



Towards a Feminist Research Ethics of Care: Reflections, Lessons, and Methodological Considerations for Doing Research During a Pandemic

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ABSTRACT *Conducting feminist research during the global COVID-19 pandemic has evoked a renewed interest in the concept of care within our research team. The purpose of this paper is to provide concrete examples of how feminist ethics of care changed the initial and ongoing design of a community-engaged research project in Ontario, Canada. Drawing from examples and lessons learned, we focus on various adjustments to our methodological decision-making that intentionally honoured and prioritized our responsibilities to community partners, research participants, broader communities impacted by research, and the research team. By illustrating the methodological and ethical implications of these decisions, we argue that attending to these responsibilities prioritized both feminist research ethics and feminist ethics of care. As a result, we propose moving towards a conceptualization of a feminist research ethics of care, and discuss the value of this concept for researchers studying social justice.*

Keywords feminist research ethics of care; research methods; feminist research; social justice research

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Introduction

Using examples from a qualitative community-engaged research project that began early in the COVID-19 pandemic, this paper demonstrates how a feminist *research ethics of care* directly influenced our methodological decisions and processes, resulting in adjustments that centred *care* and *relationship* with our community partner, research participants, and research team. Specifically, this paper illustrates the nature of a research project between an academic research team and our local anti-violence healthcare agency. Furthermore, we describe the theoretical and literal ways we activated a feminist ethics of care, “trading a detached, distant, and hierarchical stance for an intimate, close, and equitable position” (Preissle, 2007, p. 527). We reflect on lessons learned and provide examples of how we upended Western research norms associated with naturalistic or positivist approaches that typically guide participant recruitment, data collection methods, and overall study design. In challenging taken-for-granted Western-centric ideas about how to conduct qualitative research, we hoped to mitigate potentially harmful and oppressive processes in an effort to move toward more just and liberatory practices when conducting qualitative research during the pandemic and beyond.

In this paper, we illustrate a nascent formulation of the concept “feminist *research ethics of care*.” This term is meant to describe a process that fosters and prioritizes just actions and ethical decision-making when doing feminist research, and it extends from already established concepts: “feminist ethics/feminist research ethics” (Ackerly & True, 2008, 2020; Kingston, 2020; Preissle, 2007; Preissle & Han, 2012) and “feminist ethics of care” (Gilligan, 1982; Noddings, 1984; Ruddick, 1980, 1989). We propose and argue that a “feminist *research ethics of care*” may be a novel framework for engaging in participant-centred research, distinct from feminist ethics. Feminist ethics is primarily concerned with epistemology and general ethical practice, while feminist ethics of care makes visible the labour of care work in research processes and procedures. Research is driven by, and methodological decisions are made in relation to, structural conditions that create and uphold inequities and oppression. The goal of feminist research is to centre care by not only studying adversity but by challenging it. We propose that feminist *research ethics of care* moves beyond incorporating discrete moments of ethical care, akin to an institutional box to be ticked, towards an approach that brings care into the entirety of the research process: from the beginning, middle, end, and beyond the life of a project.

Feminist *research ethics of care* works towards a more fulsome framework for conducting participant-centred research, challenging Western academic expectations about “productive” research programs and the “publish or perish” convention of (some) academic cultures, hierarchical relationships among researchers, and relations with those who participate in research, as well as the communities to which participants are connected. Loyd and colleagues (2022)

operate within this type of feminist care model by calling on feminist researchers to take time, to resist neoliberal markers of success, and to collectively slow down as a means to achieve ethical care in our research, teaching, and service. These elements can be seen as contrary to often fast-paced, measurable, (preferably) funded, and outcome-oriented priorities of Western academia. When applied to study design, feminist care models would contravene the fixed and less malleable nature of dominant modes of inquiry, such as experimental and quasi-experimental designs, that have specific rules governing how to create replicable and valid results and tend to be significantly less responsive to contextual factors that may impact the research (Campbell & Stanley, 1963).

