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Researching Gay Men's Health: The Promise of Qualitative Methodology

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1 Introduction

Public health research has always been dominated by the cross-sectional population survey as the most frequently used technique, and it frames much thinking about how social and behavioral research is conducted on public health issues (Kavanagh et al., 2002). It has become the dominant and default research methodology. Nevertheless, in recent years there has been a growing interest in developing new research techniques to investigate public health in the humanities, social science, and even in clinical research in medicine. One area of growing interest lies in qualitative methodology.

Although qualitative methodology is not new in other research fields, it would not be untrue to say that there has, at times, been a suspicion in public health that qualitative methodology is "soft," unrigorous, and therefore unable to answer key questions that public health seeks to clarify or answer. The irony is that qualitative data-gathering techniques have long been part of health: The clinical case study is a good example of an important research technique that has yielded valuable information and insight into health issues. Field observation and other ethnographic techniques used in medical anthropology have also proven their worth over the course of the twentieth century in investigating other cultures (and sometimes our own) and the relation of social practices and processes to health experiences and outcomes. Also, for quite some time there has been effective use of qualitative methodology as a rapid appraisal or pilot data-gathering technique to ground a later survey in appropriate languages or to flesh out the list of options available to use in structured questionnaires.

The distinction made between experimental and observational studies in health research, with the former seen as truly scientific and the latter as producing less-rigorous evidence, has tended to cluster many qualitative data-gathering techniques into a single category (at the observational end) artificially contrasted to quantitative methodology and assuming some substantive differences. More recent experi-

ence has softened this contrast considerably as complex public health problems seem to require new and varied approaches to information gathering and more sophisticated understanding of persons and context. For gay men's health—the focus of this chapter—the advent of the human immunodeficiency virus (HIV) epidemics in many parts of the world proved a significant stimulus in calling forth qualitative methodology to assist in comprehending one of the most complicated public health problems of the modern period. Yet it is important to remember that gay men have health issues other than HIV infection and acquired immunodeficiency syndrome (AIDS), and the discussion below, although referring to HIV/AIDS at times, aims to be applicable to gay men's other health issues as well. Indeed, much of what follows might well apply to lesbian health (or even to transgender or bisexually active people); but the examples used and the argument mounted are most directly focused on gay men (for a critical framework for these issues, see Wilton, 2002).

1.1 Sexuality and Health Research

There is no moment more important in the conceptualization of sexuality as a field of scientific study than the invention of the *homosexual*. This categorization by Benkert in 1868 of a wide range of sexual activity and interests into a single common category (to be joined by its alter ego *heterosexual* some 10 years later) signaled the first significant step in subjecting human sexual activity to a new form of scrutiny and investigation (Foucault, 1978; Weeks, 1985). These scientific research endeavors, their epistemological bases in positivism, and its belief in the facticity of natural science converged with a parallel development in the human and social sciences. Within this framework, the invention of sexuality as an object of study was to produce more than a century of scientific work in health, psychology, and biology, in particular, that attempted to categorize, classify, investigate the causes of, and seek to reform and cure the homosexual—men as well as women. The term homosexual (or *homosexuality*) is used here to name that scientific and discursive invention; the common term *gay men* is very much a construct of the late twentieth century and originated in the West. Its growing usage as a common "hold-all" term should not mask the fact that this term does not describe all the various cultural understandings and forms in which male-to-male eroticism occurs globally (this is elaborated later). Moreover, until only recently, the major frame of reference for thinking about gay men (and lesbians) was primarily as a category of the *sexual*—and a deviant and "sick" one at that; and the deeper and various cultural understandings just referred to were often neglected or unrecognized by science.

Defining gay men's (and lesbians') health as a field that includes but goes beyond sexual matters has been a long struggle—ironically, one that HIV/AIDS both hindered and stimulated. The definitional frameworks through which the HIV pandemic has been seen have changed, progressing from an sexually transmissible infection to a disease defined by certain sexual and cultural practices and meanings (e.g.,

men's sexual privilege or risks present in commercial sex work), then to a disease of development and socioeconomic factors (e.g., in relation to poverty), and now increasingly to one involving human rights. Yet, for some reason, HIV/AIDS is often still thought of as a gay disease first and foremost.

1.2 The Rise of Critical Sexuality Studies

The post-World War II period witnessed a rise in new scientific approaches to studying sexuality, particularly after in/famous Kinsey reports (Kinsey et al., 1948, 1953) revealed, *inter alia*, widespread same-sex sexual interests and practice among men and to a lesser extent among women. This research stimulated the last 50 years of sex research, in the United States in particular, which continues to reveal a diverse sexual culture in this country and in many other Western developed countries. That research eventually provided evidence for, and argument on, the nature of human sexuality, which supported the rise of the sexual liberation movements (mainly among women and among homosexual people) from the late 1960s onward. These new social movements fostered new forms of research on sexuality in general and homosexuality in particular that began to utilize qualitative methodology more. Historians, psychologists, sociologists, anthropologists, and cultural and media studies intellectuals began to investigate homosexuality in what came to be called *gay and lesbian studies*, which later merged, in the United States mainly, into *queer studies*. *Sex research* and *sexology* (as the traditional twentieth-century fields of study were known) themselves became the object of a new *critical sexuality studies*, which continues to question these older formulations. Gay and lesbian studies, queer theory, and the new critical sexuality studies not only challenged the prevailing understanding of human sexuality, its origins, and elaboration in science but also raised the possibility of studying sexuality with new methods.

1.3 What Does This Mean for Gay Men's Health?

Raising these issues here is important for gay men's (and lesbians') health because the presuppositions that are prevalent in our culture about homosexuality often formulate research questions in ways that are either *heterosexist* (i.e., based on, and working with, models, assumptions, and ideas that mostly apply to opposite-sex-attracted people and their activities and see them as normal because of a larger prevalence of those sexual interests) or *homophobic* (i.e., directly growing from frameworks and predispositions that render homosexuality as bad, sad, or abject and include ideas that demonstrate considerable negative affect in relation to homosexual people and engender support for punishment, violence, marginalization, and stigmatization). Beyond these formulations, seeing gay men and lesbians first and foremost as sexual beings in a world that has distinct and often contradictory values concerning sex and sexuality makes it important—and often complex and difficult—to understand what and how social issues such as health are shaped for and by gay people.

