

THE TYRANNY OF FEMINIST METHODOLOGY IN WOMEN'S HEALTH RESEARCH

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Awareness of the insufficient degree to which mainstream research has created useful knowledge about women's health has drawn many researchers to feminist methodologies. Such approaches tend to privilege qualitative designs, emancipatory objectives, and cooperative strategies. They challenge the notions of expert power, the appropriation of voice, and ownership of the research products. By uncovering the extent to which power inequities are embedded in our research traditions, including such issues as who conducts research, which questions are studied, and how they are studied, feminist critique can be a powerful tool toward stronger research with more socially relevant findings. However, taken to extremes, feminist methodological requirements can immobilize and discourage active inquiry. In this paper, we articulate major directives of a feminist stance, explain the extremes at which they become problematic, and propose responsive options for women's health researchers. We intend such analysis to overcome divisiveness and promote inclusiveness without sacrificing excellence in research and action.

In defiance of claims that traditional research has ignored issues of importance to women, extrapolated to women from research conducted on men, denied women's experience, and silenced women's voices, feminist research has arisen and evolved to a position of prominence in the study of women's health. Indeed, feminism seems an ideal posture from which to develop a body of health knowledge for and about women. Harding

Received 24 July 1997; accepted 2 March 1998.

The ideas contained in this paper were developed in the context of lively discussion in the feminist research cross border seminar group of faculty and doctoral students from the University of British Columbia School of Nursing and the University of Washington School of Nursing.

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(1987, 1989) argues that the distinctive power of feminist research arises from features such as (1) using women's experiences as a resource for determining the questions to be asked and theories to be developed, (2) designing research *for* women, (3) focusing on new subject matter for inquiry (studying ourselves and studying up), and (4) locating the researcher in the same critical plane as the subject matter. Such power offers women's health research a platform on which to build inquiry based on women's experience and focused on issues of importance to women.

As committed feminist researchers, we have struggled with what it means to counter the ideologies of traditional, nonfeminist science in order to do feminist research in relation to women's health. There is no "one way" to "do" feminist research; indeed, there are multiple "feminisms" that provide profoundly different directions for research (Miller, 1997). For example, Harding (1987) contrasts the epistemology of feminist empiricists and feminist standpoint theorists. However, across and within the various feminisms that have been applied to women's health research, we have encountered strands of ideology that we believe are counterproductive to the goals of women's health.

These insidious forms of feminist ideology are most counterproductive when they are articulated in the form of rather absolute claims. Absolute claims have been made regarding who can be considered a legitimate researcher, what problems are appropriate for feminist inquiry, how feminist research must apply gender as its primary analytic variable, how researchers must locate themselves, which research methods can be applied to the study of women's health, what the objects of research ought to be, and who ought to have authority over the products of research. As Grant (1993) explains, some of the notions that have come to be considered the core of feminist theorizing have paradoxically imposed a structure on feminist theory, reinforcing certain aspects of the theory and ignoring others. The purpose of this paper is to examine the more extreme form of some of the claims with a view to exposing their implications for the larger project of women's health knowledge development and thereby preventing the rhetoric associated with some feminist ideology from replacing traditional science ideology with an even more restrictive orientation. Toward this purpose, we identify the manner in which the extreme positions are expressed, explore the problems these claims may impose on the larger project of women's health knowledge, and suggest alternative perspectives that we believe serve the goal of knowledge development in a fundamentally acceptable manner.

SELECTIVITY AND SPECIFICITY

One of the implicit claims made in feminist research is that the only valid feminist research is on, for, and about women (Romyn, 1996). We see several serious difficulties arising from this position. Research that is

concerned only with women can be problematic in that considering women separately from men implies that women can be studied in isolation from their cultural contexts and that women's health issues are unaffected by men and structures dominated by men. The claim that feminist research is on, for, and about women rests on the assumption of an antagonistic relationship with a male "other" (Strathern, 1987), which reinforces essentialist notions about women (Alcoff, 1988) and ignores men as part of the "solutions" to women's health problems. Finally, exclusive attention to women can contribute to blunting critical analysis by closing avenues of inquiry and analysis. For example, knowledge in such fields as violence against women will develop quite differently if it is assumed that the only meaningful forms of knowledge are those that can be constructed from the victim perspective, and practically applicable knowledge toward correcting social injustices may be entirely inaccessible (Maguire, 1996). Thus, we believe that the selectivity argument may restrict a notion of what counts as feminist research in a manner that it inappropriately limits knowledge development.

