesaurus. Noun: [Thought] consideration, absorption, imagination, observation, thinking, contemplation, rumination, speculation, musing, deliberation, study, pondering, meditation, concentration, cognition. see also thought; [An image] impression, rays, light, shine, glitter, appearance, idea, reflected image, likeness, shadow, duplicate, picture, echo, representation, reproduction, see also copy (p. 372). Verb: [to contemplate] speculate, concentrate, weigh, see consider, think; [to throw back] echo, re-echo, repeat, match, take after, return, resonate, reverberate, copy, resound, reproduce, reply, be resonant, emulate, imitate, follow, catch, rebound; [to throw back an image] mirror, shine, reproduce, show up on, flash, cast, or give back, give forth (p. 372).

Lauterbach and Becker (1996)	Reflective process: continuous cycle of awareness, reflection & action; through reflection person sees similar experiences differently, incorporates old & new knowledge; depth & breadth of knowledge gained from reflection on experience determined by life history, meanings & values; a very personal process; bending back of attention to focus on self; connection with larger social world embedded in self-reflective process; connect nurses to patients, each other, groups & communities (p. 58-61).
Lowe & Kerr, 1998	Learning by experience involves being able to reflect on a personal happening & through a process of analysis come to understand (pp. 1030-1033).
Lumby, 1998	Reflection: a way for practitioners to "validate" their paradoxical lives; someone who naturally sees & responds to each unfolding clinical moment through a reflective lens; reflection-within-the moment (p. 14).
Marienau, 1999	Hallmark of educated person is capacity to reflect on & learn from experience so the learning yields meaningful interpretations of life occurrences & informs future actions; when educated person is also a practising professional, ability to reflect on & learn from practice becomes paramount (pp. 135-144).
McCormack & Hopkins, 1995	Peer supervision: a mode of reflection whereby individuals of same rank or status facilitate each other's reflection-in-action (p. 165).
Mead, 1934	Reflective thought: arises out of real problems present in immediate experience; reflection has no clear value in & of itself; value lies in potential for dealing with next action or interaction; does not occupy separate place in social processes but is already embedded in them; reflection is inherent in the lived experience (p. 7).
Moch, 1990	Personal knowing: "discovery of self-and-other arrived at through reflection, synthesis of perceptions, & connecting with what is known" (p. 155).

Moore & Carter, 1998	Learning through reflection essentially subliminal learning through experience, recognizing that by looking back over time & seeing self as changed person.
Noddings, 1984	Consider the person as subject not as object, base interpretations & decisions on subjective natures of persons. Reflective thinking becomes a process of trying to understand the subject & to see the world through his/her eyes.
Noffke & Brennan, (1988)	1. Reflection - not purely "internal," psychological process; > action-oriented & historically embedded 2. not purely individual process: like language, > social process 3. involves human interests; > political process 4. shaped by ideology; & shapes ideology 5. expresses our power to reconstitute social life by how we participate in communication, decision-making & social action 6. Research methods which fail to account for these aspects of reflection limited & mistaken; to improve reflection, must explore double dialectic of thought & action, the individual & society 7. Research program for improvement of reflection must be conducted through self-reflection; must engage individuals & groups in ideology critique & participatory, collaborative & emancipatory action research (p. 18).
Pierson, 1998	Reflection: purposeful inter-subjective process requires employment of both calculative & contemplative thinking (p. 169).
Richardson, 1995	Reflection: multi-faceted round about process of thinking which may be entered, exited & re-entered at any one of a number of points; process of reviewing an experience of practice in order to describe, analyze, evaluate & so inform learning about practice (p. 1045).

Sawada, 1991	Reflection: new order that emerges within a conversation in far-from-equilibrium enclaves; generated by recursive self-& cross-perturbation processes; as recursion drives conversation to states that are farther & farther from equilibrium, each state is an enclave in which new order may emerge in the form of new relations that, by their coherence maintain & stabilize new steady state as an ongoing process; reflection - maintenance of new order in form of <i>network of relations</i> that define new order at a higher level. Reflection - simultaneously new order & maintenance of new order; (conduit metaphor replaced with conversation postulate) (pp. 349-366).
Schon, 1983	Reflection: learning from events & incidents experienced during a course or practical professional program; reflection-in-action - the capacity to think about & change what one is doing while doing it.
Schon, 1987	Reflection: a conceptual move, reconstruction of experience through which learner begins to attend to features previously ignored, or the integration of knowledge with action through thought. "A dialogue of thinking & doing through which I become more skilful" (p. 31); challenged traditional professional schools as not preparing students for competence in real life practice; urged to centre on enhancing practitioners' ability to reflect, reflection in learning can facilitate integration of theory & practice.
Sparks-Langer & Colton, 1991	Reflection: three elements in reflective thinking: cognitive, critical & narrative; cognitive, concerned with knowledge to make good decisions; critical, concerned with moral & ethical aspects of social compassion & justice; narrative accounts of own experience, contextualize experience & provide richer understanding (p. 39).
Sykes, 1986	Reflection: The Oxford dictionary: mental faculty dealing with products of sensation & perception; idea arising in the mind, mental or verbal (p. 871).