Sexual health as a field suffers in particular from this assumption about gay people primarily as a sexual category. Yet it may also be that the historical effects of such categorization and its stigmatization do produce real, adverse health consequences: for example, how might we seek to understand the evidence on late presentation by lesbian women for breast cancer screening or on the growing concern about gay men's approaches to recreational drug use and sex, as just two examples (Leonard, 2002). The issue for anyone concerned with gay men's and lesbians' health is to recognize the convergence of, and clash between, these historical and scientific paradigms and their influence not only on determining what health is for homosexual people but also on how homosexuality and health have ridden in tandem throughout the development of modern medicine and public health as fields of major scientific scrutiny and social endeavor. It behooves any social researchers working in public health to familiarize themselves with this history and with its residual effects in shaping current research approaches to gay men's health and to assess in our own research ways in which this history of the homosexual in biomedicine and public health still shapes the prevailing ideas about gay people and our health needs and concerns.

2 Gay Men as Subjects of Research

This background begs an important question. Just what is a *gay man*? The same question could be asked about lesbians even though that term has been in common usage longer. How do we recognize a gay man as such for our research, and where or what is the boundary between him and other men? These are not silly or simple questions; they recognize both the modernity of gay and its uncertainty. By this is meant that gay as a category of human beings recognizing themselves and defined as such by others—who, by default, must be nongay—is a very recent event in human history and not a fully achieved or stable one. In pointing to the invention of the modern homosexual (noted earlier), British gay historian Jeffrey Weeks and homosexual French philosopher Michael Foucault alerted us to the historical and discursive contingency residing in the category gay. Their work reveals, in Western thought, the unfolding delineation of human beings (usually men) into categories defined by sexual interests and activities (one might call them *sexual preferences*) over the previous two centuries. This resulted in the eventual transfer of interests in certain sexual practices (iconically, sodomy, defined mostly by that time as anal intercourse between men) from an occasional or regular act into a kind or person (one might call it a *sexual orientation*). This, in turn, became the defining characteristic of the self (one might call it a *sexual identity*). To paraphrase Foucault: sodomy, the act, became homosexuality, a category of persons (i.e., a *sexuality*).

This achievement in Western thought, though exported imperially to the rest of the world ever since, has yet to consolidate its global dom-

ination, even if it has gained a hegemonic position in medical and health research with the onset of the HIV pandemic. Many other cultures have other meaning-making systems of action and thought to understand same-sex attraction and activity. Indeed, many postcolonial legal and moral systems reflect the contradictions between the Western-derived and Western-imposed categories of sexuality and the lived experience of local, historical sexual cultures (Altman, 2001).

Less well known are analyses in our own Western culture that reveal the same uncertainty about sexuality categories and their applicability in describing sexual interests exercised by men (and women) in New York, London, Sydney, San Francisco, Amsterdam, and other such major Western cities. We often think we know what gay is and who gay men are in such cities where *gay community* is a valid concept, a geographic precinct or neighborhood, a political mobilization, or an infrastructure that provides goods, services, public validation, and sex to those who inhabit it. Much of the mid-to-late twentieth century saw concerted scientific and political efforts to develop those very communities, those very categories, and those sexual practices as not *un*-normal, as worthy of civil equality before the law, and deserving fair treatment as human beings just like you and me. In partly achieving those ends (full civil equality has not been achieved anywhere yet), this concerted action had the effect of "hardening" the very categories with which it was forced to work. To use the social scientific term, gay was reified.

That historically contingent moment that invented the homosexual operated largely unquestioned, even in science, for most of the twentieth century and generated a much warranted critique only with the advent of the gay liberation movement during the late 1960s. Ironically, it was that movement—whose ideas were by the late 1970s questioning all sexuality categories as historically contingent and to be eventually supplanted or discarded—that needed the very terms it eschewed to mobilize its forces, consolidate its "membership," and demand social and civic space. The more that gay liberation claimed gay as a standpoint from which to mount a critical appraisal of sexuality itself, the more gay as a category of persons became firm.

Soon, during the early 1980s, the liberationists' deconstructive urgings ("everyone can be bisexual") were seriously weakened—and the countervailing convergence toward the category gay was strongly bolstered—by the need to mobilize to fight HIV/AIDS in those very gay communities that had been consolidating by the end of the twentieth century as one consequence of the gay civil rights struggle. Gay men were soundly nominalized and the gay community also reified into definitive social categories more so than ever before. The social research in public health that pursued gay men and gay communities to help us find out how HIV was spread and how sexual acts between men might be transformed to prevent transmission of the virus was itself an important contributor to this nominalization and reification. Science was productive here, not simply reflective, of the very sexuality categories it researched.

2.1 Gay Men as Study Populations and Samples

This history and science's part in it still have important implications for researching gay men (and lesbians, bisexual, transgender, and intersex people). The first important issue here is the definition of gay men as the "population" for our research. *Population* in this usage is the totality of persons who are known to form a bounded or whole cluster of like people and who constitute the focus of, or are constituted by, the research questions in our studies. For example, if we are keen to study the experience of a flood that affected a whole small town, the population for our study might be all the people in that town. If we are keen to understand how households manage having a member living with a particular disability, the population might be all households living with that disability. It is from the potential population of any study we plan that we select a sample (a smaller group representing the larger) for our studies when the population is too large to study in its entirety. Therefore, in the case of the flooded town the whole population might be small enough to constitute the sample; in the case of the disability study, there may be too many such households in the United States, so we might take every one in one hundred such families across the country, or we might sample all those in one city in the hope that the sample represents the whole population well enough to allow us to speak from our findings about and to the whole population. Sampling techniques and issues concerning them are discussed technically elsewhere in this volume and in many research methodology textbooks. Here, and first, I want to canvass some of the population definition issues and sampling consequences for us when we are researching gay men's health.