A unique feature of feminist research is its focus on historical, political, cultural, social, and economic gendered ways of knowledge creation itself (the knowledge we seek to create with community or others). The concept feminist research ethics of care extends these foundational features to the process of conducting research. While the concept of a feminist ethic of care has been used in feminist research for many years, it has focused on researcher/participant interactions, and thus is limited in scope. The concept of a feminist *research* ethics of care extends this approach to consider how we contextualize relational processes in all steps of the research.

The reflections and lessons discussed below emerged from our research conducted during the COVID-19 pandemic. For our team, the experiences of living and conducting research during the pandemic and uncertain times forced each of us to reflect on why we do research, how to do research, and what role care should play in our project. While the impact of the pandemic led to our reflections, it should not take a global pandemic to convince us to pause and reflect on ethical research processes. Methodological reflection is central to feminist research (Letherby, 2003); this includes critically evaluating our assumptions, design, and research processes. Centring care is also not only a strategy for pandemic or crisis times. Rather, attending to care is valuable at all times in redefining the fundamental elements of what should be prioritized in community-based research. In the following, we first reflect on time and place and our positionalities. We then outline the research project, followed by a brief discussion of key feminist and ethics of care scholarship that inspires our work. Finally, through reflection, we demonstrate how we methodologically adjusted our project to centre care.

Reflecting on Time and Place

The research project we draw on was conceived, designed, and implemented during a global pandemic. In Canada and many places around the world, the arrival of COVID-19 brought with it an emphasis on community public health, shared responsibilities for care, personal accountability to sustain public health measures, and a general sense of looking out for our “neighbour” to combat

transmission and infection. For long periods of time, we were (necessarily) required to stop in-person contact with loved ones and our broader communities to lessen risk and increase safety. At various times throughout the pandemic, businesses, schools, and other institutions in Ontario, Canada were closed or limited; gatherings were restricted, and we were told to stay home except for essential reasons (Nielsen, 2021). The notion of care and social responsibility was a huge part of our lives and was sustained in public health messaging for almost two years. We also know that the impacts and consequences of the pandemic were most detrimental to Black, Brown, Indigenous, and racialized peoples, as well as those living with disabilities. Consequently, there was an increased call to collective care and mutual aid models among communities who were made vulnerable (Neely & Lopez, 2022). Looking back, we see how this global call for public responsibility and mutual aid work (being undertaken by communities made even more vulnerable by pandemic conditions), amplified the tendency of our research team to not only rely on feminist methods and ethics in our study design, but also sharpened our attention towards enacting a feminist ethics of care and encouraged us to go beyond this to develop the concept of feminist research ethics of care.

For the most part, university expectations for conducting research remained unchanged in the context of the COVID-19 pandemic, and research activity continued (Parr-Vasquez & Newman, 2021). These expectations were consistent with neoliberal principles that guide university institutions to focus primarily on research productivity and outcomes, especially among scholars working toward tenure and promotion (Caretta et al., 2018; Pitt & Mewburn, 2016). Research ethics review boards may have shifted the parameters of research activities (research travel was curtailed, face-to-face interactions halted, etc.), but generally academe maintained a somewhat “business as usual” approach to scholarship, publishing, and knowledge dissemination. For example, while most post-secondary institutions paused humanities and social science research involving human subjects (see Parr-Vasquez & Newman, 2021) regardless of being conducted in-person or virtually, other research, including critical medical research, continued (Ontario Ministry of Health, 2020).

