A FEMINIST DIVERSITY APPROACH IN HEALTH-INTERVENTION RESEARCH

Janneke van Mens-Verhulst

Keynote speech ate the 3rd Gender and Health Conference 2002, September 17th in Vienna.

Abstract

From a feminist point of view a gender-specific approach in health care research is not `good enough'. Extension to a diversity approach is needed to ensure that not only sex/gender but also race/ethnicity, age, class, sexual preference, philosophy of life and other categories of differences will be taken into account.

With that aim, health care researchers' decision-making is symbolised as eight stepping-stones: epistemology, intentions, models and concepts, participants, research relationship, procedures, logic and presentation of results. In contrast with the traditional representation, these are neither coupled linearly nor in a fixed order.

The conceptual space is extended with constructs that guarantee attention for the characteristics of a diversity-conscious health care while the methodological space is explored with new selection criteria: how to respect heterogeneity and complexity, to expose power dynamics and to reckon with the geographical and temporal context?

The result is a preliminary decision-support system for transformative feminist health intervention research.

Keywords: research, health care, intervention, gender, ethnicity, diversity.

*) j.vanmens@uu.nl.

Address to be used (at home): Prof.dr. J. van Mens-Verhulst, Kastanjelaan 24, 1214 LH Hilversum, The Netherlands, phone +31-35-6246850.

INTRODUCTION

Health-intervention research has not been transformed by feminist studies as much as could been hoped for, let alone that feminist health-intervention research has been transformative itself for the field of health interventions. In my opinion, this is due to the cultural and socio-economical context as well as developmental logic. The domain of health-intervention research is dominated by strong positivist orientations and strivings leaving little room for non-conventional approaches. In addition, health intervention research is very complex because it combines three different strands: illness, health and deliberate change processes. But the most important reason probably is that feminist inspired intervention research finds its foundations on feminist bodies of knowledge from different basis disciplines, and that it will always be second in line in its dependence on the conceptual and methodological developments in psychology, medicine, biology, sociology and anthropology.

Superficially, the feminist influences on health care research may seem considerable, but closer inspection learns that the influence has been limited to documenting sex/gender differences in diagnoses and outcomes mainly. Few studies apply a more radical gender perspective in the sense that targets, treatments and outcomes themselves are examined with a gender approach -- a lack that has been detrimental to the development of feminist health care, and still is. Only recently the publication of articles to further such gender sensitive health care research has started: for example, Bekker (2003), Dickey (2000), Israeli & Santor (2000), Noordenbos & Vlugt (2003), Wilkinson (2001).

Following the developments in feminist studies, however, it can be concluded that a gender-conscious or gender-specific approach in health intervention research is not good enough. Extension into a diversity approach is requisite to ensure that not only gender as a bio-psycho-socio-cultural difference but also race/ethnicity, age, class, philosophy of life and sexual preferences will be taken into account, as well as their intersections. The reasons for this extension are moral and practical: the research results ought to allow for the establishment or development of interventions, these interventions must be adequate for different types of women and men, and should avoid to reproduce existing social inequalities.
Doing feminist responsible research on health interventions, therefore, means researching into differences as well as similarities between people in health care (between the clients on the one hand and the medical practitioners and therapists on the other). It goes beyond the usual differences and similarities in complaints, diagnoses and effects of intervention between, and among, men and women. It is also concerning their perceptions and stories of health and illness, their coping with illness, and patterns of seeking help; the roles adopted in the practitioner's or therapist's consulting room; the patterns of communication with those professionals and the participation in intervention.

This article will briefly point to the problems of the conventional research approach and introduce the feminist diversity perspective. Subsequently it will explore the conceptual and methodological space of a diversity approach. This has taken the form of a `postmodern' stepping-stone model for the decision-making of health care researchers. And although the focus is on the domain of health care (preventive, medical and mental interventions) I expect it to be worthwhile for the educational domain as well.