Taylor, 1998	Reflection: key to making sense of human experience, lived experiences accumulate & gather interpretive significance as they are remembered (p. 141). Reflective practice: systematic & thoughtful means by which practitioners can make sense of their practice as they go about their daily work; need for reflection built upon supposition that practitioners know more than they realize & they need ways to bring this knowledge to realization; intends to find meaning within lived experience. Action research cycle - take action based upon understandings arising within a continuous cycle of action-reflection-action (p. 138).
Teekman, 2000	Reflective thinking is a highly adaptive & individualized response to a gap-producing situation & involves a range of cognitive activities in which the individual deliberately & purposely engages in discourse-with-self in an attempt to make sense of the current situation or phenomenon, in order to act. Reflective thinking contributes to better contextual understandings & as such may influence future behaviour (p. 1133).
Van Manen, 1990	Four kinds of reflection: Anticipatory: thinking about possible actions, interventions & outcomes; Active: maintaining & promoting an awareness of what you are doing; Mindful: developing the capacity to be actively reflective & thoughtful; Recollective: considering the success of actions & interventions; cannot reflect on lived experience while living through the experience; not <i>introspective</i> but <i>retrospective</i> ; reflection on experience already passed or lived through.
Visinstainer, 1986	Reflection: gives access to past experience to develop reservoir of tacit knowledge; new horizon of opportunity towards realizing nursing's therapeutic potential.

von Wright, 1992	Greater expertise in reflection is associated with the development of the concept of self. Self reflection implies observing & putting an interpretation on ones own actions, eg, considering one's own intentions & motives as objects of thought; provides access to a new domain of knowledge - relating to the self (p. 61).
Walker & Redman, 1999	Reflection enables us to bring together the essence of nursing with evidence that supports interventions taken; reflective practice includes nursing process skills of self assessment, therapeutic intervention & evaluation, utilization of philosophy, theory & research bases for practice; critical thinking, utilization of multiple patterns of knowing; & self-corrective reasoning (pp. 33-40).
Watson, 1998	Reflective practice, at its most basic core, is about "seeing" & uncovering nursing at its core. In so doing, it has evolved from a critical model of scholarship, which critiques any dominant discourse or overlay of theory. This process of uncovering new meanings "from the ground up," in contrast to "seeing" from the "top down" through the lens of discipline defining theory, creates an inherent dissonance between the latest developments in reflective practice & the movement in theory guided practice as a means of demonstrating nursing's unique approach to both knowledge & practice (p. 214).
Wubbels & Korthagen, 1990	Reflection: mental process of structuring or restructuring an experience, a problem or existing knowledge or insights (pp. 29-44).

Appendix B

Selected Models and Frameworks of Reflection

Source	Model
Armeline & Hoover, 1989	Likened field experience to "night sky" - what we say we see & what that sight means to us is direct function of what we know about what we are seeing. Learning is a direct function of the knowledge structures we employ to make meaning. Education for critical reflection is process by which students become aware of perhaps unarticulated beliefs that have shaped their conception of meaning. In critical reflection those beliefs are subject to examination & may be modified or replaced. Critical reflection is not a point of view but a process of validating or invalidating a given point of view (pp. 42-48).
Astor, Jefferson, & Humphrys, 1998	Framework promotes both objective and subjective outlook. Based upon Mezirow's six levels of reflection (as adapted by Powell, 1989) & O'Brien's five service accomplishments (community presence; community participation; choice; competence; respect). Reflection matrix formed (pp. 567-575).
Atkins & Murphy, 1993	Four stages. <u>First stage</u>: awareness in response to uncomfortable feelings or thoughts; surprise or unique situation where current knowledge insufficient for explanation, even curiosity a trigger. <u>Second stage</u>: critical analysis of situation, constructive, includes examination of both feelings & knowledge of how situation affected person & how person affected situation. Knowledge may be aesthetic, moral, personal, or empirical. <u>Third stage</u>: development of new perspective on situation; outcome is learning of some sort. Person transformed by analysis or application of new information to experience. <u>Fourth stage</u>: make difference to practice outcomes; includes commitment to action. Action is final stage (pp. 1188-1192).

