Discovering New Connections: Insights From Individual and Collective Reflexivity in a Mixed Methods Study

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Abstract
Through intentionally engaging in reflexivity, researchers can be transparent about potential areas of social inquiry and analysis that might be subject to a priori assumptions, personal biases, and interpretations that are not rooted in the data. In the context of conducting research with others, reflexivity also includes a collective dimension in which each researcher’s positionality interacts with the others and shapes research outcomes. Fostering collective reflexivity within interdisciplinary teams enables the researchers to process conflicting perspectives, allow creative and innovative approaches to emerge, and develop a shared vision of the research concepts, methods, and outcomes. Despite its acknowledged value, the integral process of reflexivity is rarely documented in mixed methods social inquiry. In this article, we describe the process of reflexivity through individual and collective team insights gained within a mixed methods study that examined the lived experiences and perceptions of breastfeeding among African American women and their support partners. We describe three components of the reflexivity practice we engaged in: 1) Self-led; 2) Relational and team-led; 3) Methods-focused and team-led. We discuss how this process challenged, shaped, and enriched data analysis, data integration, and finally, our understanding of the research findings.

Keywords
individual and collective reflexivity, mixed methods social inquiry, positionality, interdisciplinary teams

Introduction
With the postmodern turn in qualitative inquiry, researchers began to question the idea of an ‘external reality’ that could be discovered through ‘objective’ research practices, leading to overt and critical examination of the partial and experiential nature of knowledge claims (Charmaz, 2014; Clarke, 2005). Reflexivity is now widely recognized as a tool to facilitate understanding of the role of self in knowledge production (Jacobson & Mustafa, 2019; Mao et al., 2016; Mauthner & Doucet, 2003). An integral part of the reflexivity process is accounting for researcher positionality and how it may influence the conduct of research (Berger, 2015; Gilgun, 2008). Positionality is shaped by the researcher’s social location (e.g., socio-economic status, race, ethnicity, gender, nationality, sexuality), academic training (i.e., research paradigms, disciplines, epistemology), and life experiences (Dill & Kohlman, 2012; Mao et al., 2016; Milner, 2007). Positionality influences researcher-participant interactions and the ways in which researchers interpret participants’ accounts and experiences (Mao et al., 2016). These influences take place in all phases of research, including the decision to conduct a research project, formation of research questions, data collection, analysis, and interpretation (Jacobson & Mustafa, 2019; Mauthner & Doucet, 2003). Thus, it is not...
only the research concepts and methodologies that needs to be scrutinized, but also the role of the researcher (Berger, 2015). Through explicit documentation of positionality, both during the research process and dissemination of the outcomes, researchers can be transparent about areas of inquiry and analysis that might be subject to a priori assumptions, personal biases, and interpretations that are incongruent with the data (Savin-Baden, 2004; Woodley & Smith, 2020).

In the context of conducting research with others, reflexivity also includes a collective dimension in which each researcher’s positionality interacts with the others’ and shapes research outcomes (Probst, 2015). Intentionally fostering collective reflexivity enables the researchers to communicate about their own positionality to others, and challenge others’ as well as their own ideas (Cain et al., 2019; Widmer et al., 2009). Reflexive thinking and action improves team-level communication and incorporates diverse knowledge and skills that each team member possesses, particularly in multidisciplinary research settings (Widmer et al., 2009). This way, research teams can process conflicting perspectives, allow creative and innovative approaches to emerge, and develop a shared vision of the research concepts, methods, and outcomes (Cain et al., 2019; Widmer et al., 2009). Thus, collective reflexivity benefits research teams in two interrelated ways: critically assessing how individual and team-level positionality influence the conduct of research, creating effective collaboration dynamics within the team (Walker et al., 2013; Widmer et al., 2009).

Reflexivity within research teams constitute the first domain of the commonly used Consolidated Criteria for Reporting Qualitative Research checklist (Tong et al., 2007). However, researcher positionality and reflexivity at the team level are rarely addressed in mixed methods research, particularly concerning the influence of researcher positionality on how qualitative and quantitative components are integrated with one another (Cheek et al., 2015). Mixed methods research draws on the strengths of qualitative and quantitative methods by combining them in a variety of ways to more robustly explain a question of study (Creswell & Clark, 2017; Halcomb & Hickman, 2015; Teddlie & Tashakkori, 2009).

Documentation of reflexivity is an expected part of qualitative research, given the naturalistic assumptions that knowledge, context, and realities are multiple, constructed, and inextricably linked to the knower/researcher (Lincoln & Guba, 1985). In contrast, quantitative research arises from a positivist paradigm, in which reality is single, separate from, and discoverable by the knower/researcher. There is an underlying assumption that researchers can and should position themselves as neutral, unbiased observers of cause-and-effect processes. Differences between these philosophical world views are even reflected in the language researchers use to describe research conduct: qualitative researchers more often use an active voice and first-person language, while quantitative researchers are more likely to use a passive voice that obscures the presence of the researcher. This incongruence of expectations in qualitative and quantitative research reporting creates an innate tension for mixed methods research, particularly in assessing the role of researcher positionality (Hesse-Biber, 2010). Scholars have been challenging this long-standing sharp dichotomy between the conventional philosophical frameworks that guide qualitative and quantitative research. There are growing efforts now to integrate reflexivity in all research practice, in a way that can engage with diverse processes included in different research designs (Kingdon, 2005; Lazard & Mcavoyle, 2020; Ryan & Golden, 2006). Given that qualitative and quantitative components are integrated in mixed methods research to produce a more nuanced, comprehensive understanding of the research phenomena, reflexivity should be essential to not only the qualitative component, but rather the entire research process (O’cathain et al., 2008).