FEMINIST PROBLEMS WITH THE CONVENTIONAL APPROACH

The conventional approach of intervention research can be typified with the Gold Standard that has been formulated for treatment-outcome studies by Foa & Meadows (1997): (1) clearly defined target symptoms, (2) reliable and valid measures, (3) use of blind evaluators, (4) assessor training for interrater reliability and calibrating assessment procedures, (5) manualized, replicable, specific treatment programs, (6) unbiased assignment to treatment, and (7) treatment adherence.

Together, these standards are thought to guarantee objective knowledge about the effectiveness of the intervention. They fit into the tradition of a randomized control trial that counts as the research ideal in medical and psychological science and assumes uniformity of clients in addition to ideal circumstances.

The list shows that, conceptually, other layers than that of the symptoms are ignored (see point 1); how the probability of relevant differences between clients other than in the realm of the pathology is passed by (see point 6); and how the relationship between client and professional and the professional therapist's characteristics is neglected at the benefit of replicability of and adherence to the treatment (see points 5 and 7). The list also demonstrates how, methodologically, the assumptions of uniformity of clients and ideal circumstances present in the points 2, 3 and 4 exclude the researchers' use of their own subjectivity and the possibility of a dialogical relationship between researcher and participant.

A FEMINIST DIVERSITY PERSPECTIVE

`Diversity' is a rather popular concept nowadays despite its lack of rigour and theoretical development (but perhaps also because of that, as it allows for spurious agreement). Used by scholars, it refers mainly to`diversity in identities'. The most circumscribed view of diversity focuses merely on diversity in race and ethnicity. A less narrow, though still limited view takes gender into account too. The broad view also includes sexual orientation, age, able bodiedness, class, and, in some cases, philosophy of life. (Nkomo and Cox, 1997).

In contemporary feminist studies the viewpoints on these seemingly fixed categories of experience and position tend to converge into intersectional theory. (Crenshaw, 1989; Lorde, 1984; Phoenix, 1998; Smith, 1998; Williams, 1997; Yuval-Davis, 1997). First and foremost, the differences and similarities involved are understood as being not so much one-dimensional, but as culturally, socially, psychologically, biologically and morally layered. Secondly, they are seen as continuous and changing over time rather than dichotomous and static. Thirdly, they are recognized as being constructed in people's day-to-day actions. Fourthly, it is acknowledged that the differences and similarities manifest themselves as multifaceted and intertwined: a woman is not only a woman, but one with a specific education, skin colour, age, sexual preference, position. Thanks to that intersection, in principle, she can identify herself - but also be identified - in many different ways. The same is true for men, of course.

Moreover, the conceptualisation of diversity is power-conscious instead of power-naïve. This implies that attention is given to the question of how differences (in gender, ethnicity or sexual preference for instance) become ranged hierarchically from more to less `normal' and desirable, and how these hierarchies are linked to processes leading to the inclusion or exclusion of people and groups. This power-conscious version also pays attention to how patriarchal, colonial or heterosexual dominances have become embedded in the societal conventions and psychic make-up of women and men, and how such power differences and commonalities may be negotiated, exchanged, modified (and even reversed) in all domains, whether physical, social, psychological or cultural.

A diversity perspective on health care

Health interventions and their results cannot be explained in terms of bodily or psychological processes alone. They are also bound by understandings grounded in culture and social positionings, and by how men and women manage their identities; even by the way professionals — and institutions — deal with the gender of their clients.

A diversity perspective helps to gain a better understanding of how the categories sex/gender, race/ethnicity, age, sexual preference, physical and mental abilities and disabilities, class, and philosophy of life operate in the area of health and care. Consequently, it enables a better clarification of health and healthcare problems experienced by different (types of) people and in addition interventions that are more appropriate to their needs, preferences and living conditions. At the same time, the perspective may serve to reduce the social inequalities evident in, and frequently reproduced by, health care. Taken together, this may contribute to a diversity approach and diversity competence within health care (Mens-Verhulst, 2003).