While in-person research involving human subjects in the humanities and social sciences was mostly stopped for a period of time during the pandemic, there was simultaneously an expectation to keep research going that did not require human subjects. But human subject research also needed to be kept “at the ready” – especially in pandemic research that might be considered novel or innovative – for when the restrictions were lifted and new ways of securely collecting data (e.g., video calls) could be established. For example, a special call for COVID-19 research was issued by the Canadian federal granting agency Social Sciences and Humanities Research Council in June 2020 (Social Sciences and Humanities Research Council, 2021). And while the call to halt research travel and in-person human subject research was a necessary public

health precaution, the pressure to carry on research activity (perhaps more explicit for some researchers as illustrated above) was sustained by granting agencies, academia, and the broader research community (e.g., Social Sciences and Humanities Research Council, 2021). While our team did not experience significant pressure from the granting agency and our academic institution to undertake our research exactly as we had outlined (as others may have), and thus we were free to adapt our project, we still felt the pressure to continue researching and producing data during the pandemic. In this paper and through our reflections, we outline a feminist research ethics of care and its necessity in meeting and resolving particular research pressures (whether implicit or explicit) with a stance that prioritizes the relational, ethical, and practical aspects of the research project.

More specifically, for researchers who engage in social justice research projects involving people and communities who are continually put at risk by structural inequities, we were faced with new questions of vulnerability, capacity, need, and consequences of engaging in research for all project members. In an effort to avoid negatively impacting project members, we questioned fundamental aspects of our research design. For example, we reconsidered when and how we conduct research, how our projects impact those who participate, how research outcomes impact communities differently, how capacity changes during a crisis, and how we as a team were equipped to manage the added labour of navigating both a pandemic and these emerging research questions.

Throughout this paper we draw on reflections to present our methodological decision-making as a result of applying a feminist *research* ethics of care in our work. As feminist researchers, we are committed to doing research that is not transactional (i.e., does not primarily benefit the researcher). Part of this commitment includes publishing our *processes* to elevate and transform feminist research practices. We are not the first scholars to look for new ways to do things, nor are we the first to avoid positivist, reductionist, and hierarchical ways of conducting research. There is a rich history of research and scholarship by Indigenous, Black, queer, and disabled communities that challenge Western research norms, including the ideas that there is one objective, knowable truth, and that rigorous research must be decontextualized and unbiased (i.e., values are excluded) (see Browne & Nash, 2016; Collins, 1990; Smith, 2012). This paper is inspired by these histories and offers experiences and examples that illustrate our journey towards actualizing a feminist *research* ethics of care.

Our Research Team

We are cis-gender settler women whose scholarship is informed by social justice research principles. We engage intersectional critical feminist scholarship rooted in Black, Indigenous, and 2SLGBTQIA+ thinkers and

researchers, and rely on reflexive research practices consistent with feminist, anti-racist, decolonial, and queer theories. Our academic training in Western research paradigms has required us to unlearn and complicate the colonial practices and white supremacy inherent to these forms of research. Consequently, we have come to design our projects in ways that intentionally challenge assumptions of positivist and other non-critical research paradigms. This intentionality will, ideally, dilute research cultures that uphold “imperialist white supremacist capitalist patriarchy” (hooks, 2013, p. 4) and associated methods.

In terms of our social positionalities, Sonia is an Indo-Guyanese woman of colour and feminist, immersed in gender, health, and technologies. She has worked in many contractual academic positions and is now in the beginning phases of a tenure track position. As an interdisciplinary researcher, her work disrupts oppressive colonial practices in mental health and healthcare systems. Rebecca is a white tenured faculty member whose teaching, research, and activism are situated in the areas of social justice, gender, sexuality, and health. Jennifer is a white tenured faculty member and social worker, practicing and advocating in anti-violence prevention and intervention spaces. Rachelle is a white sociologist teaching and researching in the area of gender and health. She is currently a contract faculty member at multiple universities in Ontario.

Finally, as it relates to our decision-making processes and group dynamic, we relied on consensus to arrive at major decisions and adopted a reflexive turn-taking style of engagement during research meetings. We intentionally create space for each member to share their perspectives, ask questions, pose ethical dilemmas, and expand on decisions. We also are intentional in bringing our “whole selves” to the research process. This means we open and close meetings by sharing recent personal and professional activities. This sharing is an important part of relationship development that contributes to our ability to have meaningful connections and allows our team to offer differing points of view without the threat of judgment or dismissal.