Greene (2006) identified four interlinked domains that constitute a methodology for mixed methods social inquiry: 1) Philosophical assumptions and stances; 2) Inquiry logics (i.e., research design, sampling strategies, data collection etc.); 3) Guidelines for practice (i.e., “how to” of the research activities); and 4) Sociopolitical commitments. Conventional applications of reflexivity often engage with domains 1 and 4. Indeed, through reflexivity researchers can clarify the philosophical framework, worldviews, and agendas underpinning their social inquiry. (Howes, 2017). It is less common that researchers intentionally apply reflexive strategies to examine and guide the choices they make in domains 2 and 3. Yet, reflexive practices are crucial in identifying: (a) the reasons for adopting a mixed methods design; (b) the temporal order in which qualitative and quantitative components take place; and (c) when and how data integration occurs (Hesse-Biber, 2010).

Despite its necessity and value, process of reflexivity is rarely documented in mixed methods scholarship (Cain et al., 2019; Cheek et al., 2015). As the “how” of reflective practice in mixed methods is still being explored (Cain et al., 2019; Probst & Berenson, 2014), the purpose of this article is to contribute to the literature by describing the process of reflexivity through individual and collective team insights gained within a mixed methods study. We start with a brief description of the mixed methods research design to help the reader contextualize our efforts, followed by the presentation of a model that depicts three main components of our reflexivity practice, and then provide individual accounts of reflexivity. Finally, we describe and discuss the process of collective and relational reflexivity, including its implications on data integration and research findings.

**Context: A Mixed Methods Sequential Explanatory Design**

When TMF and JRJ, African American women faculty at the University of South Carolina, came together and planted the seeds for this study, their greatest motivation was to gain a better understanding of the complex, multi-level reasons...
behind low rates of breastfeeding in African American communities. It was striking that despite the substantial number of quantitative and qualitative studies on breastfeeding attitudes and experiences among ethnic minority women, African American women’s lived experiences, particularly in the South, were not captured comprehensively (Felder et al., 2022). Thus, they decided to adopt a sequential explanatory design to: a) assess knowledge, attitudes and perceptions of breastfeeding among African American women and their partners/family members; and b) explore breastfeeding experiences and identify the barriers to and facilitators of breastfeeding among this population in South Carolina. Subsequent qualitative data collection to make sense of the findings from the quantitative phase would allow the researchers to further examine the sources of negative attitudes and perceptions, inaccurate knowledge about breastfeeding, as well as understand how these were at work when African American women were not able to breastfeed even when they wished to do so. As a team, we reflected on their decision about the research design retrospectively, as it concerned the “methods-focused and team-led” (Figure 1) component of the reflexivity practice that will be discussed in the following section.

In Phase I (April – June 2015), TMF and JRJ administered a multiple-choice questionnaire to 50 pregnant, African American women at a local women’s health clinic. They assessed the participants’ socio-demographics (e.g., relationship status, education, insurance status), intentions for feeding their new baby (breastfeeding and/or formula), reasons for their feeding decision (e.g., convenience, plan to return to work), actual and preferred sources of information on infant feeding (e.g., websites, health care providers, mobile applications). They also assessed general knowledge, attitudes, and perceptions about breastfeeding using the Iowa Infant Feeding Attitudes Scale (Mora et al., 1999). Phase II (January – March 2016), consisted of semi-structured, qualitative interviews with a convenience sample of four dyads of African American women in South Carolina who were currently breastfeeding or had breastfed in the previous 24 months, and their designated support partner. In the interview, the researchers asked participants about their breastfeeding experiences, including their reasons for breastfeeding, challenges experienced, and their perceptions of reasons why breastfeeding is not widely practiced within the African American community.

Following the quantitative and qualitative data collection phases, TMF and JRJ invited two doctoral students to the research team, EC and CN. EC was from Turkey and CN was from Nigeria. EC and TMF led the quantitative data analysis while all team members participated in the qualitative data analysis, interpretation, and integration of results.

Components of the Reflexivity Practice within a Mixed Methods Study

Reflexivity practices in our study included three main components: situating oneself and examining positionality (self-led), examining interactions between different perspectives that exist within the research team (relational and team-led), and providing rationale for decisions at different stages of the mixed methods research (methods-focused and team-led) (Figure 1). Figure 1 depicts these components and the questions that guided how we engaged with each component.
These questions were informed by the theory of reflexivity (Alvesson & Sköldberg, 2009; Denzin & Lincoln, 2011; Ellis & Bochner, 2000), and a literature review of previous studies that documented how researchers have engaged in reflexivity during qualitative and mixed methods studies (Berger, 2015; Cain et al., 2019; Carolan, 2003; Dowling, 2006; Lambert et al., 2010).

Another important framework that guided the ways in which we engaged with these questions as well as the data was intersectionality. Originating from the early work of Black feminist scholars, and coined by Kimberlé Crenshaw, intersectionality is both a theoretical orientation and an analytical tool that guides the researchers in developing a critical understanding of the mutually constructive, fluid and complex relationships between social identity categories such as race, ethnicity, gender, sexual orientation, nationality and class (Carbado et al., 2013; Crenshaw, 1991). Even though we did not apply intersectionality systematically from the earlier stages of our research, starting with the data analyses it became a prominent lens that shaped how we understood diversity of participant experiences and their implications for breastfeeding outcomes. All female participants shared the same racial and gender identity; however, their class, educational status, and marital status differed to result in a diverse set of breastfeeding knowledge, attitudes and resources needed to care for an infant. Thus, looking through an intersectional lens promoted a nuanced, deeper, critical understanding of the data. Furthermore, this lens aided us in sharing and discussing multiple perspectives of data within the research team.

In the following section, we describe how each researcher engaged in the “self-led” component of the reflexivity practice. Then we follow by discussing the team activities and insights that capture the “methods-focused” and “relational” components of the reflexivity practice (Figure 1).