A closely related claim is the position that women's health research is exclusively concerned with issues that are gender based. Stated differently, this position assumes that gender is *the* central organizing variable in understanding women's social reality (Acker, 1989; Lather, 1991). This stance privileges gender over other socially constructed identities, invoking a feminism that is solely concerned with gender and gender oppression at the expense of attention to other sites of oppression (Fraser & Nicholson, 1990). It assumes that gender operates in a particular manner to influence social reality regardless of cultural or historic context (Di Stephano, 1990). And it overshadows the influence of other locations, such as race, sexual orientation, age, or social class as important determinants of health in women's lives (Coser, 1989).

Instead of beginning from a position where women are considered the sole focus of inquiry in women's health research, we contend that women's health issues should be examined as gendered but not *only* as gendered. Rather, the larger context of women's health can only be understood within networks of relationships, within contexts of culture, and with an awareness that women subjectively experience themselves as individuals defined by many and diverse factors beyond gender (Alcoff, 1988). Thus, an overly narrow interpretation of women's health issues may systematically bypass critical elements of knowledge and produce understandings that distort what the women themselves would recognize as truth.

LEGITIMACY OF THE RESEARCHER

In congruence with these first two claims, it is often implied, and sometimes stated, that only women and only feminists can do feminist research in women's health research (Sigsworth, 1995). This is problem-

atic in three ways. First, privileging "woman" as the social location of importance denies the importance of other social locations. Such privileging can reinforce issues of knowledge ownership, and gender distinction in knowledge form, that may, in turn, reinforce stereotypes. Second, the claim that only women can research women leads logically to the conclusion that the researcher's social location must match the social locations of subjects in other ways (Gorelick, 1991). If this is so, then, for example, only poor people can do research with poor people, only disabled, diabetic, nonwhite women can do research with disabled, diabetic, nonwhite women, and a paralysis of legitimacy ensues. Attempts to match the social positions of researcher and subject raises challenging questions. How could one account for multiple positionings? Which declared positions would "count"? Which undeclared positions would "count"? And how can we contend with those social positions for which research is not feasible? Finally, the idea that women's health researchers must be feminists raises the question of what qualifies one as a feminist. Is it adequate to "declare" a political position as a feminist? Or are there (and if there are, they are hotly contested) criteria for qualifying as a feminist? How would a feminist who is also a man be judged in terms of legitimacy in undertaking women's health research?

Rather than interrogating the legitimacy of the researcher on the basis of declared social locations, we consider it far more useful to strive for a much more complex accounting for both the positional and the theoretical legitimacy of the researcher (Coser, 1989). Instead of presuming that simple declarations of location vis-à-vis the critical variables ascribed to the subjects of research are sufficient, we argue that a much deeper analysis is required of the match between the researcher and the research questions, the researcher and the methodology, the researcher and the data, and the researcher and the analysis. Thus, a researcher's legitimacy would arise from such credentials as expertise in method or substantive knowledge rather than such dubious qualifications as womanhood or declared feminist intentions. In and of itself, location is not the central issue; rather, reflective accounting for the way in which the researcher may have influenced the question, the data, or the conclusions should form a critical element of all inquiries into women's health issues.

LOCATION

In a similar vein, it is commonly understood as an imperative for feminist researchers to locate their own identity in relation to the identities of those they are researching (Romyn, 1996). For example, Harding (1987) says that researchers must strive "to avoid the 'objectivist' stance that attempts to make the researcher's cultural beliefs and practices

invisible while simultaneously skewering the research object's beliefs and practices to the display board" (p. 9). She recommends that the class, race, culture, and gender assumptions as well as the beliefs and behaviors of the researcher be placed within the frame of the picture that he or she attempts to paint. The imperative of locating the self has made the practice of listing the researcher's categorical locations endemic to research claiming to be feminist (Patai, 1994). Routinely feminist researchers position themselves as a white, middle class, heterosexual woman or a *Metis*, wealthy, lesbian woman, using some combination of self-applied labels to position their credibility as researcher. Similarly, many feminist researchers feel obliged to report such attributes as their own educational level, relationship status, history of violence, or taste in reading in order to be considered credible to a particular feminist audience.