Baker, 1996	Reflection: exploration of an experience to create meaning, with potential of generating new knowledge. Six aspect process: 1. sense of inner discomfort 2. identification or clarification of concern 3. openness to new information from internal & external sources 4. resolution, "aha" stage where one feels has changed or learned something personally significant - spontaneous, unpredictable, manifestation of creativity; new perspective 5. internalization of new perspective, change in oneself 6. deciding whether to act on outcome of reflective process (pp. 19-22).
Boud, Cohen & Walker, 1993	Reflection on learning model: going back through experience & drawing out what seemed significant (return to experience); working with feelings coming out of it, that might help or hinder reflection (attending to feelings); going on to reappraise experience in light of what had arisen (re-evaluation). Final stage involves singling out an aspect of experience & relating it to previous experience & learning (association), integrating new experience with previous learning (integration), testing its validity (validation), & making it our own (appropriation) (p. 73).
Boud, Keogh & Walker, 1985	Individual encounters an experience, responds. Reflective process initiated when individual returns to experience, recollecting what has taken place, replaying experience & re-evaluating. Four elements in re-evaluation: 1. Association - relating new data to already known; 2. Integration - seeking relationships among data 3. Validation - determine authenticity of resulting ideas & feelings 4. Appropriation - making knowledge one's own. ... next page

Boud, Keogh & Walker, 1985 (<i>cont'd</i>)	Outcomes may include the development of new perspectives or changes in behaviour. Synthesis, validation & appropriation of knowledge part of the reflective process, can also be outcomes. Elements separated to draw attention to the various features; elements do not proceed in linear sequence & are not independent of each other. Some stages can be omitted or compressed.
Boyd, & Fales, 1983	Reflective learning & developing understanding - pattern of becoming aware of one's own reflective learning patterns & consciously deciding to use them. Six Stage Reflective Learning Process: 1. a sense of inner discomfort; 2. identification or clarification of concern; 3. openness to new information from internal & external sources, with ability to observe & take from variety of perspectives; 4. resolution, expressed as "integration," "coming together," "acceptance of self-reality," & "creative synthesis;" 5. establishing continuity of self with past, present, & future; 6. deciding whether to act on outcomes of reflective process. Reflective learning key element in learning from experience & a key element in changes of perspective (pp. 99-117).
Brookfield, 1991	Four conceptual clusters central to theory of critically reflective learning in adulthood: praxis of action, reflection on action, further action, reflection on the further action - a continuous cyclic loop.
Carr & Kemmis, 1986	Action Research Model with 4 cyclical phases of planning, acting, observing, reflection.

Cruickshank, 1987	Reflective teaching, ability to analyze one's own teaching practice. Helps teachers become more reflective through structured laboratory experiences in which designated "teacher" teaches predetermined, "content-free" lesson to small group of peers. Reflection here is instrumental to enabling students to replicate teaching behaviours. Knowledge used for application & analysis of practice & reflection is based upon the learners' achievement (pp. 704-706).
Day, 1987	<i>In-Service Model for Promoting Professional Development of Teachers:</i> Intuitive reflection" ("natural" state) which through <i>intervention</i> (provision of time to think, opportunities to identify needs, plan to meet it, share with others, critical theory by external consultants) one moves to conscious reflection. Intervention: deliberative inquiry through school-based action research, leading to self-confrontation. Intervention - support of critical friends, "learning networks" (p. 220).
Dewey, 1910	1. a felt difficulty 2. its location & definition 3. suggestion of possible solutions 4. development by reasoning of bearings of suggestion 5. further observation & experiment leading to its acceptance or rejection (p. 72) <u>Steps/Aspects</u>
Dewey, 1933	1) perplexity, confusion, doubt due to nature of situation in which one finds oneself; 2) conjectural anticipation & tentative interpretation of given elements or meanings of situation & their possible outcomes; 3) examination, inspection, exploration, analysis of all attainable considerations which may define & clarify problem with which one is confronted; 4) elaboration of tentative hypothesis, suggestions; 5) deciding on plan of action or doing something about desired result.