**Individual Accounts of Reflexivity: Stories that are Woven into Our Research**

Each team member identified the most relevant dimensions of their multiple and intersecting identities within the research context, and reflected on how their lived experiences, values, and beliefs shaped their approaches to data analysis and interpretation. We also discussed how our understanding of the research phenomenon was influenced, and in some cases, transformed through the diverse perspectives offered by each research team member.

**EC - Graduate student, physician from a different context, feminist public health researcher**

Although being a trained physician and public health researcher provided me the general knowledge on international breastfeeding promotion efforts, I was aware of my outsider position in this study which concerned experiences, attitudes, and beliefs of breastfeeding within the African American communities of South Carolina. Also, I became a part of this research project after the data were collected by two other team members. Having limited familiarity with the research context, I initially felt hesitant about arriving to strong judgements on participants’ accounts and tried to consult with the team members whose work and lives were situated in this context for a longer time.

EC, a physician from Turkey, moved to US in 2011 to pursue a doctoral degree in Public Health. Growing up as an ethnic minority member in Turkey, she recalls always having a heightened awareness of the unique health problems and disparities faced by the ethnic minority populations and therefore, developing an interest in community-level collaborations to address those disparities. At the time of this study, she has been living in South Carolina for 5 years. Her understanding of the ways in which socio-cultural context of the South shapes breastfeeding disparities among African American women living in the state was grounded in her educational experiences as an international graduate student in the US. She acknowledged her positionality as an outsider and scrutinized its role in the contributions she made to the knowledge production within this study. However, she did not allow this outsider position to dominate her relationship with the participants’ accounts and the analysis process. This would not be possible without engaging in reflexivity and answering the guide questions developed by the research team (Figure 1).

During the iterative stages of coding and analysis, she considered not only the differences, but also similarities between women’s experiences of breastfeeding in different cultures. The training she received at a medical school in Turkey was shaped by social, political, and cultural dynamics of the Turkish society, but it was also rooted in the traditions of Western medicine. Therefore, she was able to reflect on how health care system factors may influence breastfeeding initiation and duration among women who receive health care in Western tradition. For instance, participants shared that they did not receive enough information and encouragement about breastfeeding from their obstetrician, an experience EC observed among women in Turkey as well. Being engaged with the data reflecting African American women’s expressions of pain, guilt and lack of support while trying to breastfeed brought back some childhood memories, and took her back to the time when her brother was born in 1990:

Although being seven years old then, very aware of my surroundings and observing what was happening in our home. I recall a crowded house, with neighbors and my mother’s friends visiting, my aunt and my grandmother staying with us. Images I carry from that time are marked with the pain and sadness on my mother’s face, amid women’s anxious efforts to help her breastfeed the new baby. Despite trying different methods (e.g., consuming galactagogues, increasing liquid intake, using a breast pump), and encouragement from friends and family, my mother was not able to breastfeed due...
to low supply. Even years later, this issue would be a source of tension between my mother and grandmother. Any small health problem my brother experienced would bring back the resentment about the fact that he was not breastfed as a baby. I sensed the guilt my mother was feeling.

These childhood memories also gave her insight into the feelings and experiences of African American women who might feel shame and guilt due to not being able to breastfeed or choosing not to breastfeed. Reflecting on the complexity of societal stigma around breastfeeding encouraged EC to critically look at the ways in which exclusive breastfeeding is often presented as the ‘most respectable’ and ‘right’ choice in the public health literature. This in turn, led to her questioning the unintended consequences of such approaches to breastfeeding promotion. This was an important consideration for EC as she strives to apply a feminist intersectional lens (Hankivsky, 2014) in her research on women’s health issues to avoid essentialist views of womanhood and motherhood:

Even though we did not consciously take an intersectional approach in analyzing the data, certain questions we were asking as a team encouraged me to apply an intersectional framework. Some of those questions were: “What are the similarities and differences between the experiences of lower income, less-educated, young, and/or single African American mothers, and middle or higher income, educated, older African American mothers who have a supporting partner or a spouse?” “Do the cultural misconceptions around breastfeeding affect these two groups of African American women in similar or different ways?

Using a feminist intersectional lens allowed EC to observe micro practices of power within African American communities which shaped attitudes and beliefs of breastfeeding, as well as the complex breastfeeding experiences among African American women. For instance, it was challenging for educated African American women to confront the stigma within their communities when they considered breastfeeding without a cover, even though they referred to breasts as “natural bottles” and criticized how breasts were sexualized in popular media images. Still, these participants seemed to be contemplating about the possibility of these community norms changing in the future, allowing African American women to comfortably breastfeed in public without a cover 1 day.

For EC, the value of working with a diverse research team was rooted in the experiential knowledge that her colleagues offered: TMF recounted her own experiences with breastfeeding, while CN and JRJ reflected on the times they served new mothers in clinical settings of two very different contexts, South Carolina, US, and Lagos, Nigeria. These exchanges were transformative for her understanding of breastfeeding norms and experiences in different cultures.

**TMF – African American Mother Of Two Children, Assistant Professor, Health Disparities Researcher**

I knew before my children were born that I wanted to breastfeed. I had several friends who were also first-time or new mothers and family members in my network who had breastfeeding experience. My husband was also a supporter of me breastfeeding our children. Like other mothers whose stories I had heard, I quickly realized that breastfeeding may be natural, but it is not easy. Both of my children had to receive formula supplementation in their early weeks of birth due to my milk supply coming in late. Having to supplement early made me feel like a failure as a mother but it did not break my desire to continue.