The main dilemma when sampling gay men is that we do not have much of an idea, anywhere, of the boundaries to populations of gay men; nor might we ever find real boundaries. This is partly due to gay men being quite a new social category, not simply evolving from the earlier homosexual but actually brought into being from its collision with left liberationist ideas during the 1960s, as noted above. This category now is evolving in its own right; but it has not supplanted earlier categories, nor has it incorporated all other forms, meanings, and cultural understandings of same-sex desire and activity still operative in our culture. It is also a category of persons who appear to be growing a sexual identity that many men with same-sex interests (but not all) take on to describe themselves. Gay men appear to be visible everywhere and therefore are easily knowable.

The rise of modern gay communities and quite a few places, neighborhoods, or precincts that are understood to coincide with gay community life, such as Chelsea and the West Village in New York City or the Castro in San Francisco, make the identification of gay men as study respondents seem fairly easy. The use of gay community resources, such as social and commercial businesses, clubs and advocacy groups, gay media, and sex venues (bathhouses and sex clubs) has featured prominently in health research, particularly regarding HIV/AIDS for the last 20 years. This has been less used or useful where such precincts

are more hidden or dispersed. In these cases, social networks of respondents are often used to recruit respondents for studies. These communities, precincts, or networks have certainly allowed a great deal of research on gay men to be undertaken in recent years and have offered valid research findings for public health purposes in most instances. The attraction of this kind of research recruitment and its underlying assumption of who gay men are is that it finds in such men all the convergence that science seeks in terms of sexual behavior, sexual orientation, sexual attraction, and a socially identified density of like men.

Yet, a great deal of sex between men takes place outside the identity-category gay man; indeed, the term *men who have sex with men* (commonly, MSM), coined during the HIV pandemic, came into being precisely because men in studies of male-to-male sexual behavior and HIV transmission risk did not use the term gay or see any sense in that term to describe themselves. Framed as an identity/practice dissonance or as some sort of social paradox, it is often incorrectly assumed that MSM are *really* gay but do not admit it or have not fully realized it yet. This dissonance or paradox is evidence that sex between men does not always find meaning or cultural definition for the men practicing it as gay sex. Such men do not live among "gay-identified" men in gay communities, do not want to do so, have other ways of living lives (e.g., marriages, male and/or female partners), are subject to other social forces that shape their choices of how to live their lives, and find the idea and practice of gay life unsuitable.

In the United States, recent discussions of African American men on the "down low" and growing awareness about institutionally produced sexual cultures (e.g., in prisons, the military, sporting teams, schools, fraternities) indicate that a great deal of sex between men finds no relevance in the constructs of gay men and gay communities at all. Indeed, Kinsey et al. (1948) found more than 50 years ago that only a small percentage of men were exclusively homosexual throughout their lives (4%), and the sexual interests of other men change over time. Their various percentages for homosexual sex between men are mostly measures over a 3-year period precisely because of the variability of sexual practice over a lifetime.

2.2 Population Definition in Qualitative Research

Our first problem in gay men's health, then, might be wrestling with the uncertainty of the population we are seeking to investigate. This is an issue for any research methodology, quantitative or qualitative; but it becomes even more pressing because of the smaller sample sizes and the different sampling frames used in qualitative studies. There is a blurred boundary between gay and "straight" (i.e., between homosexual and heterosexual), and we must make important definitional compromises and assume population boundaries that are often arbitrary and not indigenous to the population itself (i.e., defined by a research project's needs rather than the population itself). Therefore, when we sample from populations of gay men for qualitative

research, we must be explicit about decisions made on population definition.

We must also be critical of any underlying assumptions about that population ("we recruited them at gay bars, therefore they must be gay men"; "all gay men live in Chelsea, New York, or the 'Castro', San Francisco—let's recruit there"). Also, we must be clear that our samples have limitations in "standing in" for gay men at large or all gay men because of the difficulty inherent in defining the boundaries of gay. This population definition issue has become more crucial as younger generations of homosexually active people resist and refuse the category of gay man (or lesbian) and use *queer* or *bisexual* or *undecided* and *questioning* (Hillier & Rosenthal, 2001) both in their daily lives and in response to researchers' requests for sexual identity choices. We need, then, to find other ways to define our populations. One way to establish more clarity on population definition and boundary in qualitative research is related to clarifying each particular study's research object.

2.3 Defining a Research Object

Even if the uncertainties of study populations are bypassed, for example by selecting to study only gay-identified men and/or those who live distinctly gay life-styles (e.g., in male domestic partnerships or members of gay community organizations), we still cannot guarantee that our sample will be gay men, clean and simple. The reason for this lies in the selection of the *research object* for qualitative studies. A research object can be defined as the "place" where the research questions will be best answered by providing data and information or materials for analysis; this has to be clarified before the population definition and sampling can be established. For example, in the study of the flooded small town mentioned earlier, the research object is the town's experience of the flood itself. There might be a number of sources of information and data in the town documenting that experience, such as affected inhabitants, emergency workers, local community leaders; and we can obtain official accounts, newspaper reports, television footage, and so on. In this example, the people in the study are not the research object as such but, rather, one of the sources of data about the research object—the town's experience. In other words, that object offers a number of potential populations to investigate. This is similar to classical anthropology, where whole villages or exotic cultures are studied; people and practices are in the study but are not the research object as such. In qualitative research, even in public health, people may not at all be the research object of a study, even if they are included in an investigation in some way.

The research objects in many qualitative studies on gay men's health can be quite varied; and although gay men might assist as research respondents, they may not always be the principal focus. For example, we might be evaluating a home care program for aged gay men or assessing the training needs of youth workers who work with young gay men. Here the care program and the training needs are the research objects. Similarly, we might see value in understanding how the "cho-

reography of drug taking" affects gay men's drug use (Southgate & Hopwood, 2001); that is, how the ebb and flow of recreational drug taking over an evening of partying takes place and how it generates any related sexual activity during such events. In such a study, we would not necessarily assess the amount of drugs taken or the frequency of sex practices engaged in for the purpose of generalizing about the amounts of drugs gay men use on average or how much sex they had when "high." Useful as it might be to find out, we would leave that to the quantitative researchers. Rather, qualitative research would seek to understand how the sensations of drug-taking are regarded by gay men and are pursued throughout the night. We might want to know what expectations gay men have of such drug-facilitated partying and sexual activity and how they plan for and execute that choreography of drug-taking. In such a study, we are seeking a complex and deep understanding of how, why, and in what ways drugs, sex, and gay men produce these events and what is possible at, and unique to, such events in relation to a broader notion of gay men's culture (Dowsett et al., 2005). Such a study might have a goal of providing findings that can inform the design of appropriate health promotion messages about safer drug use and sexual activity; the amount of drug use and sex occurring are less relevant here than the meanings of, and expectations associated with, such activity for contextualizing, specifying, and tailoring health promotion messages for such events.