Ertmer & Newby, 1996	Expert learners strategic, self-regulated & reflective. Metacognition facilitates performance of expert learners & reflection provides critical link between knowledge & control of learning process. Concepts of metacognition, expertise & reflection central to this formulation, although relationships among them are not fully articulated. Reflection is the key in the concept of expert learning. Metaphor of warehouse, where reflection transports knowledge between warehouse & learner, stored knowledge may be loaded onto reflection vehicle & delivered to dock. More than acquisition & storing of information, reflection involves ability to draw inferences & to create possible action plans for future (pp. 1-27).
Farra, 1988	<i>Reflective Thought Model</i> I. Pre-reflection of perceived problem II. Reflection on solving problem INFERENCES A. Previewing (observation) B. Suggesting various definitions of problem C. Forming felt difficulty into specific problem to be solved D. Hypothesizing guiding or leading solutions E. Elaborating and reasoning best solution F. Testing the solution in two ways I. Inner coherence with one another of various elements of solution 2. Action or overt verification - imagined or real G. Looping - if testing fails then return to C, D, E, F H. Checking one's attitudes & motives I. Reviewing history of problem & solution J. Forecasting success of solution II Post-reflection of restored stability (p. 6).

Fish, 1991	<i>Strands of Reflection Model</i> (not categories). <u>Four strands</u>: factual, retrospective, sub-stratum & connective; strands both cognitive & affective. 1) Factual strand involves reconstructing practice, drawing mainly upon procedural knowledge of it. 2) Retrospective strand developing holistic theory about & critique of entire piece of practice, mainly procedural knowledge. 3) Sub-stratum strand involves uncovering & critical exploration of personal theory underlying that piece of practice along with consideration of how formal theory relates & could be helpful. Propositional knowledge supports this strand. 4) Connective strand - considering how present theory & practice will relate to future theory & practice, again featuring propositional knowledge. Framework as useful for reflection-in-action & reflective learning. Learners enabled to learn to theorize, moving toward propositional knowledge. Values & beliefs of learners incorporated. Learners assisted to use range of data & consider range of interpretations (pp. 22-36).
Griffiths & Tann, 1992	Five different levels & purposes, all necessary & important. A) Reflection-in-action: likely to be personal & private. 1. Act-react (rapid action); 2. React-monitor-react/rework-plan-act (repair) B) Reflection-on-action: likely to be interpersonal & collegial 3. Act-observe-analyze & evaluate-plan-act (Review); 4. Act-observe systematically-analyze rigorously-evaluate-plan-act (Research); 5. Act-observe systematically-analyze rigorously-evaluate-retheorize-plan-act (Retheorizing & reformulating) (pp. 22-36).

James & Clarke, 1994	Build on three cognitive interests of Habermas: technical, practical, moral-ethical (emancipatory). Add fourth domain - personal. Personal domain serves cognitive interest of emancipation & liberation. Historical evolution (3 phases) to reflective practice: <i>Habituated practice</i>: nursing practice habituated & ritualistic, little attention to rationale, little encouragement to question or reflect on practice; The <i>assumption of empirics</i> - what is known is that which is accessible through the senses - that which can be seen, touched & so forth - basis of research-based practice; leads to "knowledgable doer," but not <i>reflective practitioner</i>. Reflective practice has many dimensions & facets making description difficult. Technical problem solving incomplete & importance of artistry of professional action, tacit knowledge & intuition also required for third phase (pp. 82-90).
Jarvis, 1992	Does not include self in attempts to define reflective practice; reflective practice potential learning situation, does not necessarily result in changed conceptual perspective. All practice is an expression of personal theory (pp. 174-181).
Johns, 1996	Role of facilitator, guide - helping learner expose & confront contradictions while supporting person to challenge beliefs & habits of mind. Process likened to clinical supervision where supervisor present to guide & sustain clinician's development. Clinician's responsibility is to share & reflect upon meaning of self-selected experiences. Cautions against guided reflection becoming "a technology to produce & ideal worker depending on the intent & emphasis of supervisor" (p. 1142).

Johns, 1998	<i>Model of Structured Reflection (MSR)</i> Write description of experience. What are significant issues I need to pay attention to? <i>Reflective cues: Aesthetics:</i> eg. What was I trying to achieve? Why did I respond as I did? How do I know this? <i>Personal:</i> How did I feel in this situation? What internal factors were influencing me? <i>Ethics:</i> How did my actions match my beliefs? What factors made me act in incongruent ways? <i>Empirics:</i> What knowledge did or should have informed me? <i>Reflexivity:</i> How does this connect with previous experiences? What would the consequences be of alternative actions. How do I now feel about this experience? Has this changed my ways of knowing? Empiric, ethical & personal ways of knowing converge upon aesthetic response. Through reflection, practitioner begins to understand how personal, ethical, & empiric ways of knowing have informed aesthetic response. Leads to process of grasping & interpreting situation envisioning what is to be achieved, & responding with appropriate action (p. 4).
Kim, 1999	Method of inquiry based upon action science, reflective practice & critical philosophy. Inquiry designed to encompass 3 phases, descriptive, reflective, & critical/emancipatory. Provides understanding of nature & meaning of practice, correct & improve practice through self-reflection & critique, generate models of 'good' practice & theories of application (pp. 1205-1212).
King & Kitchener, 1994	Levels of reflective judgement Reflective judgement begins in adolescence, pass through seven stages of cognitive growth with last occurring around age 25. Suggests most college students not ready for mature critical reflection.