As a researcher committed to improving the breast-related health of African American women, TMF was aware that racial breastfeeding disparities between African American and White women were not fully explained by socioeconomic status and education level and continued to disadvantage health and well-being among African American women of different social locations. Collaborating with JRJ to formulate a study that would focus on breastfeeding experiences in African American communities, she decided that the complex questions they were asking required a mixed methods research design.

Her interests as a public health researcher and activist academician were intertwined with the close ties she developed with the research phenomena through the lens of her own motherhood experiences. Although she had a supportive partner who was responsive to her needs, having to continue breastfeeding while one of her breasts bled and cracked made it very challenging for the first 2 weeks. Experiencing a limited flow of breastmilk at times, she felt disappointed that her body was failing her. Her partner continued supporting her through these challenges and she exclusively breastfed her first child for 5 months, and her second child for nearly 6 months. Yet, physiological hurdles of breastfeeding were not the only challenges she faced during this time. Returning to work added a more complex layer of difficulty:

I really wanted to breastfeed my children longer, but when I had to return to work, found it to be very stressful. Even though I had wonderful support in the work environment, I had a hard time relaxing while using the breast pump, and in general, never seemed to have a flow of milk when pumping. My particular job pressure at that time was to obtain external research funding and it was constantly in the back of my mind. I also felt a constant, inner pressure to be an even more productive scholar to avoid the “baby penalty” that negatively affects the careers of many women faculty in academia. I did not want to be a statistic. With all these pressures, it is no surprise that I had difficulty pumping. This was very discouraging to me and overtime it seemed impossible to rebuild my milk supply.
Her experiences taught TMF that “choosing” to breastfeed is not always a simple, one-time decision. Rather, it was a decision that needed to be made and remade daily based on the tangible and psychological resources at hand. There were only two options: breastmilk or formula. Understanding how this decision was wrought with emotion and tension from both internal and external expectations and pressures, TMF approached this research with an eagerness to make sure that the research team would not demonize women who choose not to breastfeed, but rather learn from the study participants’ experiences, perspectives, and transform this knowledge into public health strategies that support women who choose to breastfeed.

TMF brought not only her personal breastfeeding experiences and social identity to the process of analyzing and interpreting the data, but also her formal academic and research training to the table. These dimensions of her reflexivity practice mutually constructed each other, and shaped the methodological approaches used by the team, through the suggestion she made at a critical point in the analysis. She participated in a qualitative research coding course taught by Dr Saldaña and realized that using affective coding approaches, particularly versus coding, would allow the research team to bring attention to the ongoing conflicts that African American mothers face when considering to breastfeed. Through this approach, she could also acknowledge her own emotions that arise while engaging with the data, as well as the difficult emotions experienced by the African American women participating in the study. After completing a couple rounds of coding with various affective coding techniques, the team decided to adopt versus coding in their analysis.

As TMF was acquainted with some of the study participants in Phase II, her reflexivity practice included thinking through her relationship and interactions with the study participants during the interviews:

I feel very connected to other African American mothers, some of whom volunteered to be research participants in our study. I acknowledge that knowing the participants could invite some level of bias; however, I also feel that it allowed for more of a natural conversation during the interviews, where the mothers and their spouses were not apprehensive about sharing their intimate experiences and challenges with breastfeeding.

TMF had access to an insider’s view about the communal norms and attitudes around breastfeeding. Her previous life experiences led to several assumptions she made prior to data analysis:

In combination with my identity as an African American mother, I was born and raised in South Carolina. Being a “Southern girl,” you learn through subtle social cues, to be both respectful and polite, sometimes to a fault. For instance, I understood that some Southerners might view breastfeeding—particularly in public—as disrespectful. So, when we started analyzing the data, I expected African American women to express apprehension around breastfeeding in public and even to receive some discouragement from their older female family members. Being judged by trusted family members about potential breastfeeding decisions can cause embarrassment and confusion well before an African American woman is faced with the decision to breastfeed or not.

As a result of team discussions and debriefing sessions, TMF began to appreciate a feminist perspective in this area of research which she had not been aware of in the past. For instance, when EC suggested that “sexualization of breasts” was emerging as one of the major themes in the data, TMF realized that she might previously have overlooked how social constructions of women’s breasts (i.e., natural vs. sexual) may shape African American women’s decisions around breastfeeding. Working with EC and CN, she also reflected on the ways in which a feminist lens on women’s sexuality further intersected with the varying international contexts of breastfeeding. Learning about other countries such as Nigeria where breastfeeding was the norm (vs. exception) within the culture, institutions, and supported through laws (e.g., paid maternity and/or paternity policies) gave her hope and encouraged her to continue her efforts as a public health researcher to address racial breastfeeding disparities in the US. For her, these learning experiences reinforced the importance of cultural breastfeeding norms within African American communities and the overall society as intervention targets to create sustainable change in breastfeeding rates.

CN — A Midwife and Maternal and Child Health Specialist from Nigeria, Graduate Student

I never imagined that a healthy mother would not breastfeed her baby at least for three months. Breastfeeding is so common [in Nigeria] that I remember having a heated conversation in a midwifery class when the professor argued for discouraging HIV positive mothers from breastfeeding. As a midwife, I advocate for exclusive breastfeeding.

CN’s approach to researching racial breastfeeding disparities was grounded in her experiences as a Nigerian nurse-midwife who has served as a head nurse at a maternity hospital in Lagos, Nigeria before becoming a graduate student in the US. During her clinical work in Nigeria, CN promoted exclusive breastfeeding at least for the first 4 months after birth and supported mothers in their breastfeeding efforts.