A DIVERSITY APPROACH WITHIN HEALTH CARE RESEARCH

How can a diversity approach in health care research be realized? To begin with, the conceptual space must be extended with constructs that allow for the multidimensional, dynamic, constructionist, intersectional and power-conscious view mentioned above. In addition, the methodological space must be explored keeping new selection criteria in mind: how to respect heterogeneity and complexity, to expose power dynamics and to reckon with the geographical and temporal context?

To explore this conceptual and epistemological space I depict eight choices, or rather clusters of choices, as stepping-stones: decision-making tasks that helps to carry out a research project by enabling us to `step' ahead. However, the decisions are neither coupled linearly, nor in a fixed order. The stepping-stones can be taken in different sequences, and — as researchers — we can move back and forth in our decision-making. The conceptual decisions do not inevitably determine the methodological ones or vice versa. It must be thought of as an iterative process in which wanderings eventually lead into a research design, and this design is still be adjustable when in its application.

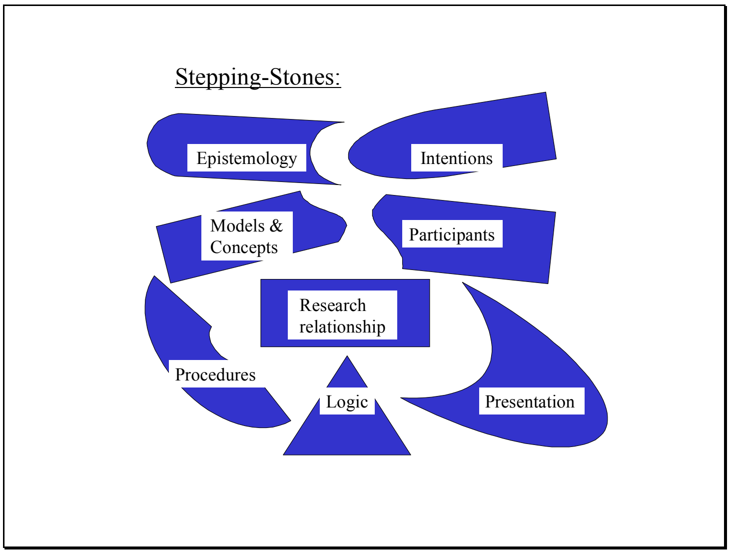

Figure 1: .

Figure 1 displays the eight stepping stones: epistemology, intentions, models and concepts, participants, researcher-participant relationship, procedures, logic, presentation. A possible `measurement instruments'-stone is not taken into consideration it would be accompanies with too many details for this article, and the decision about use of quantitative and/or qualitative methods is preferably an outcome of the iterations.

Of course, the decisions to be taken will be bound by external pre-conditions, such as, on the one hand, the size of the budget, the time available, and the tools at one's disposal, and, on the other, by the researcher's personal skills and orientation. Another factor that should not be forgotten is the state-of-the-art, both in theory and practice.

Epistemology

As a stepping-stone, epistemology offers many positions along which we can progress. One option is the realist position, which assumes that diversity can be `found' in an external reality. In contrast to this, the constructivist position states that differences and similarities are constructed, in people's (also scholars') day-to-day actions. Hence, speaking about differences and similarities among clients and therapists, and in health-care interventions, and so on, is only possible by deliberately articulating specific distinctions and by negating other ones. Both epistemological positions — and the many interesting possibilities in between — provide knowledge that is relevant in effecting health care (Ussher, 1999; Wilkinson, 2000). The realist position has the advantage of at least providing something tangible, something that can be grasped when action is expected. The constructivist position, on the other hand, makes the limitations of existing knowledge more discernable, so that it becomes easier to develop and integrate additional insights.