The Research Project

At the invitation of our community partner, we designed a qualitative research study focussed on frontline helping professionals in hospitals (e.g., social workers, nurses, counselors) with the goal of mapping changes in supportive practices due to the pandemic when working with domestic violence and sexual violence survivors (D/SV). We intended to conduct online focus groups with these helping professionals in December 2020. Pandemic mitigation efforts and local public health directives that aimed to slow the spread of COVID-19 (e.g., stay at home orders, social bubbles, work from home) heightened already unsafe conditions for people who experience violence in their homes, within their families, and from their partners; these directives contributed to conditions resulting in increased rates of D/SV (Kourti et al., 2021; Piquero et

al., 2021) and impacted the way violence intervention and prevention services were offered by social service and healthcare sectors (e.g., greater reliance on telephone, video chat, social distanced services) (Ghidei et al., 2022; Jack et al., 2021). Our project, which was imagined and designed in late 2020, considered the convergence of two problems that could precipitate a potential crisis period for frontline workers. The rapidly changing landscape of trauma-informed care for survivors of D/SV meant that helping professionals were working without the benefit of time to measure or track the impacts of these shifting practices and to reflect on what was and was not working well. At this point in time, our goal was to assist our community partner in tracking and making sense of their adaptive practices.

During the early phases of the pandemic, we designed our focus group study to recruit active frontline hospital workers who could detail their experiences providing D/SV care during the pandemic in rural and remote healthcare settings. We intended to map how COVID-19 altered trauma-informed care, and to document how shifts in care practice was impacting frontline workers and survivors. We also intended for the design simultaneously to provide an opportunity for frontline workers to hear and share strategies with one another that could inform their quickly changing adaptive practices. Beside the potential for immediate knowledge exchange between participants, we hoped focus groups would lead to the creation of community- and region-specific knowledge that could guide trauma-informed care when public health orders require reduced in-person support.

Despite these hopes and intentions, we opted to delay the focus groups until a time when our community partner and frontline practitioners were not operating under extreme distress as a result of the pandemic. We altered our initial research design by creating a two-phase study; Phase 1 would entail an academic and community review of best practices, while Phase 2 would include the focus groups. This methodological shift would provide time for the pandemic context to potentially change out of a crisis period, thereby reducing the possible extractive nature of participant engagement. It also gave us time to synthesize emerging literature and practice standards, which enabled us to draw together important information directly related to the study goals (i.e., mapping supportive DV practices during a pandemic). By drawing out the timeline of the initial study, our team was also afforded time and space to reflect and centre our own personal and professional needs, including prioritizing mental and physical health amidst a global pandemic.

Towards a Feminist *Research Ethics of Care*

As we call for care to be integrated into all aspects of the research process and work towards a feminist research ethics of care, it is important to situate our approach in the scholarship that has inspired this work and move away from reclamation projects under the guise of feminist practices. We recognize the

harm that white feminism has done by appropriating, ignoring, plagiarizing, and silencing the voices, experiences, work, and theory of racialized and marginalized scholars (Phipps, 2016). We are not suggesting that we are the first to think about research as integrated with care or that ethics of care is the only approach; we want to put feminist research ethics, feminist ethics of care, and feminist methodologies in conversation with one another as a way to begin extending and framing research in complex and dynamic ways.

We make distinctions between (1) feminist research ethics, (2) feminist ethics of care, and (3) feminist research methodologies as a point of clarity, and also to specifically point to the contribution of this paper. Our work contributes to feminist ethics of care literature by extending it to include feminist *research* ethics of care. Even among seasoned feminist researchers, it can be easy to conflate these closely linked concepts, and as a research team it took us several conversations to sort through what we consider are important distinctions in the literature.

Feminist research ethics have long been examined in epistemological and methodological discussions about feminist projects (Ackerly & True, 2008, 2020; Kingston, 2020; Preissle, 2007; Preissle & Han, 2012). For example, Ackerly & True's (2020) careful attention to feminist research ethics, notably the concept of intention, will ideally shape how researchers attend to reflexivity, power, and trust when conducting feminist research.