An important thing to recognize about the many uses of qualitative methodology in health research, and one of its central strengths, is that we are not necessarily constrained to focus only on individual people and their knowledge, attitudes, and behaviors; we can actually formulate quite different questions that might throw light on health issues using the strengths of quite different theories—theories of culture, theories of practice, theories of language, social learning theories, theories of communication and media—focusing on groups of people, institutions and their processes, the role and effects of policy, program activities, value systems, the effects of powerful discourses and ideas, and many others. This is health seen as a social process, a product, a resource, an ideal, an effect, a focus for broader social issues (e.g., health inequalities or disparities), a way identity is lived and assessed, and so on.

This type and variety of research objects utilizes the strengths of qualitative methodology. With such issues, processes, experiences, and ideas as our potential research objects when studying gay men's health using qualitative methodology, defining the research object comes first. Identifying the population of gay men and how to determine its boundary then becomes primarily an issue of establishing and clarifying how such men relate to the research object and for which aspect of it they offer information or evidence. Here lies the crucial importance of problematizing the definition of gay men in any study and seeking to define which men in what groups, networks, or clusters of potential research participants whose same-sex sexual interests relate best to the research questions of any project. That is the starting point of defining the population and thereafter any sampling technique to employ. The research

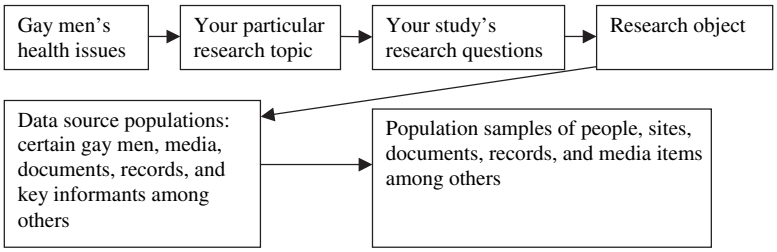

Figure 16.1 Research design sequence.

design and decision-making sequence of these issues are shown in Figure 16.1.

2.4 A Case Study in Qualitative Research Design

As a research design example, here is a brief description of my own recent study of how Australian gay community HIV/AIDS educators understand, utilize, and deploy the idea of gay community as part of their HIV prevention messages and in support for people living with HIV/AIDS. In terms of the design sequence in Figure 16.1, the general social problem was clearly the broader issue of *gay men's health education*, and this study's particular *research topic* (or focus) was the discourse of gay community itself (the full methodology of this study can be found in Dowsett et al., 2001). The *research questions* were as follows:

1. How are constructs of gay community deployed in HIV/AIDS health education and among gay and other homosexually active men? What is the role of, and meanings attached to, the construct gay community in HIV/AIDS health education as a result?
2. What are the educational practices and professional paradigms of gay community-based HIV/AIDS educators? How do the activities of HIV/AIDS health education engage their meanings and experiences of gay community?
3. What are the forms of sociality (i.e., the structuring of human relationships) emerging among gay and other homosexually active men in current "post-AIDS" contexts (Dowsett, 1996a)? How do gay and other homosexually active men experience "community" in their everyday lives and sexual practices?

The *research object* was the "discourse of gay community" in operation and/or practice.

This study, of course, involved gay men; but it also involved investigating how the idea of gay community played out in community events and venues, in documents (e.g., educational program protocols, resources, and in the gay media), how it was assumed in other research findings being used in the community, and how it was deployed by and among community leaders. These then comprised the *data source populations* available for the study and from which to sample. In this study, there were a number of *population samples*, both human and non-

human. For some populations, the definition was relatively simple. For the nonhuman populations of documents, venues and events, and other research findings, we bounded data collection by site (there were three identified gay communities), the fieldwork time period (6 months), and by community mapping or audits undertaken with the guidance of key informants and the project's community advisory committees in each site.

Defining the human populations to be involved (i.e., gay men) was more complex in light of the earlier discussion of population definition. The key lay in the study's research questions listed above. We theorized that a certain population of gay men was more likely to utilize and deploy ideas of gay community in HIV/AIDS work. Therefore, the gay men involved were quite specifically chosen: gay community HIV educators who work with the idea and instance of community every day; gay community "performers" (defined as those whose cultural and political work utilizes notions of gay community); and gay men actively involved in HIV/AIDS programs as "consumers" (not just gay men as some generic or ubiquitous group out there passively exposed to HIV/AIDS efforts). The sampling was done from these specific groups. These men were clearly important to the study, yet formed just one part of the research population to be sampled and investigated.

It can sometimes be difficult for traditional public health researchers to grasp the fact that qualitative research does not always have people and their knowledge, attitudes, practices, and behaviors as the primary focus of its attention. This is not new for anyone in program evaluation research, in some health education research, in ethnographic studies of contemporary subcultures, or when undertaking rapid assessment research in developing countries. In these kinds of studies, sampling decisions are made not just concerning nonhuman populations of data sources but also in human subjects sampling based on criteria that can look quite strange to classic public health researchers.