Our diversity approach would be best served by taking a pluralistic stance, initially including all options, to bring more to the fore the interaction that is taking place between the various positions. Of course, the final epistemological choice must be tuned to the knowledge problems at hand and to the recipients who need to be reached. (MacLachlan, 2000; Wilkinson, 2000) For example, mothers talking about their asthma can be analysed according to how their actual illness is managed. This may result in knowledge that is interesting for other mothers who suffer from asthma, and for the professionals who help them. But it can also be analysed from the point of view of the discourses that prevail in their talk. This is knowledge that can be relevant for educators who are training future social professionals in supporting mothers with a chronic illness; and it is informative for fellow researchers too.

Intentions

The adoption of a power-conscious diversity approach asks for an account how our project is situated in social-political, moral, professional and practical processes: which parties are involved, who have the power to define the problems and who have not? The next question is which specific developments and groups we would like to support by our research, and what would be the best type of research problem to tackle, to achieve that aim. A general formulation is `displaying the variety of actualities and possibilities in the best way possible'. More specifically, the emancipation processes feminist health researchers may want to contribute to, can be furthered by a range of research goals.

A well-known goal is the voicing of specific groups — such as older migrant women, lesbian and gay clients or mothers with a chronic illness. This can be done by collecting their stories about their challenges, difficulties and resiliencies and presenting these in professional circles. Or by articulating their needs and wishes in the form of quality standards for health care — such as, for example, `offering clients choice in the sex, sexual orientation and ethnicity of their counsellors'. However, voicing is an intention that should not just be limited to clients. In their trying to develop alternative health-care services, professionals may also need to be voiced.

Another option is to deconstruct and reconstruct dominant problem formulations to shift the focus of attention to other aspects of a health problem or intervention. For example, calling victims `survivors' to emphasize their resilience, redefining healthy people as `temporarily able bodied' to draw attention to the fragility of the healthy condition, or replacing the term vague complaints with `medically unexplained complaints' to shift the responsibility from the clients to the medical professionals, and turning the non-compliance phenomenon into a proof of clients' own rationality.

A third option is to aim at the improvement of existing interventions and programmes, usually by means of evaluation studies that tune in to the needs of specific groups and are sensitive to opportunities for empowerment. As will become clear in the frame of the next stepping-stone this intention is coupled to a range of conceptual issues.

Other options are to investigate assumed uniformities among client- or professional groups by looking for internal socio-cultural variety, or to disseminate knowledge about diversity-sensitive health practices by listing and describing them — perhaps comparatively.

Mostly our intentions will crystallize further when struggling with the choices represented by the other stepping-stones.

Models and concepts

The stepping-stone `models and concepts' covers not only models for clients and interventions, but also those for helping professionals because, according to the diversity perspective, professionals cannot be considered as neutral users of evidence-based techniques.

With regard to clients, it is not sufficient just to know about their symptoms and diagnoses. Other layers of their existence, such as their self-identification and socio-cultural positionings are important as well. These may be multiple and even contradictory because privileges and disadvantages may intersect with one another — as in the case of a young white man with a disability. Distinctive social positions may help us spot specific transitions in a client's life path, such as, for example, becoming a mother**,** `coming out', migration, going into retirement, or receiving `the' diagnosis; and additionally to explore if they meant a threat or challenge.
The continuity and dynamics of clients' existence can be expressed by paying attention to stories about their lived experiences — including their experiences with health care in the past and, consequently, their current expectations.
Their power — or lack of it — can be portrayed by articulating the extent of their agency in: firstly, their (individual or collectively shared) frames of meaning and ethics for understanding and valuing health and well-being, illness and death, risks and advancements; secondly, their needs, wishes and priorities concerning health care: which may range from problem solving to problem recognition and being listened to; from being nursed and lifted efficiently to helping them maintain their social status; or from individual to community services; thirdly, identifying their resilience and assets — because these are strengths on which intervention programmes can be built, taking into account any experiences of subjection to discrimination, marginalisation, or violence.

With regard to professionals, it is important to uncover what assumptions and beliefs professionals carry about all types of bio-psycho-socio-cultural differences and the way these will affect their clients and the potential for change, thus tracing possible biases and impediments for a successful treatment. Besides, their diversity competence should be mapped, i.e. their knowledge about diversity processes combined with intercultural, dialogical and empowerment skills and experiences, and their attitude of self-reflexivity and cultural sensitivity.