This practice of prefacing research with inventories of one's own location, which Viveswaren calls an "increasingly sterile" maneuver (1994, p. 49), is problematic for a number of reasons. First, there is an underlying assumption that locating oneself communicates clearly the impact of these categories on the research and on the relationship between researcher and researched (Harding, 1990). Using such reductionist categories implies a known set of essential influences that flow from whatever leads to the act of self-labeling in a particular manner (Buker, 1991). Stating that one is *Metis* may come from the experience of having lived on an "Indian reserve" in poverty, with little status in relation to one's neighbors, or the act of identification may arise from having *Metis* parents but having lived within an adoptive family in which being *Metis* was reviled, experiences that may influence the researcher in profoundly different ways. In using such categories to locate the researcher, the influence of experience underlying the labels is lost and the richness of meaning is disregarded (Harding, 1990).

Second, as Dorothy Smith argues, beginning with these categories is to begin in discourse that is already constructed by what she terms the "relations of ruling" (1990). The categories that are commonly used (e.g., woman/man, white/black) are dichotomous and oppositional. Leaving the analysis of the influence of such categories to the mercy of the reader's thinking, whether it be critical or stereotypical, invokes the reader's assumptions regarding these categories and, worse, reveals the researcher's uncritical acceptance of such categories. For example, to claim nonwhite status may lead to readers assuming that the researcher has experiences of racism, whereas the writer may have been able to "pass" as white. Indeed, in invoking the legitimizing claim, the researcher may not have recognized the profound difference between the two. Further, the selection of categories to be used in this manner is necessarily

limited and may or may not capture the experiences that are most influential in each particular piece of research. Increasingly, it appears that there is an implicit protocol for feminist research that suggests which types of categories are required, with little critical analysis of why certain categories of location are selected.

Even when preset categories are avoided and more detailed descriptions of experience are employed to locate the researcher, we believe that there is danger that the categorizations that emerge invoke stereotypical assumptions. For example, a researcher in the field of violence against women who positions herself as having been in an abusive relationship may invoke the category of "battered woman," and that experience may be seen as the defining feature of that researcher's contribution. Perhaps even more dangerous is the possibility that locating the researcher through categorization may lead to a similar reduction of those being researched.

Finally, merely locating oneself does not necessarily reflect analysis of the influence of the categories or experiences identified. For example, if a researcher self-identifies as having experienced racism, does that imply that the researcher is free of racial bias? Does self-identifying as a woman negate the power differential between the researcher and the women being researched? While location of the self is considered an obligatory preface to research, the influence of the researcher's location may be only briefly, if at all, explored and then dismissed as having been "done."

Locating the self is complicated by the common practice of uncritical use of labels that arise from certain world views and the further practice of relying on location to imply that the researcher's identity is impervious to the influence of the research. The consequences of locating the researcher in this manner can be detrimental to the relationship between the researcher and the researched, and to the research itself. The act of locating the self can appear to absolve the researcher from examining the influences of his or her multiple positionings throughout the research. How one articulates location may lead to dismissal or acceptance of research based on the assumptions of the reader. In the attempt to make visible his or her beliefs and biases, the researcher may further obscure them with categories and preemptively dismiss their influence.

Rather than beginning from a location defined by particular categories or experiences, it may be more useful to analyze the influence of the researcher's frame of reference by beginning from the assumptions, values, and biases that the researcher brings to the research. Then, for example, a researcher in the area of violence against women could locate the self by stating that, from various experiences, s/he assumes that although violence occurs without regard to race, class, or sexual orienta-

tion, women who have less access to resources because of racism, classism, and heterosexism may experience violence differently. Instead of treating location as a preface to research, expressing the researcher's location as assumptions, values, and beliefs may more usefully serve as an analytic backdrop to the entire research project.

NONREDUCTIONIST METHODOLOGY

In keeping with the notion that women's health research ought to reflect women's reality rather than the traditional scientifically accepted norms for what counts as knowledge, feminist scholars increasingly reject reductionist methods, objectivist epistemological stances, and realist ontologies (Jayaratne, 1993; Smith, 1989). Recognizing knowledge as a social construction, such scholars argue that what we know cannot be detached from the ideological origins of our truth claims (Gorelick, 1991; Stanley & Wise, 1990). Thus, it is often suggested that knowledge reflective of women's reality cannot derive from objective positions (J. K. Smith, 1990); rather, the scholarship privileges subjective, multiple, and coexisting realities and reveals a deep suspicion toward any objective notions of truth (Grant, 1993). This kind of reasoning leads to the claim that qualitative research methodology alone is consistent with feminist objectives (Mies, 1993).