2.5 Sampling Gay Men

Sampling in classic public health research usually relies on frame sampling, using social descriptors (sometimes called demographic variables or factors) such as sex, age, race/ethnicity, occupation, income, educational level, residence, family role (mother, father, child), faith, and so on. For qualitative studies, such sampling criteria should only operate *if* and *when* they relate directly to the research questions. So, in the example above of researching gay men's sex and drug-taking activities at dance parties, the population might be all those who attend certain events or venues within a certain time frame (e.g., in the United States, over the summer on Fire Island or during annual gay celebrations such as Gay Pride). Depending on the research questions, race/ethnicity, relationship status (single, involved, married), occupation, education level, and so on may not necessarily be the central population and sample-defining attributes in such studies. Sex (male)

certainly is, and age might be, as such partying tends to attract younger people; but sexual identity may not be, as we are not necessarily sure that all such men participating in such events are gay, and we cannot assume that all participants can stand in for gay men in general. If there are too many participants at such events to include them all as study respondents, it might be far more pertinent, for example, to frame the sample by drug of choice (e.g., alcohol, marijuana, "speed," crystal methamphetamine, heroin). Alternatively, or in addition, we might interview dance party organizers, DJs, bar and security workers, even drug dealers to obtain different perspectives on the practice of drug-taking at such events. The researcher observations undertaken at these events might yield different information, and sampling is quite a different issue when this field method is employed. This is just one illustration of the kind of possible sampling frameworks that mark one of the key distinguishing features of qualitative methodology.

When examining gay men's sexual health, sex practices are often the focus—in part a legacy of sexually transmissible infection (STI) epidemiology—and seeing sex practices in terms other than as behaviors of people to be measured (instead of, say, rituals or rites of passage, as cultural affirmation and group membership, as identification with collective activity, as enactments of mutuality or interpersonal relations, or merely as codified pleasure) is unexpected and not well understood in much of the public health arena. Yet it is when examining these formulations of sexuality that qualitative research comes into its own, as it helps us understand what drives sexual interests and the cultures they create. That can mean quite hard thinking is needed again on how we understand the practice of sex between men beyond the notion of gay men as a sexual identity category. This could mean seeking different kinds of men: men who engage in unprotected sex; gay men with substance use problems; young men or older men; men of particular racial or ethnic origin; men from various social origins and classes; men in certain geographic locations, precincts, or sites (such as gay bathhouses) or homeless gay men; men with various health-related concerns (disabilities, aging, other illnesses); and, important often for HIV/AIDS, men who are HIV-positive, HIV-negative, or untested.

Beyond the specific health-related activities and practices we are researching, when determining who are gay men and whom shall we select for our research, we may need to define that population differently each time based on the men's own *sexual subjectivity* (Dowsett, 1996b) as: gay identified men; homosexually active men; men who occasionally have sex with men; bisexually identified men; men who have sex with men but would never admit to doing so; men who once had sex with men but do not do so now; men who have sex in men only in institutional settings (prisons, schools); men who have sex with men but do not understand those acts as sex; men who see themselves as female when having sex with other men; men who claim a gay identity or membership of a gay community irrespective of life-style or sex practices; those who refuse gay as an identity and choose queer instead; and so on. There are so many potential subsets of gay men, each relating to the specificities of each research project. When in doubt, we must

return to our research questions; if these do not tell us how to decide, there is something amiss with the questions themselves.

3 Importance of Social Theory in Qualitative Methodology

Note in the argument above that a sample in qualitative studies is not necessarily and always constituted by individual people. One can sample households, institutions and processes, programs, places, practices, language, interactions, meanings, cultural objects such as art images used in health promotion for gay men, and so on. Yet seeing gay men as individual men with individual health problems is the predominant way of understanding health. The emphasis on the individual (as patient, as research respondent, as *the* unit of analysis) masks the origins and processes of many social determinants of health for gay men. Today, new theories—for example, social network theory and its simple versions used in contact tracing among gay men for STI detection—help us understand that individuals alone are not always sufficient as a research focus, particularly in infectious disease control. Collective cultures are as much part of the issue as other social and contextual influences, such as institutional policies and practices (e.g., condom provision in gay bath houses or in prisons), community expectations (e.g., growing a safe sex culture, or regularly providing risk reduction measures in drug-facilitated events, such as needle exchange), political and legislative action (e.g., the illegality of male-to-male sex driving men away from services, or providing a national health scheme for the uninsured), and subcultural forms (e.g., initiation rituals, gang membership rules). In other words, in public health today we are not just concerned with behaviors alone and do not see them as lying only within the locus of individual choice and control but, rather, understand them *socially* as *practices* embedded in complex forces that facilitate and constrain individuals and groups in relation to health-related decisions and actions.

This becomes particularly important when gay men are seen not just as sexual beings first and foremost, and other health issues come into focus, such as oppression and violence, homophobia and stigmatization (particularly related to mental health), alcohol and drug use, dilemmas of body image (steroid use, excessive dieting), aging, relationships, and social circumstances (health-care insurance, old age provision), ownership of resources (the gay marriage debate deals with much of this), and other health-related issues. These all affect the health and well-being of gay men. Therefore, there is a need to develop ways of understanding and investigating the situatedness of gay men's health issues, as embedded in social process and relations and contextualized by circumstance. Part of the reason qualitative methodology is useful is that it can more readily focus beyond the individual on more complex social determinants of health that cannot be easily quantified or are understood best when measured. Complexity in social and sexual life often requires more detail and subtlety.

Indeed, sometimes social processes do not lend themselves readily to measurement, for example in understanding how trust works during sexual negotiation of condom use. Even if a survey found that a certain percentage of unprotected sex acts among gay men in regular partnerships involves trust as the main factor in decision-making, we would still not know how this actually operates, particularly if we were to develop health promotion initiatives that seek to utilize that dynamic and ensure that sexual safety is always maximized. Even if we can define trust as "confidence in or reliance on some quality or attribute of a person or thing, or the truth of a statement" (*Oxford English Dictionary* online), we still do not know how gay men determine that they trust each other, how it operates from situation to situation, in what contexts, or how HIV/AIDS might have forced new versions of trust to be developed and operate.

Hence, the importance of those new theories of sexuality discussed earlier, as they have grown not from and with a legacy of a pathologized homosexuality but as ways of seeing sexuality as a creative field of human practice, socially as well as individually generated, historically and culturally contingent and specific, and mutable. These ways of seeing sexuality offer real research resources that can be utilized well by qualitative research, particularly with its multiple and various typical methodologies and data-gathering techniques, and in ways that can make best use of the flexibility that qualitative methodology provides the researcher.