CN shared that in Nigeria, social and cultural norms were supportive of breastfeeding, which was considered the “normal practice” when it comes to feeding an infant. Formula feeding on the other hand was seen as “an irresponsible act.” Despite the wide support in society however, CN recalled that some women she served at the hospital chose to feed their babies with “pap” – a mix of mashed corn and water. Women sometimes would use “pap” based on a family member’s,
friend’s advice, or due to breastfeeding challenges such as not having a sufficient supply of milk, cracked or engorged nipples, not latching the baby properly, difficulty of weaning the baby from breastfeeding, and not having a live-in nanny. CN and her team in Nigeria developed a program including home visits within 2 weeks of delivery and regular phone calls prior to the 6 week’s postpartum visit to encourage mothers to exclusively breastfeed and address their physical and psychological needs during this time.

Lived experiences of African American women in South Carolina, of which CN learned during this study, were contrary to her priori assumptions:

I naively thought that breastfeeding experiences, attitudes, and beliefs within African American communities of South Carolina would be similar to the ones I observed in Nigeria. With this study, I was exposed to the literature on breastfeeding among African Americans and became conscious of the differences in social practices and policies about breastfeeding between the two countries. For example, in Nigeria, women are given minimum of four months paid maternity leave, and they work half day (6 hours) till their baby is at least nine months old. Most women in the US don’t get to benefit from such policies which makes it impossible for them to spend enough time with their infant when they are willing to do so. Also in Nigeria, the collectivist culture allows for a more supported transition into motherhood through mobilizing extended relationships; the grandmother or an elder woman in the family often moves in with the mother for at least a month of postpartum care.

In South Carolina, paid maternity leave was much shorter for many African American women, and such close family support upon birth was not always an option. Reflexivity practices we engaged in resulted in a realization that I needed to ground my research efforts and conclusions within the unique context of the participants. Then I asked myself: “How have my past experiences in Nigeria influenced the assumptions I made prior to analyzing the data in this study?” and “How can I re-situate my understanding of the participants’ experiences and perspectives that are rooted in this context that is socially, culturally and politically different than the one in which my beliefs were shaped?”

As the analysis of the interview data revealed how community-level breastfeeding beliefs, norms, and attitudes might influence African American women’s willingness and ability to breastfeed, CN re-evaluated the preconceived notions she brought to the study. The social location(s) African American women occupied within the US society as members of a minority population were quite different than those Nigerian women experienced within their country. CN expressed: “Even though there are tribes and there is tribalism in Nigeria, we are all black. I have not observed significant cultural differences among tribes in terms of how they perceive exclusive breastfeeding. Exclusive breastfeeding is supported widely and the prevalent norm across the society is that the main purpose of women’s breasts is to breastfeed.” Applying an intersectional lens when answering the reflexive questions, she scrutinized the complexity of meanings that “being black” takes on in different countries and cultures, as well as the implications of this complexity for breastfeeding behaviors and support levels for breastfeeding women.

Being exposed to new coding techniques that she had not used before helped her keep an open mind about the data, and critically think through every participant account. For instance, using versus coding was remarkable in that it revealed the conflicts and tensions about breastfeeding within the participants’ communities, as well as the potential solutions to those issues from the perspectives of the study participants. She was fascinated by how a participant’s account could have multiple meanings when filtered through different lenses, and how teamwork could yield innovative results when collaborating with researchers from diverse backgrounds. Comparison of the geographical, political, and cultural determinants of breastfeeding in Nigeria and US provided her a unique insight on context-specific interventions to promote and support breastfeeding among African American women in the US.

**JRJ - Junior Faculty, Maternal and Child Health Nurse, Women’s Healthcare Researcher**

As a Southern African American woman, I am very familiar with the popularity of formula feeding and the commonality of such a method within our culture. In the South, there is an air to being “proper and respectful.” A woman baring her breasts in public is seen as disrespectful by most despite the purpose of this revealing act.

JRJ’s beliefs and values about breastfeeding were shaped by her experiences as a clinical nurse, instructor, and an African American native of South Carolina. She did not recall seeing many women around her breastfeeding during her youth. Her aunts and older cousins formula fed their newborn babies, and as she got older, she helped her relatives out by changing diapers and feeding the baby. Formula feeding appeared to be the “normal” choice, and the idea that there was another option seemed foreign and unknown in her community. It was common for women to formula feed their babies during the day’s service in her church:

I would observe as young mothers would retrieve bottles laden with white powder into which they would add water. It would magically turn into formula and then they would proceed to feed their frustrated and hungry infant. During service, some mothers would quietly get up and escape out of the side door towards the back of the church where I assumed they were going to change the baby’s diaper. If they were breastfeeding, I had no idea as it was considered a private matter and not something you saw or likely discussed.
In one of JRJ’s childhood memories about breastfeeding, a young woman disrupts the unsaid rule of breastfeeding invisibly:

I grew up in a Southern black church in South Carolina. I was around nine or ten years old, and I was active in many facets of our church, one being the youth choir. On this beautiful, sunny Sunday morning, we had just finished our song, and our pastor had gotten up to preach… That Sunday, there was a young woman and her family who visited with us. They sat on the front seat of the church. She had an infant with her, perhaps only a few months old. The choice she made by sitting on the front row was not what I expected. What’s more, she chose to publicly feed her newborn during the service. She casually opened her blouse and put her fussy infant to her bosom. She did not use a cover or attempt to hide this exposure. I remember being shocked as she was displaying a part of her body that I was taught was private and should not be visible to others. She politely smiled as many of us, young children looked on amazed from the choir loft. I thought that this exposure would surely mess up the preacher or disrupt the very air of the congregation. Her husband and surrounding family did not make an issue of this at all and continued to listen to the preacher. She continued to smile when she noticed our glance and continued to nurse and care for her child. She seemed very happy and at ease with her choice and the experience.