Feminist ethics of care is a concept that calls for feminist ethics to include and engage *care*. Feminist ethics of care scholarship understands the meaning of care as attending to the needs of others with whom we are in relation (Held, 2006). Early work on care focused on women as caregivers – an area that was left out of mainstream research – and centred social and temporal context, relationality, mutuality, and moral decision making (Gilligan, 1982; Noddings, 1984; Ruddick, 1980, 1989). Although this early work affirmed the significance of care, it has been critiqued for being essentialist and more relevant to a white *feminine* ethics of care than a *feminist* ethics of care (Tronto, 1987). This is because a *feminist* ethics of care is inherently political in its focus on power and systems of oppression, which problematizes essentialism.

Facing this critique, feminist ethics of care work moved to analyze gendered power relations more explicitly and intersectionally, exploring the complexities of women's lives and the social, racial, economic, and political context of care (see Keller & Kittay, 2017, for a review). Care theorists argue that care work hinders carers and has citizenship (Sevenhuijsen, 1998; Tronto, 2013), economic (Bubeck, 1995; Folbre, 2002, 2012; Kittay, 1999), and political (Kittay, 1999) implications for women. Other scholars address inequalities in the giving and receiving of care among women based on class and race (Sevenhuijsen, 1998; Tronto, 1993), recognizing how low-waged care is devalued (Duffy, 2005) and how race impacts who receives care and what that care looks like (Raghuram, 2019).

Mainstream scholarship on care ethics is often Western-centric, and Black feminists have long given attention to care. Black feminist ethics of care

centres collective caring and views care as a site of liberation where community care, interconnections, and relationality are its core (Neely & Lopez, 2022). It is often rooted in “othermothering” (Collins, 1990) as a revolutionary practice of women caring for children both across the community and intergenerationally (Butler, 2019; James, 1993; McDonald, 1997). Care ethics bring attention to mutual responsibility, vulnerability, and building communities of care (Nash, 2018) while rejecting individualism (Collins, 1990). While we situate our thinking and practices about care within a feminist paradigm, prioritizing and attending to gender as a key factor shaping a research ethic of care, we acknowledge the parallel and complementary theorists and thinkers who have shaped and continue to conceptualize ethics of care in relation to multiple power relations.

While there is no singular feminist research methodology and employing feminist research practices does not mean research is free from harm, feminist research is concerned with power relations and creating space to reveal and challenge inequities with the goal of social justice and transformation (Jenkins et al., 2019). Feminist research practices emphasize power and knowledge production; attention is drawn to the context in which the research occurs and the exercise of power in research, including the relationships between researchers and participants and among the research team (Bell, 2014). Feminist research rejects notions of objectivity and positivist research principles, contending that knowledge is shaped by contexts and those who produce it (Aranda, 2018; Gillies & Alldred, 2012). The principles of reflexivity and positionality recognize and make our connection and relationship to our research explicit (Aranda, 2018; Harding, 1992) as we take ourselves as the object of critical gaze (Aranda, 2018; Green & Thorogood, 2014). With a focus on participants, feminist research practices are also often participant centred, breaking down exploitative research practices and valuing participatory research approaches (Jenkins et al., 2019).

Taken together, feminist ethics, methodologies, and ethics of care scholarship challenge typical ways of doing research and are political by nature, centring power while working towards justice. These research approaches challenge dominant masculine research practices, liberalism’s rights-based approaches to ethics that centre rights, individualism, and ethical protocols (Keller & Kittay, 2017), and the regulation and box checking focus of Western research ethics boards. As we have conducted our research project throughout the pandemic, we have come to realize that care needs to be expanded and implemented at all stages of the research process. What our research has led us to ask then is what does it mean to build and work towards a feminist *research* ethics of care?