4 Choosing a Qualitative Methodolgy

Although qualitative methodology is often contrasted with quantitative methodology as if they are two singular, competing frameworks, in fact there are a number of qualitative methodologies. This does not refer to the many field methods available in qualitative research; rather, it refers to different epistemological frameworks that may use different or similar combinations of those field methods but seek different ends and pursue different intellectual purposes—hence the importance of social theory. For example, anthropologists undertaking ethnographic description (e.g., using interviews, observations) of diets and nutritional understanding of other cultures are using *ethnography* in a quite different way from that of urban sociologists using similar field methods to investigate urban homophobic violence by gangs of young men. The various social theories underpinning such research efforts form the key to these differences in the application of qualitative methodology and the knowledge it generates (May, 2001). That said, these different frameworks and their differential uses of field methods all register one important common characteristic in their application in qualitative research design and research practice: flexibility.

4.1 Flexibility

One of the beauties of qualitative research is that we do not have to settle completely the details of the operation of our methodology

during the research design phase (beyond what research funders require), and we can adopt a flexible approach to field work. This means that, in practice, if the field work and the data gathered during one phase of the research suggest changing interview guides or sampling techniques, for example, we can change them to achieve a better study. We are not trapped with an inapposite question or an unreliable measure (as might happen with a predesigned, structured questionnaire); if a question does not elicit useful responses, we can dispense with, change, or even replace it. Also, if the fieldwork suggests that the phenomenon being researched is manifesting differently than at first envisaged with a slightly different group of gay men than anticipated (e.g., recreational drug injection is occurring with an older age group than originally thought), the sample can be reshaped to fit better with the research questions. Similarly, if community stakeholders or gatekeepers decide to hamper a study for any reason, attention can be shifted to other related populations as sources of information. Rarely in qualitative research are data-gathering techniques structured on rigid operational lines, such as asking each question in the same way in the same order; instead, we prefer more conversational ways of engaging with respondents, and most field methods are conceived in broad outline rather than specified line-by-line or minute-by-minute, and they do not need to be tightly replicable.

This flexibility is important when working with gay men and gay communities because, as discussed earlier, these men and communities are new phenomena, indeed newly created and still in the process of creation. Study populations are fluid and difficult to define *a priori*. Previous theories about community or sexuality might be seriously contradicted by newly emerging sexual and community formations, and in-depth investigation might reveal that our precepts when designing a study are wrong, inadequate, or just ill-informed. We may have to change approaches, ideas, theories, and the fieldwork in midstream, and qualitative methodology allows this. Yet this is not a haphazard or accidental process. Using such flexibility to advantage takes experience and is guided by a long history of methodological debate and exemplification; it is also encoded within a set of typical qualitative methodologies and trusted field methods that bring security and rigor to this flexibility.

4.2 Typical Qualitative Methodologies

Those not experienced in qualitative methodology may puzzle about the best way to investigate such complex framings of sexuality noted above, particularly when there seems to be an ever-enlarging set of field methods (or data-gathering techniques) available to be used. However, there are *typical methodologies* used in qualitative research that have been tried and tested in the health arena over the years and that form the starting point when designing research. There are many textbooks that can provide detailed descriptions of, and rationales for, such methodologies—particularly good is the *Handbook of Qualitative Research* (Denzin & Lincoln, 2000)—so these methodologies are not fully discussed here. Some examples can suffice.

Table 1. Examples of Typical Methodologies

Research focus	Typical methodologies
Specifics of individual experience	Phenomenology
	Oral history or biography
Culture, language, and society	Ethnography
	Descriptive
	Critical
	Comparative
Politics/patterns of practice	Action research, evaluation studies
Theory building	Grounded theory
	Theorized life history
Elucidation, description	Case study
	Individual
	Institutional

In Table 1 are examples in which studies with certain research focuses typically suggest certain methodologies. Note that for quantitative research—the most common type of public health research—the cross-sectional population study typically uses a survey method fully structured with various types of question, established (reliable) measures, and preformed answers to be selected (forced-choice). In qualitative research, if we are interested in individual experience (i.e., not as part of aggregated population studies but in its own right), we might approach this *phenomenologically* (as a descriptive study of experience) or as an *oral history* or *biography*, including using various data sources [see Plummer (2001) for a rich account of this kind of research]. *Ethnography* is particularly useful when we are focused on the study of cultures or unities of forms (e.g., studying a gay community, as if it were a separate small society, in its responses to HIV/AIDS; e.g., Dowsett, 1996a). *Case studies* are useful in clinical settings but can also be done in institutions (research in a prison, for example; e.g., Wacquant & Willis, 2002), or on particular controversies (research on gay and lesbian parenting; e.g., Dempsey, 2004).

There are other typical methodologies in qualitative research, each with its own logic and assumptions about knowledge production, so the field is not just a catalogue of field methods (e.g., interviewing, group techniques, document analysis) that we choose at random. We can rely on these typical methodologies as frameworks to guide our research design; and each prefers various data-gathering techniques that then constitute an individual study's approach.

4.3 Data-Gathering Techniques in Qualitative Research

One of dilemmas for new researchers starting qualitative inquiry is choosing data-gathering techniques or field methods. Often a choice of methods can drive a study; for example, using focus groups because it seems a popular method nowadays or other studies using in-depth interviews may seem to achieve the goals. Unfortunately, this is the wrong approach to choosing data-gathering techniques; the research project and its research questions should determine the field methods

used, not the other way round. Thus, a health policy analysis might include individual interviews (maybe with policymakers) but would clearly need to review policy documents as well, thereby calling also for a method of systematically collecting documents and reviewing and analyzing them. This kind of connection between research question and field methods is epistemological at heart (i.e., it is about understanding knowledge building) and a key decision-making task in qualitative research because there are so many methods, each with strengths and limitations. We often use a combination of complementary methods in qualitative research, depending on the project (as we saw in the gay community discourse study discussed earlier). Also, new methods are being invented all the time. For example, research on the Internet has called for new ways to understand that phenomenon and investigate it, particularly as the certainties in other human subject research are less so in this medium (Hine, 2000).