Prior to her work as a nurse, JRJ did not think that she would be willing to try breastfeeding in the future. Over time, through her clinical training and experience, she started to see breastfeeding under a different light. Working with new mothers at the hospital and supporting them in their efforts to breastfeed was transformative for her: she went from planning to only breast pump and bottle feed to feeling excited about the idea of breastfeeding her own child 1 day. Another significant experience that shaped her attitude towards breastfeeding was her mother’s breast cancer diagnosis in her early 30s:

My thoughts on breastfeeding have changed. The concerns I had about feeling pain while breastfeeding, the chance of breast engorgement, or not having enough support were early deterrents. I also feared not being able to go back to work, my breasts sagging, and the sexuality component of my marriage being lost because of breastfeeding. Perhaps education about benefits to mom and baby or the relationship of breast cancer to breastfeeding have altered my thoughts. I think back to my mom’s fight with breast cancer in her early 30’s and contemplate about its implications for my own health. Fortunately, it was caught and treated early, and I remember very little about that time. Now in my mid-thirties, I am constantly aware of what I need to do for breast health.

JRJ observed breastfeeding disparities firsthand while she served as a nurse at a hospital in South Carolina. Although her patients consisted of both African American and White women, most of the mothers she assisted with breastfeeding and pumping were White. In addition, most adolescent mothers did not breastfeed, regardless of their race. Most White mothers receiving breastfeeding support ranged from 20–30s in age, were privately insured, educated, and married. While some African American women also fit these characteristics, majority were young mothers who did not have private insurance, were single, and had lower levels of education. It was striking for her to see that the results of this study mirrored her past observations as a nurse. Her own life experience and fears around breast cancer, along with knowing that African American women rank highest in breast cancer rates and lowest in desire to breastfeed fueled her passion to educate and empower African American women in South Carolina.

Engaging in reflexivity made it clearer to her why she was motivated to conduct this study in the first place: to transform negative and misguided communal norms around breastfeeding and eliminate the societal shame some African American women experienced within their communities when they attempted to exclusively breastfeed. Her clinical practice and research efforts were guided by the mission to transform racial breastfeeding disparities. Reflexive practices built a bridge between her past experiences as an African American community and church member and present efforts as a clinical nurse and researcher, as well as her own breastfeeding plans for the future. Her own fears and newly discovered desires about breastfeeding informed how she understood and coded data, such as the time when some participants she interviewed said they would probably breastfeed in public without a cover in the future, if things were different. Transgenerational tensions within the data about the best way to feed an infant appeared under a different light when considering her past observations as a member of the church and within her family and in turn, provided her a unique insight into the emotional challenges and tangible barriers the participants have experienced in their breastfeeding journeys.

**Collective and Relational Reflexivity**

We met bi-weekly throughout the qualitative data analysis, interpretation, and integration phases of the study. These meetings served as a consistent space where we debriefed on the emerging analytical codes and themes, compared and contrasted results from both phases of the study, and discussed how we could make sense of these dynamics to paint the whole picture (Ivankova, 2006). Our analysis approach was constructivist, interactive, and relational; we considered ourselves as part of the research process and understood that the results were co-produced by meanings created by the study participants and us (Creswell & Clark, 2017). To operationalize the theoretical framework that guided our analysis and interpretation, we actively engaged in reflexive thinking and writing prior to the team meetings.

Different perspectives we had on the data produced a multifaceted understanding of the participants’ accounts. We challenged each other to look through unfamiliar lenses to
understand the research phenomena and disrupt habitual thinking patterns and explanations that could be taken for granted. Having both “insider” and “outsider” researchers within the research team aided us in this process (Finefter-Rosenbluh, 2017). The moments when we reached consensus in our coding, proved to be the moments that sparked a more nuanced, contextualized, and “thick description” (Ponterotto, 2006) of the data.

Diverse epistemological orientations, skills, and resources we had as a team fostered critical discussions during which each of us questioned the analytical paradigms we were previously using and examined alternative interpretations of the results. An important example of this took place when we were working towards finalizing the core themes that emerged from the qualitative analysis. We first reached a consensus on the five core themes and their constituents that focused on the individual, interpersonal, community, and society level dynamics that shaped breastfeeding behaviors among African American women. While other team members agreed that these were the final themes, one of the student researchers, EC, whose doctoral research was grounded in feminist and critical methodologies raised a concern that we might have overlooked another significant theme that captured the “sexualization of the breasts.” She highlighted that this theme emerged in all participant interviews, in a way that crosscut the multilevel influences we observed, suggesting the salience of sexist social norms attached to women’s breasts, and explaining some of the hostile behaviors in society towards breastfeeding in public. She suggested that using an intersectional lens would enable the team to better understand how African American women’s breastfeeding experiences and intimate partner relationships were affected by the representation of female bodies in the media. After having a team discussion, we collectively agreed to include the “sexualization of the breasts” as one of the major themes in our qualitative data. Using an intersectional lens also helped us examine the complex and shifting nature of breastfeeding experiences and attitudes that existed within the African American community which were reflected in discrepant findings from two phases of our research. It is important to note here that two faculty members in our research team, TMF and JRJ consciously made an effort to create an egalitarian team culture in which students could comfortably express their opinions and contribute to the research project as equal collaborators. This kind of intentional effort on the side of faculty creates space for transformative conversations at the team level and is necessary to challenge power differentials that exist in academia between faculty and students.