Korthagen, 1985	A spiral model - <i>ALACT Model</i> 1. Action: confrontation with a concrete situation requiring action 2. Looking at or looking back on situation (analysis) 3. Awareness of essential aspects 4. Creation of alternative solutions or methods of action 5. Trial (pp. 11-15).
MacKinnon, 1996	Propeller image. Each level or stage from other frameworks could be represented by one blade on a propeller, viewed from seat on airplane. In flight (action/practice) propellers spin rapidly, none of blades distinctly visible, function as a whole; see blades together as blur, detecting their function only as work as a whole to move us forward. Unable to say what a move is as distinct from a philosophy; what a theory of practice is, in absence of our activity. Could look through propeller upon a distant landscape, would be aware of a blurring in our vision, reminds that theoretical representations & beliefs about practice may distort world as it is (pp. 653-664).
Mezirow, 1981	Seven level hierarchy of reflexivity: 1. <i>Reflectivity</i>: aware of specific perception, meaning or behaviour; 2. <i>Affective reflectivity</i>: aware of feelings re perception, thought or action; 3. <i>Discriminant reflectivity</i>: assess efficacy of perception, thought, action, habit; 4. <i>Judgemental reflectivity</i>: make & become aware of value judgements; *5. <i>Conceptual reflectivity</i>: assess degree of adequacy of concepts for understanding & judging; 6. <i>Psychic reflectivity</i>: recognize habit of making percipient judgements with limited information; *7. <i>Theoretical reflectivity</i>: aware of why one set of perspectives is adequate to explain personal experience * only occurs in adulthood. cont'd

Mezirow, 1981(cont'd)	Three distinct domains of learning: a) instrumental, task oriented, problem-solving; b) dialogic, understanding others through communication; & c) self-reflective, understanding ourselves. <i>Non-reflectors</i>: no reflective thinking, habitual action. Thoughtful action - selective prior learning review, not deliberate appraisal or reappraisal. <i>Reflectors</i> attend to feelings, & evidence association &/or integration, no critical changes in perspective. <i>Reflection</i> - assess assumptions implicit in beliefs, confirmation, addition or transformation of ways of interpreting experience. <i>Critical reflectors</i>: exhibit reflection & changed perspective. Premise reflection: challenge validity of presuppositions; transform meaning; challenge habitual patterns of expectations, question validity of long-taken-for-granted meaning perspective (pp. 3-24).
Noffke & Brennan, 1988	Model - expressed as cube: two focusing "faces," 'sensory' & 'determinants' dimensions, connected by "ideals/ideology" & "historical-comparative" dimensions. <i>Sensory</i>: all things perceived <i>Determinants</i>: eg. politics, economy, culture <i>Ideals</i>: ideological: eg race, gender, class Reflectivity might be judged in terms of area or volume, with several, non-hierarchical points of entry. No "more is better" but understanding & action in relation to all dimensions should be the goal (p. 25).
Pugach & Johnson, 1990	Four steps 1. clarifying problems of practice by self-questioning in guided learning situation (particular questions posed & responded to) > reframe nature of those problems; 2. summarizing redefined problems; 3. generating possible solutions & predicting what might happen if used; 4. consider various ways of evaluating effectiveness of solutions chosen (p. 189).

Reid, 1993	Takes focus of reflection from description to: a) examine associated feelings; b) evaluate the experience; c) analyze or make sense of the situation; d) reframe to consider alternative actions; e) identify what can inform future actions (pp. 305-306).
Ross, 1990	Five elements of reflective process: 1. recognizing dilemmas; 2. responding to dilemma by recognizing both similarities to other situations & unique qualities of particular situation; 3. framing & reframing dilemma; 4. experimenting with dilemma to discover implications of various solutions; 5. examining intended & unintended consequences of implemented solution & evaluating it by determining whether consequences desirable (p. 98).
Sawada, 1991	Reflection specified as new order that emerges within conversation. Perturbation conversation: system of mutually interacting components/participants. Each component/participant "perturbs" other components, or <i>disturbs their equilibrium</i>. Perturbations may accrue recursively to drive components (& possibly conversation itself) far-from-equilibrium. Generated by recursive self- & cross-perturbation processes. Recursion drives conversation to states farther from equilibrium, each state an enclave in which new order may emerge in the form of new relations that, by their coherence, maintain & stabilize new steady state. As an ongoing process, reflection is the maintenance of the new order in the form of a <i>network of relations</i> that define the new order at a higher level. Reflection is simultaneously new order & maintenance of new order. Conversation postulate - contrast to I-O (input-output) postulate (conduit metaphor). (p. 349-366).