Adjustments to Our Project

Our team has reflected on the various adjustments we made throughout this project, and we have arrived at this general conclusion: our methodological decision-making processes were directly informed and aligned with feminist research ethics of care from the outset. For example, one of our first significant adjustments to the design came at the height of a pandemic wave in Canada when COVID-19 infections and hospitalizations skyrocketed. While the goals and objectives of our research remained the same, as the impacts and consequences of the pandemic began to escalate, we immediately entered a reflexive space to consider how our initial research tasks (i.e., recruiting participants) could centre caring. We reflected on the pandemic, the D/SV crisis, the impacts on frontline service providers, and our responsibilities as researchers to each other, our community, and our participants. These are some of the reflective questions we posed:

- Is this the best time to engage an already overburdened sector?
- Do frontline healthcare workers have the capacity and time to commit to a focus group?
- Will engagement in a research study impact service delivery with survivors?
- Who will this research, in its current design, benefit?
- What is our responsibility to our community partner?
- What is our responsibility to survivors of domestic and sexual violence?
- What is our responsibility to each other, as a research team?

We began reflecting on the project and discussing the above questions after we received funding for our initial project design and as we prepared to begin the process of recruiting. After lengthy discussion and deliberation among the research team, we decided to move from our initial design in favor of a more *care-full* plan. Our reflections also included extensive decision-making about how methodologically to maintain the research purpose and objectives while preventing potential for further burdening our research participants and the survivors who access supports provided by potential participants.

Another conclusion we have drawn regarding the way our team operated relates to the way we negotiated and distributed research labour tasks. One could describe our approach as a non-hierarchical approach to leadership, or perhaps a cooperative approach to teamwork. We again suggest that feminist research ethics directly informed the way we attended to labour and the distribution of the work of care. While the two tenured members of our team developed the funding application, once funding was awarded the team shared equally in all aspects of the implementation phases of the research. Research tasks were identified and then opted into by each member of the team. We were four leaders in a four-person team, each taking a turn to lead and be responsible

for various aspects of the project. For example, given two of our team members are not yet tenured (one is tenure-track, pre-PhD; one is post-PhD part-time faculty), we would often explicitly ask about our personal and professional capacities, career stage, and interest in the task (e.g., literature review, writing drafts). We created space for each team member to take on tasks that felt manageable or did not interfere with other important activities beyond this project.

Adjusting for our Community Partner and Participants

As we reworked our project and reflected on our original decisions, we focused on the potential needs and the impact of the pandemic on our community partner and possible research participants. Given the considerable increase in requests for help and fast-paced transition to virtual delivery of services, was it responsible or reasonable to ask them to engage in a research project? For example, our original intention was to provide an opportunity for knowledge exchange between practitioners during focus groups. As a part of our reflexive process, we aimed to be attuned to the needs and future relationship with our community partner, especially during a global crisis. Specifically, we asked ourselves: Was it an appropriate time to ask practitioners to participate in our research? What value would the research process and findings bring to their practice? Was the potential benefit of participation greater than the loss of time to support survivors? Could a simple research invitation be interpreted as obtuse and out-of-touch with the demands on frontline healthcare practitioners? Recognizing that the pandemic was all-encompassing, would participating in our study take time away from practitioners to care for themselves and to rest and recharge outside of the hospital? As we reflected and the pandemic continued, we recognized that the invitation and actual participation in a focus group study would likely feel burdensome for practitioners. These communities were already relying on their training and networks to navigate this crisis moment and moving quickly to ensure the best possible supports were in place under tremendously stressful conditions. Given this, would our research have added value to their practice?

Centring our community partner and practitioners, we decided to postpone the focus groups. Doing so not only centred care but moved us away from the “good intentions” framing of our research as the space where *we* would create the opportunities for frontline practitioners to connect as part of our topical, fast-paced, “on the ground” research. Practitioners were already doing this every day. Our research processes, with all the bureaucratic procedures, consent forms, and pre-arranged Zoom times for focus groups, could have been an additional burden as it shifted to documenting what they were doing rather than creating the space to have conversations and thus add value to their practice. Instead, we opted to wait for the crisis to subside and offer a more manageable time and space for participants. As previously mentioned, we

extended the work plan of our study to draw out time. By dividing the study into phases, we created a six-month window to complete Phase 1 (literature review and community review of best practices) before entering Phase 2 – the focus group and interview phase of our study.