That said, there are some often-used and central field methods that can guide the choice for any particular project: the individual interview, often called an in-depth interview and one capable of a variety of formats and processes; various group techniques such as in-depth group interviews, less-intensive focus group discussions, memory work groups (Haug, 1992), and group observations; participant observations of many kinds; and document or textual analysis. Documenting personal experience through these methods is a vital tool of qualitative research: For example, we have learned much about early sex research and its misplaced efforts to cure homosexuality through personal accounts of aversion therapy, institutional confinement, and chemical interventions (e.g., hormone therapy). Personal papers, photographs, and documents are also wonderful sources of material for health research, as are newspaper reports, electronic media resources, and other public records (Plummer, 2001). Those undertaking public health history research are expert users of such materials.

The field methods just listed are the main types, but each can take many and varied forms. Indeed, as public health research questions proliferate and postindustrial society becomes ever more complex, field methods are always being refined and adjusted, and innovative methods are being developed. Again, as one example, the Internet and its resources, the potential for communication, and technical reach has called for and already developed a plethora of new field methods (e.g., Carballo-Diéguez et al., 2004, and their use of *cybercartography*). Gay men are major users of the Internet and have become a testing ground for, and one of the first populations to be involved in, research using this medium. There are some interesting studies underway in the United States and elsewhere; but we are still unsure how to judge the validity of such research findings given the unresolved issues of population definition and sampling discussed earlier and a great deal of uncertainty about the reliability of instruments developed for the Internet. The most difficult question of all is: How do you really know who is on the end of the computer your research is reaching?

The key issues concerning typical methodologies and their field methods concerning gay men's health research relate to the earlier

discussion of research objects. Gay men's lives and histories of engagement with public health have much to teach us about modern medicine, its health systems, and its professional practice. Many minorities or marginalized populations have similar stories to tell and an understandable reluctance at times to participate in research that comes from the very sources that were so hurtful and damaging in the first place. The selection of a typical methodology and its field methods must recognize that marginalized, oppressed, or stigmatized populations are mildly skeptical or deeply distrustful of researchers in the light of these histories. Thus, when choosing methods we must take that into account as well as simply relying on the technical strengths of the methodology itself—or the field method preferences of the researcher for that matter.

That said, the experience of researchers working in HIV/AIDS has been one that reveals just how generous gay men have been in participating in research about themselves, their lives and communities, their histories, and *inter alia* their sexuality by keeping diaries, being guinea pigs for prevention intervention research, and undergoing a relentless battery of questioning about their sex activities regularly over the last two decades. Perhaps it is the ease with which gay men talk to each other about bodies and sex that enables their ready participation in such a public (and publicly funded) scrutiny of their intimate lives. Perhaps it is a collective commitment to ending this terrible HIV pandemic that supports such research participation by those who, less than a generation ago, were forced to hide their sexuality from view. The good will gay men show public health research is to be neither squandered nor taken for granted. Methodology becomes, therefore, not just the preferred mode of operation of a researcher but something that engages the consideration of the researched. Gay men are no longer passive research subjects, and that demands something from the researcher that qualitative methodology uniquely enhances: reflexivity.

5 The Reflexive Researcher

Whatever methods we utilize in qualitative research and what methodological frameworks they constitute, there is a central and overriding principle that applies to understanding the way qualitative research works. The key idea here is *reflexivity*. There is a major ongoing debate in qualitative methodology (see Denzin and Lincoln, 2000, for a full discussion) about qualitative research and its presumptions concerning the nature of scientific inquiry and the nature of knowledge itself. Mostly, in qualitative work we do not seek to distance the researcher from the researched in pursuit of some specious kind of objectivity; rather, we embrace the situatedness of the researcher as actively contributing to the research, and we see the dialogic nature of the interactions between the researcher and the researched as a major and positive component of the research process at every stage—indeed, the dialogue is itself data. This becomes clear when embarking on community-based

or action research; working with gay communities during the HIV epidemic has stimulated a great deal of innovation in such typical research methodologies, partly at the insistence of gay men critical of the legacy of earlier scientific research, particularly biomedical research, that mistreated homosexual people in the name of science.

This movement toward more collaborative and participatory forms of research did not occur merely as a political maneuver but was required to find ways to investigate aspects of gay men's lives that did not readily lend themselves to scrutiny through standardized survey techniques and other classic public health methods. A second contribution to the shift in approaches derived support from earlier feminist critiques of the scientific method and its assumptions about knowledge, the researched, and objectivity itself (May, 2001). These critiques noted the domination of (heterosexual) men in research and the domination of findings based on research conducted by men on men (excluding and sometimes inaccurately describing women). Far from being objective, such research often deployed sexist assumptions and understanding of women and their situation. This critique had significant effect in the humanities and in certain social science disciplines, mainly social psychology, comparative anthropology, and critical sociology but less so or to a lesser effect in other places. The critique came to occupy a central place among those engaged in critical sexuality studies and queer theory and has provided a solid basis for a serious and sophisticated reappraisal of the way gay men (and lesbian, transgender, and more recently intersex people) have been and are researched.

The researcher's familiarity with, and understanding of, these quite significant and sophisticated critiques becomes an important part of any research done on gay men. The researcher must be situated within these debates as well as within his or her own disciplinary traditions and experience. In HIV/AIDS work, it is not surprising to find many qualified and experienced social researchers who also happen to be gay men (as am I) and some are HIV-positive gay men as well (e.g., Willis, 2002). Does this mean we are likely to be biased in our approach or better situated to research gay men? These are not the right questions: The key question is how do we understand, explain, and work with the situatedness of researchers no matter what their relation to the issue at the core of the research questions, the populations being studied, or the paradigm within whichever academic disciplines framed the research in the first place. In qualitative research, these are central issues being constantly debated, refined, and rehearsed. Such issues become quite important in participatory and collaborative research projects where the interaction between the researched and the researcher is an explicit and prominent part of the process; but these issues are not irrelevant to even the most classic kinds of research.