While the traditional overreliance on empiricist traditions and quantitative, reductionist methodologies is acknowledged as a limiting factor for women's health knowledge, we believe that the opposite position is equally problematic. If subjective knowledge is considered more real or true than objective knowledge, a relativist conclusion is inevitable (Allen, 1992; Buker, 1991). If multiple coexisting truths are assumed, it becomes difficult to justify discrediting some of those competing truth claims that must be addressed in order to advance a feminist agenda (Harding, 1990). For example, it can be argued that individualism and subjectivism are inconsistent with a feminist stance on collective consciousness as social, rather than private, reality. From our perspective, countering the traditional overreliance on objective reality should not require the extreme stance that subjective reality is the only truth acceptable to feminist research. Our understanding of feminism is that it inherently derives from a notion of some realist epistemological positions at the same time that it acknowledges the subjective primacy of "experiences" of truth. Because social realities cannot be considered irrelevant to individual realities, the forms of knowledge amenable to quantification will remain necessary for the larger feminist project (Jayaratne, 1993; Jayaratne & Steward, 1991; Maguire, 1996). We believe that feminist researchers ought to interrogate the tensions between individual real-

ities (the particular) and social realities (the general) in order to construct knowledge that transcends method.

EMANCIPATORY INTENT

Because feminism emerged from a critical social orientation toward correcting injustices, some researchers have taken the position that feminist research is always concerned with emancipatory aims for the research subject as well as for the social group (Anderson, 1991). While no one would argue the converse (that it is appropriate to oppress research subjects for the purpose of uncovering liberatory knowledge), some conclude that a full partnership model is the only acceptable manner in which to conduct women's health research from a feminist perspective (Mies, 1993). Thus, action research and other models in which the research questions arise from those being studied and in which the researcher takes no special privilege with regard to the process of the research have become prominent within women's health research scholarship.

While many inquiries work well from this perspective, we believe that it is important for feminist researchers to remain mindful of the theoretical origins of emancipatory work. Because such research emerges from a critical social theory perspective (Fraser & Nicholson, 1990; J. K. Smith, 1990), it presumes a "false consciousness" amenable to study and assumes at very least an agreement about the greater social good that is inconsistent with the notion of coexisting multiple realities (Gorelick, 1991). Focusing emancipatory intent on the participants of the research itself rather than the larger objective of the research can lead to a number of systematic errors in what gets studied and how. For example, such a position fails to recognize the social inequities that might render full partnership impossible, especially where "community" has not been constructed naturally. If partnership research is the only credible form of feminist research, knowledge about the most disadvantaged women may lag behind knowledge about the groups of women most available for such participatory forms of inquiry. Another problem inherent in emancipatory research is that it can permit representative appropriation of voice by more powerful members of a community over others in a misguided attempt to avoid researcher misuse of power. Where research subjects control findings or interpretations, some will inevitably acquire more authority than others, and the implications of a subset of voices will be overlooked. While a researcher may enter a project with emancipatory intent, such intent is clearly not the equivalent of an emancipatory outcome, nor is an emancipatory outcome precluded from an intent that stops short of emancipation (Lather, 1991). Finally, it may be recognized that in the more extreme forms of partnership models, anyone with edu-

cation or research training would be precluded from active involvement in relation to some research questions (Ladwig & Gore, 1994).

While we would agree that the intent underlying the partnership model is worthy of consideration in any women's health research project, we argue that the position must not be so rigid as to constrain inquiry into issues that are not yet within the collective consciousness (Gorelick, 1991). Instead, emancipatory methodology can be oriented to the possibilities for consideration of emancipatory change rather than the expectation of such change (Gore, 1992). Further, we believe that knowledge toward creating an expanded repertoire of viable options may be in and of itself emancipatory, regardless of whether the options are selected. Thus, claims about emancipatory research as a requirement for feminist methodology may detract from the full range of issues about which we need to know to advance women's health.

CONSENSUAL VALIDITY

A final extreme position that we hope to challenge is that feminist research requires negotiation of meaning between the researcher and researched throughout the research process. From the perspective of some feminist researchers, research findings and interpretations are inherently suspect if they are not shared with or cocreated by research participants (Finch, 1993; Hall & Stevens, 1991; Maguire, 1996; Mies, 1993). As is evident in much of the current literature, research participants read transcripts, approve or disapprove certain interpretations, and control the dissemination of findings. However, we believe that such a position denies the existence of tacit knowledge (which we understand to be a foundational assumption in feminist theorizing). In many instances, because it denies consciousness-raising processes, such an orientation may also preclude an emancipatory intent, since the researcher may be forced to re-create or perpetuate hegemonic ideology that emerges from subjectively constructed knowledge. Further, it stands in direct contradiction to claims about multiple coexisting realities and may inhibit researchers from consideration of explanations that are not as yet accessible to participants. Thus, the value of obtaining participant agreement on all research interpretations may well constrain researchers from interpretive options beyond "common knowledge" (Fine, 1994).