Schon, 1987	Three stages: Conscious reflection; Criticism; Action Process involves two aspects: 1. reflection-in-action, reflections on phenomena & on one's spontaneous ways of thinking & acting, undertaken in midst of action to guide further action; 2. reflection-on-action, reflection after event & reflection on reflection-in-action. Levels of reflective activity in the "ladder of reflection" 4. reflection on reflection on description of designing 3. reflection on description of designing 2. description of designing 1. designing (where designing is ... in its own way, a process of reflection in action) (p. 115) Reflection: a conceptual move, a reconstruction of experience through which person begins to attend to features previously ignored, or integration of knowledge with action through thought. "A dialogue of thinking & doing through which I become more skilful" (p. 31); challenged traditional professional schools as not preparing for competence in real life practice; urged to centre on enhancing practitioners' ability to reflect, reflection in learning can facilitate integration of theory & practice.
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Shapiro & Reiff, 1993	Reflective Inquiry On Teaching Practice; 5 level model as framework, levels arranged in vertical hierarchy top to bottom, various sizes of boxes of decreasing size: philosophy > basic theory > theory of practice > technique > moves. Descending from theory into practice begins with philosophy to deduce a basic theory of practice, & so on, until a particular move is specified. Alternately, ascend "from practice to theory" beginning with a specified move in practice to infer a technique, then from technique to infer a theory of practice & so on, until one arrives at an overarching philosophy. The two forms of reasoning (top down & bottom up) purported to work in tandem to relate theory & practice in a hypothetical-deductive system (pp. 1379-1394).
Smith & Hatton, 1993	Four types of writing related to reflection. <u>Descriptive</u> - not reflective <u>Descriptive reflection</u> - reflective, attempt to provide reason/justification for events/actions <u>Dialogic reflection</u> - "stepping back" leading to different levels of mulling about, discourse with self, & exploring experience/actions; analytical &/or integrative <u>Critical reflection</u> - awareness that actions & events are located in & influenced by multiple perspectives (pp. 13-23).
Stern & Keffer, 1996	Properties of reflective action: movement, intuition, client-driven. Three processes of reflective action: - spreading the word, - political initiative, - community & academic mobilization (pp. 221-226).

Stockhausen, 1995	<i>Action Research Clinical Learning Spiral</i>. Used other models of experiential learning: <u>Action Research Cycle</u> (Carr & Kemmis, 1986): 4 cyclic phases - planning, acting, observing & reflecting; <u>Reflective Process Model</u> (Boud et al., 1985): 3 cyclical stages - returning to the experience, attending to feelings, processing; <u>Critical Experiential Learning Model</u> (Chuaprapaisilp, 1989): 3 phases - preparation for practice, managing experiential learning process, reflecting on experience. Clinically & goal oriented, dynamic & flexible CLS - 4 phases - preparative, constructive, reflective, reconstructive. No limit to # spirals (pp. 363-371).
Teekman, 2000	Spiral of reflective thinking: Begins with each person having unique, pre-perceptions as a result of 'personal baggage;' come across & experience or event requiring creation of meaning in order to (inter)act; range of mental activities (from comparing & contrasting, to discourse-with-self), i.e. reflective thinking, take place to create meaning of event in order to act; person might continue reflective thinking & focus on next level. Model is a spiral leading to ever-increasing amounts of experiential insights & knowing, which feed back into system, returning to awareness & baggage (p. 1132).

Van Manen, 1977	Three hierarchical levels of reflection, related to the Habermas categories. 1) First interest: technical application, enhancing efficiency & effectiveness of technical aspects of practice. 2) Second interest: practical, consideration of appropriateness of purposes & objectives of action in light of experiences, presuppositions, perceptions & understanding of context, with underlying assumptions of action & worth of competing goals. 3) Third interest: emancipation & liberation - served by critical reflection of social, political, & economic constraints on action or moral & ethical issues related to social, political, & economic conditions of practice. The three levels of reflection build on each other. Practice needed to reach identified goals. Relationships exist between practice & principles. There is awareness of ethical & political influences on practice (pp. 205-228).
von Wright, 1992	Programs for <i>adult</i> learning emphasizing reflective skills: Variations on four parts: First you do & you experience; Second you reflect upon your experiences (what did I learn, what did I feel) so as to understand them in perspective; Third, you conceptualize new insights & use them to shape more adequate conception of matter in question, a better theory of it; Fourth, you try out your revised theory & look for new feedback (p. 65).
Wellington, 1996	Five orientations to reflective practice - immediate, technical, deliberative, dialectic, transpersonal - described & discussed. Five orientations depicted as interactive, interdependent aspects of reflective practice, used to develop a framework for research & practice (pp. 307-316).