While it may seem that these adjustments were merely logistical, they were informed by a feminist research ethics of care. The adjustment to our study meant that the study accounted for and considered the context and lives of possible participants. The height of the pandemic did not feel like the moment to ask practitioners to do more. This decision challenges and confronts contemporary ideas about the intention and purpose of research; we centred care and relationship with practitioners rather than research outputs and adjusted accordingly. When we make decisions about research, we should adjust to do the least harm possible, and in some cases, not doing the research at all may be the least damaging approach (Razack, 2022).

Adjusting for Survivors

While our study focused on practitioner experiences, the purpose of our research is to help ensure survivors receive the best support possible now and into the future. This means we were also accountable to and responsible for impacts on survivors of D/SV. We often rely on a familiar principle when doing research with those who are made vulnerable and marginalized: “nothing about us, without us.” This principle was on our minds as we imagined study implementation and engaged in methodological decision-making. Even though we were not engaging survivors as research participants, we were intentional in considering how adding to the plate of service providers and their organizations at any point during the pandemic could impact survivors.

Community based research and other critical research approaches often focus on ethics solely in terms of the research participants. Feminist research ethics of care must be expansive; not only should we consider care directly to the participants but think about who participants are in relationship with, thereby expanding care to those individuals. This approach to research and ethics moves away from understanding and viewing participants through a lens of individualism. Instead, this approach is community focused, expanding care and ethical considerations to the collective.

This is an example of how survivor experiences and voices should be at the forefront in research about D/SV, even when survivors are not necessarily directly involved in the research project. The implications and unintended impacts of research for survivors – such as adding to the burden of frontline practitioners and thereby potentially negatively impacting the time and capacity they had to provide support to survivors – should be accounted for as much as possible when conducting gender and sexual violence research.

Adjusting for Each Other

As we reworked the project, we also centred our research team. In doing so, we rejected positivist notions of researcher objectivity and moved beyond typical notions of reflexivity to recognize our positionalities and the context of research and knowledge production (Bell, 2014). In other words, we worked with concepts of care to account for us, as researchers, as social beings who are deeply impacted by a global pandemic. At different points we were all exhausted, afraid, and grief stricken. Given that we are part of the research (Maxwell, 2009), we did not want to engage in work when we were not well ourselves. If we want to prioritize the well-being of participants, why would we also not hold ourselves and each other with the same care? Attending to and being intentional about our capacity to do work reflected feminist research practices.

As a result of turning care practices towards ourselves, we intentionally created space for us to name our feelings of isolation, burnout, and grief, and our personal health concerns. We made space to have these conversations in centring our team. This meant being open to rescheduling meetings without question and encouraging self-care. Our meetings started with a check-in at which we discussed teaching (including pandemic teaching strategies), publishing and all the challenges that come with it, and other academic happenings. We spent time chatting about our families and gardening, and sharing cooking tips, including the team's love of air fryers. During one meeting, we were each nearly in tears from life and academic stressors. After our check-in, we decided to end the meeting and give the gift of time to ourselves to do whatever it was that would make us feel more grounded in the world. These check-ins were and continue to be more than friendly gestures among a research team; they allow our team to engage with one another in a safe and supportive space, gain mutual support from colleagues, and gauge whether we have the capacity to be present in the meeting. By centring our team's well-being, we employ a feminist research ethics of care, which recognizes that researchers, like participants, are impacted by the social world.

While it is true that canceling and rescheduling meetings may impact the project time frame, and that time frames are often structured by academic constraints (e.g., obligations to funders, funder expectations and timelines, publishing and research expectations), this prioritizing of our teams' well-being was a methodological choice. This choice influenced how we adjusted our research design, including how time and place shaped our abilities to do data analysis, interpretation, and our abilities to disseminate findings. Rather than simply acknowledging that "stuff happens" in people's lives yet you keep working, our goal was to fully integrate care practices for ourselves and others into the research process. Our ability to do meaningful work was guided by paying attention to our team's needs and well-being. We recognize that our experience may not be the same as others. Academics are at different stages in their careers and face various demands that affect their ability to change

research plans. We acknowledge these realities and encourage fellow researchers to consider what narratives and expectations they might challenge to create more space to care for themselves and others in the research process, thereby resisting a more extractive approach to research.