With regard to interventions, the frequently used problem-solving, communication and narrative models should be enriched with concepts that articulate the dynamics of power and connection in a multidimensional way. Firstly, it requires attention for the differences and commonalities between clients and professionals on the distinct layers. Hereby, the so-called `rapport' between clients and professionals will be materialized with the bodily and existential (Baart, 2002) aspects of the encounter on the one hand (Crossley, 2002: 133), and will be contextualised within the dynamics of patriarchal, colonial or western, heterosexual and capitalist domination on the other hand.
Secondly, concepts like discrimination, rejection and exclusion must be included to facilitate the tracing of rehearsal within the health care system itself of external or historic cycles of sexism, eurocentrism, classism, heterosexism and ableism -- to name a few dangers.
Thirdly, concepts are needed to shed light on the mutuality of influence between clients and professionals. Herewith the traditional one-sided orientation on the influence of the professional will be opposed, while the alternative claim of a dialogical and symmetric relationship is simultaneously put into perspective.

Additionally, it should be made manifest which party is in control of the agenda, the rules of communication, negotiation, problem solving or story-telling and how the control is performed; but also, how the decision about the control distribution is influenced by the social-cultural environment- including the professional context. In other words, a decision and policy-making perspective is desired that in itself is layered because it pays attention to the distinct levels involved: not only personal, but also interpersonal, social, cultural and moral.

Finally, the outcomes to be assessed call for a careful account of the relevance of `objective' and subjective (self-reported) data, the health status domains (physical, mental, social, general) with their gender specific aspects, the perspectives to be included (see the stepping stone `participants') and the genderspecific weighting of all this in the light of the intentions of our study (Bekker, 2003; Dickey, 2000)

Participants

As researchers, we have to decide which of the parties involved (clients, family members, professionals and managers) should or may participate in our projects. And, as the parties themselves are not of one voice, any homogeneity that we assume, or heterogeneity that we permit, has to be our own responsibility.

A helpful criterion here is the notion of variation covering — in other words, by listening carefully to insiders, it is often possible to determine how much of the variation is relevant. It is a specific way of purposeful sampling (Patton, 1990).

Also, in applying seemingly `objective' selection criteria of gender, ethnicity, age and religion, we should at least check the self-definitions of the intended participants — How do they consider themselves: As woman, migrant, older, Moslim or Christian? Are all the definitions important in their self-imagery, or just one or two? In applying our inclusion criteria, we may observe interesting discrepancies between how others see participants and how they see themselves.

The researcher–participant relationship

In addressing the relationship between the researcher and the participants the first question that needs to be answered is what type of participation is intended: will participants only be required to give information (as on a panel); or will they be asked to help collect data and set the norms (as in programme evaluation); or will they be invited to join the analysis and decision-making process, possibly initiating the agenda (as may happen in participatory action research)?

It will be almost impossible to determine in advance what the differences and commonalities should be between participants and researchers. In addition to practical limitations (elderly people cannot always be interviewed of the same age; not all ethnicities may be available and so on), the answer may depend on the aims of the research project, and stage it has reached. For example, does insider knowledge need to be elicited, collected or transposed — as in the case of voicing; or does insider and outsider knowledge need to be compared and mixed — as in evaluation studies?

For reasons of trust and empathy, similarities in gender, ethnicity, class, philosophy of life and physical validity may be preferred. To achieve a critical reflexive analysis, however, certain differences may also be beneficial. (Hurd and McIntyre, 1996; Bell, 1996)

In making these choices, it can be helpful to try looking at ourselves through the eyes of the participants. Thus, as researchers, we must be willing to reflect, firstly on our own assumptions about the groups of participants and about the interventions we examine; secondly on our skills for joint decision making — if that is what we are planning; and thirdly on the impression we ourselves give to others, on our own socialisation and social positionings because these are all factors that can help or hinder the research relationship.