Zeichner & Liston, 1987	Three hierarchial levels of reflection, related to the Habermas categories. 1) Technical 2) Practical 3) Emancipation & liberation Four qualities 1. technical competence 2. ability to analyze practice 3. awareness of practice as activity with ethical & moral consequences 4. sensitivity to needs of students with diverse characteristics & ability to play active role in developing respect for individual differences (p. 25).
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Appendix C

Orienting Interview Questions and Probes

Introducing questions

Can you tell me about how you understand reflection? How would you describe reflection? What is the nature of reflection?

Do you think there is a purpose/reason for reflection? What would that be?

Are you aware when you are reflecting? How do you know when you are reflecting

What sorts of things/events do you reflect upon? When are you most likely to reflect?

How did you come to know/learn about reflection?

Follow-up questions

Could you tell me in as much detail as possible about a situation in which reflection occurred for you? Can you tell me about an everyday experience of reflection? a difficult experience of reflection? a memorable experience of reflection?

What do you find easiest about reflection? Are you able to identify reflection - in your practice, in someone else's practice?

Can you describe any concerns you may have about reflection? Any attributes, abilities, attitudes necessary for reflection?

Probing questions

Could you say something more about that? Could you give me a more detailed description of what happened; Do you have other examples of reflection?

Interpreting questions

You mean that Does the expression cover what you have just expressed; Do you see any connections. When you think about reflection, what sorts of things come to mind?

Silence

Giving the participant the opportunity to ...

Appendix D

Invitation To Participate

Attention Registered Nurses

You are invited to participate in a study

- ▶ THE PURPOSE OF THE STUDY IS: TO DESCRIBE THE EXPERIENCE OF REFLECTION AMONG SELECTED PRACTISING NURSES IN LONG-TERM CARE.
- ◆ *No preparation required*
- ◆ *You would participate in two audiotaped conversations/interviews each about 45-60 minutes*
 - *In the first conversation you would talk about how you understand reflection, what it means to you, that's what I am interested in.*
 - *About four to six weeks later, you would again participate in a conversation to talk about/consider the meanings and themes which came from the first interviews.*

See abstract (attached) for more information.

If you are interested please give me a call at 722-6521 ext 6002, I would be delighted to hear from you.

Nancy Brookes, RN 722-6521 x 6002

Clinical Nurse Consultant - Royal Ottawa Hospital

Graduate student - University of Ottawa, Faculty of Education

Appendix E

Modified Abstract

Understanding Reflection:
An Interpretive Study Among Selected Practising Long-Term Care Nurses
Nancy L. Brookes
Faculty of Education, University of Ottawa
PhD Research Proposal

Reflection has a long history as a valued component of professional practice. Reflective terminology has entered the discipline of nursing and enthusiasm for the use of reflection and reflective practice is evident. Participation in reflective practice has recently become a basic requirement of the College of Nurses of Ontario (CNO) for all registrants. In order to discuss reflective practice, first it is necessary to consider reflection itself. In requiring nurses to be reflective practitioners, there is an assumption that we know what reflection is. We are, therefore, challenged to explain the phenomenon of reflection, and to wonder whether reflection is a plausible or attainable reality. One significant knowledge gap that remains unexplored is practising nurses' experience of reflection. Review of the extant models of reflection together with the focused literature review reveal selected attributes of reflection which form a developing framework for understanding the nurses' experience of reflection.

The purpose of this study is to describe the meaning of reflection from the perspective of registered nurses engaged in active practice.

* The phenomenological question which will guide this study is: how do practising nurses experience reflection? Where, when, and how does reflection enter the experience of practising nurses?

The nature of reflection as experienced by practising nurses, using a hermeneutic phenomenology design, will be explored in this study. An inductive, descriptive qualitative research method, phenomenology attempts to study phenomena as they are consciously experienced and to come to a deeper understanding of the nature of the experience. This study focuses on first person accounts of nurses' experiences of reflection, because this particular perspective is absent in the nursing literature on reflection and reflective practice.

Eight nurses engaged in practise in long-term care in Ottawa-Carleton will comprise a purposive, cohesive sample; and they will engage in two audiotaped interviews. Analysis of the data will enable the identification of themes and patterns. Themes and interpretations will be presented for discussion and further illumination in a focus group.