From our perspective, to remain true to the ideals of a feminist tradition, it makes sense that our interpretive work should remain as close to the data as possible and attend to a number of validity principles. However, we argue that because the possibility of theoretical explanations beyond the conception of individual participants must be preserved, alternative credibility measures must be legitimized. In our view, the

logic of any individual pattern of credibility standards will be considerably more important than a fixed position on which set is used. Because the reader of feminist women's health research must be able to access the logic of the interpretation, researchers should be called on to explicitly and credibly account for any discrepancies in consensual validity.

DISCUSSION

As researchers apply and develop feminist perspectives within their inquiries into women's health issues, they may be tempted by the moral superiority inferred by some of these absolute methodological claims. It is our view that scholars within nursing and the health sciences cannot afford the academic luxury of mere theorizing but, by virtue of their practice imperatives, must work out epistemological and methodological options that simultaneously respect both the ideological underpinnings and the moral intents of feminist knowledge development. Because they must construct knowledge of the general (patterns, shared realities, common experiences, and so on) and apply that knowledge in the particular (inherently unique individual cases), researchers within the health care disciplines are perhaps ideally placed to address tensions between the abstract and the concrete implications of knowledge. In an applied, practice context, both subjective and objective knowledge must be understood, neither inherently more nor less true, but each applicable on its own terms and in its own contexts.

Thus health professionals working from a standpoint consistent with feminist theorizing will not disregard the potential for quantitative research or empirical science within the larger project of developing knowledge for the reduction of gendered social inequities. Neither will they ignore the insights that can be drawn from inquiry that permits construction of subjective truths and multiple coexisting realities. Rather, they will devise ways in which both can be examined as part of feminist inquiry and work out techniques whereby "probable truths" can be determined. As members of socially constructed disciplines whose mandate inherently presumes action toward a greater social (as well as individual) good, their practices must be founded on knowledge that is shared, accounted for, and applied. However, as socially conscious and historically constituted entities, the health professions should also be capable of accepting that all shared truths are amenable to ongoing scrutiny, that some will be found faulty as time and context reveal their ideological linkages, and that new and compelling (sometimes competing) truths will be discovered or agreed on as the evolution of disciplinary scholarship and practice evolve. It seems to us that health professionals working within feminist scholarship traditions can contribute, not only to

women's health knowledge, but also to feminist inquiry itself, offering a moderate realism that balances absolute claims in the postmodern context and a respect for individual subjective reality that balances ideological primacy within critical social theory.

In conclusion, it seems apparent to us that the health professional disciplines stand to benefit greatly from application of feminist perspectives in their women's health scholarship but must retain a sense of perspective that permits them to rise above the ideological morass apparent in some of the more rigid claims about what constitutes feminist methodology. In our view, issues about legitimacy and location of the researcher must not be permitted to stagnate the scholarship; rather, health professional researchers using feminist approaches will do well to draw upon and apply knowledge about perspective and bias, using reflexivity and critical scholarship as mechanisms to make explicit their interpretive claims. While a feminist orientation toward research methods that are not in themselves oppressive is entirely consistent with the objectives of the health disciplines, the absence of oppressive strategies within research is not a sufficient condition to constitute feminist scholarship. Knowledge that will address and correct socially constructed inequities will necessarily extend beyond questions specific to women's lives and women's health; thus, overly narrow claims about what inherently counts as feminist research will not be widely acceptable. Feminist scholarship within health care will also have to include multiple forms of science and a range of methodological options, respecting both the individual and the population mandates of the health professions as well as the mandates at all levels in between. While the emancipatory intent of feminist scholarship is not at all inconsistent with a moral duty to society, health professional knowledge must always include consciousness of the problem of the individual—the fact that the subjective reality of each unique individual we confront in the clinical encounter must be respected, supported, and dignified. Because they live in the world of multiple realities, health care professionals are ideally placed to address the inherent complexities of respecting diversity and at the same time acknowledging that some fundamentally agreed-upon principles underlie their practice. Applied thoughtfully, we contend that feminism can provide some of those principles.

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