Procedures

It is clear that in order to show the heterogeneity, layeredness, complexity and dynamics of the phenomena under study, we need to make creative use of the numerous available procedures, strategies and methods, and the stepping-stones that they offer.

We can choose either top–down or bottom–up designs**,** or any type of combination in between. Top–down procedures mostly contain quantitative analyses directed at homogeneous patterns in homogeneous populations — patterns that are possibly produced by stratification.

If the heterogeneity within the population being studied is not already fairly well known, it might be better to start bottom-upwards, by gradually familiarizing ourselves with the existing variety. This can be done by interviewing members of the target group or, for instance, by consulting key figures from that population. A bottom-up procedure mostly implies using a qualitative methodology both in collecting the data and in analysing it.

To demonstrate the intersection of differences and similarities, it is very helpful to `ask questions from another angle' (Matsuda, 1991). In other words, the perspectives of the analysis need to be systematically alternated. This implies that an analysis of gender, for example, should be followed by the questions `how can this process or event be understood from the point of view of age, ethnicity?' and so on.

To preserve some of the complexity and dynamics inherent in the diversity approach, methods such as case studies, programme evaluation, participatory action research, and gaming or computer simulation are, in my experience, fairly suitable. However, this inevitably brings to the fore, the question of which logic we should adopt.

Logic

How much freedom of choice we have in the methods we use depends on how dogmatically we adhere to traditional ideas about generalisation and objectivity. Alternative reasonings are available: think of the standard work on verification (14 techniques) by Miles and Huberman; the idea of analogue or theoretical generalisation of Yin (1984, 1994) and the elaboration of communicative generalisation into a receptive, participative and exemplary variant (Smaling and Maso, 2002)

Even so, objectivity does not need to be understood so much in the sense of excluding researchers' subjectivity, but more as the `reflexive, intelligent and positive use of one's own subjectivity' (Smaling and Maso, 2002).

Causality is another issue. It's possible non-linearity — meaning that small differences may develop into big ones (remember Lorenz's butterfly) — unjustly has been ignored for a long time while it is especially relevant for health interventions. It gives new insights into the effects brought about by the recurrence of diversity patterns, also in health-care processes.

In the same vein, the current argumentation routine is not always a practical option. Sometimes, the explanation of similarities (for instance, why men and women, or black and white people, profit alike from the same intervention programme) is more interesting and revealing than focusing on the explanation of differences.

Nor should we automatically follow the simple scheme of explaining similarities with similarities, and differences with differences. Especially General System Theory offers us an alternative scheme: differences may be attributed to the chronic rehearsal of processes with similar initial conditions (so-called equipotentiality) and similarities may emerge from different starting conditions (so-called equifinality). And as many aetiological routes are possible we cannot assume that if a treatment is effective for a significant proportion of women, this is the final cure. (Ussher, 1997/9).

Presentation

With regard to the presentation stepping-stone we should note that we can avoid presenting something as `the truth' by showing the different possibilities involved. In doing so, we comply with the notion that researchers' representations are mere generalisations of a more complex and constantly changing `reality' (Smaling and Maso, 2002).

FINAL REMARKS

Research in general, but health-intervention research in particular, implies that we are involved in multiple hermeneutics: not only do we have to interpret interpretations, but also the behaviours, feelings, intentions and interactions of the participants in the field and in our research projects (including ourselves). In doing this hermeneutic work, we are constantly trying to make epistemological, intentional, conceptual and methodological choices compatible. Clearly, this results into methodological eclecticism.

The here presented stepping-stones may help us in performing, developing and discussing the distinctive features of a diversity approach in research. In this way, we may become more competent in handling diversity, and better able to contribute to feminist responsible and transformative research in reducing unjustified and unhealthy inequalities in our world, as well as transforming intervention research itself.

References

Baart, A. (2002) Ruimte om bij het vreemde te blijven. *Sociale Interventie 2*: 15-27.