The pragmatic aspects of collective reflexivity helped us engage with the “inquiry logics” (Greene, 2006) and choose the methodological tools most-suited for our research questions. For instance, when we were considering various strategies to analyze the qualitative data, TMF shared with the team about an array of affective coding techniques that she had recently been exposed to while attending a qualitative research workshop. She stressed the potential for the use of an affective coding strategy referred to as “versus coding,” due to the “hotly debated” nature of breastfeeding. Following this discussion, each of us read a book section on affective coding techniques (Saldaña, 2015) to learn more about this approach. Then, two student researchers in our team completed initial coding of the interview data using ‘values coding’ and ‘versus coding’ techniques. We reviewed these codes during our next meeting and reflected on the belief systems, emotions, and tensions of breastfeeding that we encountered in our own lives and scholarship. As a result, we decided to use ‘versus coding’ to capture the tensions, conflicting beliefs and attitudes of breastfeeding that exist within the African American communities of South Carolina. We documented the decision-making processes that took place prior to and during the initial coding of the data through individual memos, and collective discussion notes. We took photographs of the notes from conceptual discussions which we led using a chalkboard and included those in the audit trail along with the individual memos.

The Process of Data Integration

Initially, we intended to start integrating the data at the participant sampling stage. We planned to draw a purposive subsample of women from Phase 1, to participate in Phase II qualitative interviews to further explain and interpret the survey findings. However, due to low response rates in Phase I and limited project resources, we were not able to recruit the subsample we desired for Phase 2. We then used social media and email listservs to recruit a sample of African American women who had breastfed within the previous 24 months, and their designated support partner for qualitative interviews. We recruited a convenience sample of four dyads and given the differences in Phase I and II samples, we decided to examine how the results from both phases were congruent and/or discrepant with one another. As a result, we integrated the quantitative and qualitative data at the interpretation and reporting levels in two ways. Using a contiguous approach first, we presented quantitative and qualitative findings separately through narrative (Fetters et al., 2013). Then we integrated the data by using a joint display (Appendix A), which allowed for a comparison of the quantitative and qualitative findings side-by-side and therefore facilitated a more complex understanding of the research phenomena (Felder et al., 2022).

Through collective reflexivity, we made sense of the congruent and discrepant results, and reached decisions about which patterns would be presented in a joint display of the results (Appendix A). TMF and JRJ shared information with the group about their relationship to the interview participants, and the observations they made while conducting the interviews (e.g., dyad dynamics). The fact that some of the interview participants had personal connections to our team members offered us a closer understanding of those participants’ perceptions and experiences around breastfeeding.
There were considerable socio-demographic differences between the quantitative and qualitative samples in our study. The quantitative sample consisted of younger and lower income mothers, most of whom were single or cohabitating, and almost one third were unemployed at the time of study; whereas all women in the qualitative sample were married, employed, and had higher levels of education. We considered these samples as sub-groups of the African American community in our city. Their breastfeeding experiences were shaped differently by socioeconomic and structural inequalities, and similarly by cultural and community-level factors. Related to this intersectional insight, a key intention we held was to avoid marginalizing younger, low income, and single mothers due to higher formula feeding rates we observed among them, and instead, consider what social and structural dynamics might be affecting their ability to exclusively breastfeed when they intended to. We also critically reflected on the influence of historical legacies of racism (e.g., wet nursing) and sexism in the Deep South (McMillen, 1985), as well as the lack of breastfeeding in previous African American generations, and misconceptions about breastfeeding within African American communities. It was through this process of intentional, collective, iterative and relational reflexivity that “meshing” (Mason, 2006, p. 9) of the data was fruitful, and resulted in a rich and nuanced understanding of the breastfeeding attitudes and experiences. For example, survey results showed that almost half of the sample were in favor of breastfeeding in public, while the other half were opposed to it (Felder et al., 2022). We discussed these results under the light of interview participants’ accounts on breastfeeding in public with or without a cover. We also considered our own reactions, experiences, and observations about seeing women breastfeeding in public. These discussions led to a realization that breastfeeding in public without using a cover was considered inappropriate or radical by many women, including those who agreed to the efforts that are aimed at improving breastfeeding rates among African American women. In addition, incorporating the feminist critiques of sexualization of women’s breasts in our analysis provided us further insight about what the cover represented, and how it modified perceptions on breastfeeding in public.

**Writing of Reflexivity: The Challenge and Rewards of Putting It on Paper**

We developed an audit trail in which we included our reflections on stages of data analysis and interpretation. In an audit trail, researchers document the decision-making processes, and influences on their actions step by step through memoing (Creswell & Miller, 2000; Shenton, 2004). However, it was not until we attempted to develop a more personal account of reflexivity that we experienced particular challenges, as well as rewards, of writing about ourselves in the context of this study (Watt, 2007). Each of us felt a resistance towards unpacking and writing about personal experiences that we recalled when thinking about breastfeeding. Turning a lens to our own lived experiences with the purpose of locating ourselves within our inquiry and sharing these insights with other team members was challenging as expressed in a shared sentiment: “It is hard to talk about myself.” Probst defines “managing emotional responses to the material or people studied” as the main personal challenge of reflexivity (2015, p. 44). Navigating the uncomfortable space of thinking about ourselves in relation to the context of the research and study participants taught us that the purpose of reflexive writing was not only the end product, but also the act of writing itself. The heuristic nature of reflexivity and the act of turning inwards led us to discover new things about ourselves and our research endeavors. At times, this process felt “messy” due to untangling how complex “layers of subjectivity” were at play (Probst, 2015, p. 38), and we felt unsure whether our efforts ‘qualified’ the act of reflexive research. Despite these challenges, we remained focused by directing our self-reflection towards the goals of our study and gained new insights into our relationship with the research content during the act of writing. Reflecting on the interactions we had during our bi-weekly meetings, decisions we made in relation to data analysis, and our inner conversations about how to understand the participants’ accounts showed us how this process was a critical component of the whole project.

**Limitations, Strengths and Recommendations for Mixed Methods Research Teams**

One of the limitations we experienced was related to the time point at which we were able to start the process of engaging in reflexivity. The full research team was formed after data collection was completed by TMF and JRJ, and the activities we engaged in as part of the reflexivity practice took place after this point. We learned that intentional reflexivity at the individual and team level is key to quantitative-qualitative data integration. We believe that an earlier engagement in reflexivity and step-by-step documentation of this process by research teams would provide greater benefits.