This exploratory study will advance our knowledge of reflection, particularly from the perspective of nurses who must enact reflection and reflective practice. Inclusion of practitioners' perspectives will broaden our understanding of the complex phenomenon of reflection and the thick description of the participants' perspective will provide a more solid conceptual foundation for reflection. This critically needed empirical research will also contribute to the advancement of the profession, where reflection and reflective practice are demanded but definitions and translation into practice remain vague. It re-enforces the concept of nurses as "knowledge workers" as opposed to "doers" and contributes to the broader social potential of the profession.

Appendix F
Consent Form

Principal investigator: Nancy Brookes, PhD student, Faculty of Education, University of Ottawa. 722-6521 ext 6002

Whenever a project is undertaken with human participants, the written consent of the participants must be obtained. This does not imply, of course, that the project in question necessarily involves a risk. In view of the respect owed the participants, the University of Ottawa and the research funding agencies make this type of agreement mandatory.

The purpose of the study is: To describe the experience of reflection among selected practising registered nurses in long-term care.

If I agree to participate, my participation will consist of attending two audiotaped interview sessions to discuss my experience of reflection. In the first session, I will talk about how I understand reflection and what I believe constitutes reflection. In the second interview we will talk about the meanings and themes from analysis of the first interview and I may change my descriptions or meanings. Interviews will be scheduled at a time and place convenient to me. I understand that the information collected will be used only for the PhD thesis, and subsequent publication in a scholarly journal. I understand that since this activity deals with personal information, it may induce emotional reactions which may, at times, be somewhat negative. I have received assurance from the researcher that every effort will be made to minimize these occurrences.

I am free to withdraw from the project at any time, before or during an interview, refuse to participate, and refuse to answer questions without penalty.

I understand that my identity will not be revealed in any way in the study as pseudonyms will be used. I have received assurance from the researcher that the information I will share will remain strictly confidential and the data will be securely stored.

Any information requests or concerns about the ethical conduct of the project may be addressed to the Secretariat of the Ethics Committee (562-5800, ext 4057). If I have any questions, I may contact Dr. M. Taylor at 562-5800, ext 4037, or Nancy Brookes at 722-6521 ext 6002.

There are two copies of the consent form, one of which I may keep.

Participant's signature

Date

Researcher's signature

Date

Appendix G
Focus Group Consent Form

Principal investigator: Nancy Brookes, PhD student, Faculty of Education, University of Ottawa. 722-6521 ext 6002

Whenever a project is undertaken with human participants, the written consent of the participants must be obtained. This does not imply, of course, that the project in question necessarily involves a risk. In view of the respect owed the participants, the University of Ottawa and the research funding agencies make this type of agreement mandatory.

The purpose of the study is: To describe the experience of reflection among selected practising registered nurses in long-term care.

If I agree to participate, my participation will consist of attending one audiotaped focus group session to discuss my experience of reflection and what I believe constitutes reflection. The focus group will take place following the completion of an education program. I understand that the information collected will be used only for the PhD thesis, and subsequent publication in a scholarly journal. I understand that since this activity deals with personal information, it may induce emotional reactions which may, at times, be somewhat negative. I have received assurance from the researcher that every effort will be made to minimize these occurrences.

I am free to withdraw from the project at any time, before or during the focus group, refuse to participate, and refuse to answer questions without penalty.

I understand that my identity will not be revealed in any way in the study. I have received assurance from the researcher that the information I will share will remain strictly confidential, and the data will be securely stored.

I assure other participants that I will treat in a confidential manner any information I obtain in the course of this study

Any information requests or concerns about the ethical conduct of the project may be addressed to the Secretariat of the Ethics Committee (562-5800, ext 4057). If I have any questions, I may contact Dr. M. Taylor at 562-5800, ext 4037, or Nancy Brookes at 722-6521 ext 6002.

There are two copies of the consent form, one of which I may keep.

Participant's signature

Date

Researcher's signature

Date

Acknowledgements

Reflection. "When I use a word," Humpty Dumpty said in a rather scornful tone, "it means just what I choose it to mean - neither more or less." "The question is, " said Alice, "whether you *can* make words mean so many different things" (Lewis Carroll 1865/1946, p. 237).

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Writing is a joy – so saints and scholars all pursue it.

A writer makes a new life in the void, knocks on silence to make a sound,
binds space and time on a sheet of silk and pours out a river from an inch-sized heart.
As words give birth to words and thoughts arouse deeper thoughts,
they smell like flowers giving off scent,
spread like green leaves in spring, a long wind comes, whirls into a tornado of ideas,
and clouds rise from the writing-brush forest.

(Lu Ji (261-303) cited in Barnstone & Ping, 1996, p. 10)