Bekker,M.H.J. (2003) Investigating gender within health research is more than sex disaggregation of data: a Multi-Fact gender and health Model. *Psycholy, Health & Medicine 8* (2): 231-243.

Bell, 1996 `White Women Can't Speak?" In In S. Wilkinson (ed) Representing the Other –Part one. *Feminism and Psychology 6* (1):197-203

Crenshaw, K. (1989) Demarginalizing the Intersection of Race and Sex: A black feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics'. In *The University of Chicago Legal Forum*: 139-167.

Crossley, M.L. 2002. *Rethinking health psychology*. Buckingham: Open University Press.

Dickey, B. (2000) Outcome Assessment in Women's mental health. *Women's Health Issues 10*(4) 192-201

Foa, E.B. & Meadows, E.A. (1997). Psychosocial treatments for post-traumatic stress disorder: A critical review. In J. Spence, J.M. Darley & D.J. Foss (eds), *Annual Review of Psychology 48*: 449-480. Palo Alto, CA: Annual Reviews.

Hurd , T.L. and McIntyre, A. (1996). In S. Wilkinson (ed) Representing the Other –Part two. *Feminism and Psychology 6* (2): 197-203.

Israeli, A.L. & Santor, D.A. (2000) Reviewing effective components of feminist therapy. *Counselling Psychology Quarterly*.

Lorde, A. (1984) Age, Race, Class and Sex: Women redefining Difference. In *Sister Outsider, Essays and Speeches*. Trumansberg, N.Y.: The Crossing press, p. 114-123.

MacLachlan, M. (2000) Cultivating Pluralism in Health Psychology. *Journal of Health Psychology 5* (3): 373-382.

Matsuda, M. (1991) Beside my Sister, facing the Enemy: Legal Theory out of Coalition. In *Stanford Law Review 43* (July): p. 1189.

Mens-Verhulst, J. van (2003) Diversiteit als sleutel tot vraagsturing in een gevarieerde samenleving. *Sociale Interventie 12* (1): 25-34.

Miles, M.B. & Huberman, A.M. (1994), *Qualitative Data Analysis. An expanded sourcebook.* London: Sage.

Nkomo, S.M. & Cox, T. (1997) Diverse Identities in Organizations. In S. Clegg, C. Hardy & W. Nord. *Handbook of Organization Studies*. London: Sage,p. 338-357.

Patton, M.Q. (1990) *Qualitative Evaluation and Research Methods*. Newbury Park; Sage.

Phoenix, A. (1998) *Reconstructing Gendered and Ethnicised Identities. Are we All Marginal now?* Inaugural speech at the University for Humanist Studies, Utrecth, The Netherlands.

Noordenbos, G. & Vlugt, I. van der (2003) *Evidence based onderzoek en seksespecifieke zorg: een (on)gelukkige relatie?* Utrecht: TransAct.

Smaling, A. en Maso, I. (2002). The Humanist Potentialities in Qualitative Research. Inner Growth, Dialogical relationships, Empowerment and Normative Professionalism. In A.

Halsema & D. van Houten (eds) *Empowering Humanity. State of the Art in Humanistics*. Utrecht: De Tijdstroom.

Smith, V. (1998) *Not just race, not just gender.* Black feminist readings. London: Routledge.

Ussher, J. M. (1999) Feminist Approaches to Qualitative Health Research. In M. Murray & K. Chamberlain, *Qualitative Health Psychology, Theories and Methods*. London: Sage.

Wilkinson, S. (2000) Feminist research Traditions in Health Psychology: Breast Cancer Research. *Journal of Health Psychology 5* (3): 359-372.

Williams, R. (1997) Living at the Crossroads: Explorations in Race, Nationality, Sexuality and Gender. In W. Lubiano (ed), *The House that Race built*. New York: Pantheon Books; p. 136-156.

Yin R.K. (1984, 1994) *Case Study Research. Design and Methods*. London: Sage

Yuval-Davis, N. (1997) *Gender and Nation.* London: Sage.