A Feminist *Research Ethics of Care*: Concluding Thoughts

Building from the feminist literature to make clear distinctions between feminist ethics, feminist methodologies, and feminist ethics of care, we propose extending these concepts into a feminist *research ethics of care*. A feminist research ethics of care centres care and relations, and in doing so challenges Western academic research norms. It includes acting with more intention (Gillies & Alldred, 2012). This means normalizing the need for care not only at the design phases but throughout all aspects of the research process. This approach integrates Ratnam and Drozdowski's (2022) contention that a feminist ethics of care should be included across the life of a research project, even beyond its completion. This includes, for example, ensuring that knowledge translation of academic materials is made available to research participants and maintaining meaningful connection with participants (and their communities) to prevent extractive research practices. Feminist research ethics of care is also consistent with Caretta and Faira's (2020) call for "reflexive, situated, and transformative research, ethical engagement with research participants and environments, and knowledge production that is participatory, collaborative, and more widely accessible" (p. 172).

We are committed to normalizing care in feminist projects (in all empirical projects, for that matter), but we recognize the critiques of feminist care as placing feminist researchers back in the gendered position of "carer" rather than researcher. Grimshaw (1991, as cited in Preissle & Han, 2012) cautions feminists about the implications of "claiming an ethics of care that may place women back into a gendered ghetto by suggesting that women operate by a different, inherently lesser standard of decision making" (p. 527). We contend that there need not be such emphasis on a binary divide in the researcher role; we can be both/and. We can prioritize care without sacrificing or jeopardizing our ability to engage in research. We want everyone to be able to reclaim care work as a way to introduce humility, relationality, equity, and justice into the research process. These practices are reminiscent of Indigenous knowledges and approaches to research (see Tynan, 2021). Intentional care work is beneficial for research, and, like the many feminist researchers who have come before us, we must challenge the gendered nature of this critique that attributes care as a weakness and supports heteronormative and cisnormative positionings. Requiring ethical care work in research demonstrates a keen understanding of the methodological assumptions and bounds of feminist projects, signaling attention to rigour and quality in the research process.

Along with intention, feminist research ethics of care includes methodological flexibility and the notion of adjustment. Adjustments to study design are, again, often framed as a weakness, and methodological changes are typically deemed problematic in certain Western research traditions. However, adjustments and flexibility actually uphold a feminist research ethics of care because flexible design allows research to be attentive to social situations and the lived realities of participants and researchers.

A feminist research ethics of care also centres community and relations. Starting with care and integrating care throughout our research means that we build trust and empathy while working towards non-exploitative research relations (Caine et al., 2020). Relations here are expansive; we extend care not only to our participants (or potential participants) but also those with whom participants are in relationship. Thinking about our participants as more than individuals, as part of a larger community of other practitioners and survivors, helps us understand the impact and implications for doing social research, and moves away from Western individualized notions of ethics.

A feminist research ethics of care builds deeper relationality by integrating self-care and comradery into the research process. As a methodological principle, this includes creating space for thoughtfulness, consideration, and concern for the well-being of the researchers and research team. While a feminist ethics of care recognizes positionality and the connection between researcher and knowledge production, we propose to move beyond positionality to centre care. Centring care involves recognizing positionality and accounting for researchers as social beings throughout the research process who are living their lives at the intersections of their positionalities, considering the ways in which researchers are impacted by the world in which they live. In extending care to researchers, care is then extended more deeply to the research project itself.

While our research and reflections on it have taken place in the context of a global pandemic, it should not take a global pandemic for us to recognize and prioritize ethical care in research. We should always prioritize a feminist *research* ethics of care.

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