Two of the team members who initiated this study were “insiders,” African American women living in South Carolina, one with previous experience of breastfeeding, and the other with previous experience of treating and supporting breastfeeding mothers in a hospital. Insider position can offer advantages as well as pose some challenges for the researchers (Berkovic et al., 2020). In our case, it helped establish rapport and facilitated honest conversations around the participants’ breastfeeding journeys. Insights gained by the insider researcher-participant interactions transformed our collective learning through the relational dimension of reflexivity.

We observed that there is a lack of discussion in published research articles on how to use reflexive practice in mixed methods research. Of the studies that have addressed this topic, reflexivity was incorporated separately into the
quantitative and qualitative components as opposed to guiding the mixed methods as a whole (Walker et al., 2013). This gap in scholarship can be related to researchers not giving due importance to the documentation of this process or having concerns about how publishing work on reflexivity will be received by other scholars. Devaluing of reflexive research is a barrier experienced by researchers in some academic settings (Probst, 2015). There are also practical challenges such as the time commitment that documentation of reflexivity requires, and space constraints in peer-reviewed journals (Probst, 2015). Yet, it is important for mixed methods researchers to share information about the actual process of reflexivity to help facilitate others’ and their own learning about: 1) the diverse approaches to reflexivity in different mixed-methods designs; 2) the unique aspects of engaging in reflexivity in the context of mixed-methods research; and 3) the role of reflexivity in ‘meshing’ or ‘mixing’ of the results from quantitative and qualitative research.

Conclusions

Engaging in collective reflexivity as a multi-cultural and multi-national team of researchers with diverse but interconnected disciplinary and professional backgrounds (medicine, nursing, public health, women’s and gender studies) facilitated a holistic investigation of the participants’ breastfeeding experiences and perspectives. The breadth of the knowledge and skills our team possessed offered us a variety of lenses that were uniquely relevant to exploring breastfeeding beliefs and attitudes. Thus, engaging in reflexivity not only individually—but also collectively—provided us new perspectives that we would not have gained otherwise. Creating more room in mixed-methods scholarship for the documentation of reflexivity processes will support novice researchers in overcoming the challenges that are inherent to conducting mixed methods research and enhance trustworthiness of their inquiry.

Appendix A

Table A1. Joint Display of Quantitative Items Indicating Mixed Breastfeeding Attitudes With Exemplar Quotes.

| Quantitative results | Qualitative results |
|----------------------|---------------------|
| % SA/ % SA/ % D/ A/ N/ D/ SD | Participant quotes |
| IIFAS item if agreement or disagreement <60% | Congruent with item | Non-congruent with item |
| "Breastfeeding is more convenient than formula feeding" | 50 28 22 | "I mean, you mix the formula bottle, you have to mix it and heat it up whereas breastfeeding, you know, it's regularly available." [female] |
| "Formula-feeding is more convenient than breastfeeding" | 48 16 50 | "It's [breastfeeding] healthier, but in my mind, it does take more time. It's physically draining at times. You have to constantly, you have to prepare. But formula is quick." [female] |
| Formula-fed babies are more likely to be overfed than are breastfed babies | 48 18 34 | No data available |
| Breast milk is lacking in iron | 48 6 46 | No data available |
| Formula feeding is the better choice if a mother plans to work outside the home | 40 18 42 | No data available |

(continued)
Table A1. (continued)

| Quantitative results | Qualitative results |
|----------------------|---------------------|
|                       | % SA/Ab % Nc %D/SDd | Congruent with item | Non-congruent with item |
| **IIFAS item if agreement or disagreement <60%** | | |
| Mothers who formula-feed miss one of the great joys of motherhood | 34 22 44 | No data available | No data available |
| Breast-fed babies are more likely to be overfed than formula-fed babies | 34 16 50 | No data available | No data available |
| Women should not breastfeed in public places such as restaurants | 32 10 58 | “Well, I preferably would not want to see that [breastfeeding in public without a cover]. Even after having, you know, three kids. I just, I don’t know. I just think that would be inappropriate and disrespectful. To openly do that.” | [male] |
| | | “Your breast is a bottle…. [Referring to breastfeeding in public without a cover] Your breast is made for feeding your baby. Now no, your breast shouldn’t be all out. I don’t feel like it should be open. Like I don’t want to see your breast. And maybe that will be down the line where, who cares? You know, you can pull out your boob. You know!” | [female] |
| Formula is as healthy for an infant as breast milk | 24 34 52 | “…mainly the health benefits [of breastfeeding] to me, was important. I mean, we’ve noticed in all three of our kids that they were very healthy their first year of life. The first two never had ear infections. So, I can attest to that.” | [female] |
| | | “I did know the nutritional value, because most of the nutrition, the nutrients coming from the breast milk is better than what comes in the formula. Because it’s more natural…” | [male] |
| | | “…not really knowing all the information about the differences between the nutritional value of breast milk versus formula. So some people would think that there’s different additives and different vitamins and minerals in formula, and they would figure that maybe their baby would get more that way, versus what they would get from breast milk.” | [male] |

*Iowa Infant Feeding Attitudes Scale; Strongly agree or agree; Neutral; Strongly disagree or disagree; Exemplar quotes are related to both items.*
Acknowledgments
The authors would like to thank Dr DeAnne K. Hilfinger Messias for her invaluable comments on earlier versions of this paper.

Declaration of Conflicting Interests
The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding
The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This research was funded by an Institute for African American Research Fellowship Award (2014–2015) at the University of South Carolina.

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