In qualitative research, the researcher is seen as a partner with the researched in the production of knowledge, not just the technical means of its discovery or retrieval. This places the burden of reflexivity on the researcher. She or he must become part of what is examined

and scrutinized; there is no place outside the research object for the researcher to stand, to find objectivity—we are always part of the world we study. There is only involvement, implication, and intervention. Reflexivity is the concept that captures the active participation of the researcher in the qualitative research process and is central to making the most of what qualitative research has to offer science and human knowledge. Ironically, gay men, by virtue of having to come to grips with sexual interests that are themselves the central object of the study of human sexuality, are reflexive by definition: Being gay in a straight world is perforce a reflexive place to reside. That makes researching gay men and their health issues using qualitative methodology decidedly queer for us all.

6 Limitations to Qualitative Methodology

All research methodologies have strengths and weaknesses, insight and blind sports, specialties and limitations. It is difficult to outline these factors as they pertain to qualitative methodology as, has been shown, this is not one methodology but multiple approaches to social research, influenced by the academic discipline involved, the epistemological standpoint of the project, the field methods employed, the researchers' experience, and ultimately the purpose underpinning the research project. So, for example, research investigating popular cultural representations of mental illness might involve a cultural studies disciplinary perspective, a standpoint on the part played by cultural representations in producing common prejudice about mental health sufferers; it might utilize content analysis of popular media forms; and it might be undertaken by a graduate student for the purpose of fulfilling course requirements for predoctoral training. This greatly affects the kind of research done and the way in which it is able to offer new insight into a complex social phenomenon.

This example reveals how specific the findings of qualitative research are to the research design and why qualitative researchers must be careful about how to present their findings in research reports. One of the major areas of difficulty for qualitative research concerns *generalizability* (i.e., the drawing of broadly applicable conclusions about common experiences or events on the basis of evidence from particular or specific ones). This capacity is generally regarded as one of the strengths of *quantitative* research because of its large sample sizes and their capacity to stand in for, or speak about, a population at large (e.g., a study of 5000 high-school students carefully structured to mirror the demographic makeup of such students in general or the sampling frames utilized that try to obtain representative samples of specific subpopulations that share characteristics (e.g., gay men) and therefore allow findings from the study to be reasonably applicable to the rest of that subpopulation).

In qualitative research, we can speak about our findings only in terms related to the specific sampling models used. If we have done a study of 20 young gay men attending a local coming-out support group

and found that 10 had experienced bullying at school, we cannot conclude that half of all young gay men had such experiences. The apportionment of findings in qualitative research's usually small samples is a trap many inexperienced researchers fall into because this is how the much larger numbers in quantitative research are reported, but it is usually wrong and misleading.

What qualitative research is good at providing at a generalizable level is an account of social processes at work. In the case study in research design presented earlier, we found that most of the gay HIV prevention educators we interviewed reported that they had increasing difficulty is being safe all the time in their own sexual behavior, even though they were undertaking prevention education in their gay communities. We cannot conclude from this that all HIV educators as a population are engaged in unsafe sexual acts or even that many of them are. This is the type of generalization that incorrect apportionment produces and is based in misunderstanding how sampling is understood in qualitative research. We can say that it is clear that gay HIV prevention educators struggle with sexual practice and safety issues even though it is central to their jobs because they are also part of the sexual cultures they serve. Clearly, also some of these educators are taking sexual risks, for they are gay men too and not outside the personal pressures the epidemic has produced. This is generalization at the level of social process and might be a finding applicable to other gay communities. It certainly warrants further research. From this example, we see that great care has to be taken in understanding how qualitative studies reveal larger social process and more depth about experience. The key to understanding how any qualitative research project can offer generalizable findings is to return to the research questions of each project and to review again that project's research object. Rarely are apportionment and measurement statements about qualitative research likely to be valid. Those not familiar with qualitative research may see this as a lack or a weaknesses, and it is if that is the only way the social world can be understood; but once the real strengths of qualitative research are grasped, its particular type of generalizability can become a powerful, efficient way to understand many social worlds.

7 Summary

Qualitative methodology offers public health research a remarkable resource for investigating pressing and difficult issues. Its flexibility, its own form of rigor, its theoretical underpinnings, its technical diversity, and its multidisciplinary approaches constitute a rich store of ideas, methods, tools, and frameworks for investigating pressing public health problems. The methodology is undergoing rapid development and change, driven largely by the experience of research itself and the inbuilt reflexivity mentioned earlier. No two projects are the same in qualitative methodology because what is learned during the process of doing one inevitably changes what happens next. More importantly,

the researcher is changed and can never simply repeat a project: Replication is not an option in this methodology.

Just as important is an increasing interest in using participatory-action research and community-based research approaches using qualitative methodology as a more respondent-friendly research style. These developments take seriously the ethical and social values concerns that have long produced complaints by respondents that researchers simply treat them as objects. People living with HIV/AIDS, often drawing on a critical activism derived from gay men's sexual politics, have been particularly forceful in challenging the lack of democracy in medical and health research. Such a challenge is more than a technical issue about field methods and community consultation processes; it concerns the way human experience is conceptualized, understood, and made available for scientific scrutiny. Such issues are at the core of the philosophy of science debates occurring among qualitative researchers the world over.

Increasingly, academic journals specializing in qualitative research are available, and more conventional health journals are opening their pages to research using qualitative methodology. This has not an easy process of change, particularly when traditional journal formats (e.g., organizing the article into background, methodology, findings, discussion) do not readily lend themselves to the ways in which knowledge is understood to be produced and assembled in qualitative methodology. It becomes important not only that qualitative researchers develop new and more appropriate ways to report our research; it is also incumbent upon us to be clearer, more explicit, and extremely careful when explaining how we do our research and what it offers.

Finally, in gay men's health issues (and this also applies to lesbians), the population with whom we are working has significant resources to bring to the research process as well in terms of ideas, experience, theories, good will, a research agenda, and research needs, to name just a few. This offers qualitative researchers in particular a real opportunity to engage in new and exciting research strategies with a willing, if occasionally skeptical, population of respondents. This is an opportunity to be embraced.

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