Auto/Biography 2006; 14: 302–319

Masculinity and Reflexivity in Health Research with Men

Steve Robertson
University of Central Lancashire, UK

Whilst a great deal has been written regarding gender and the research process, only a limited amount of this work relates specifically to masculinity and the research process and even fewer reflexive accounts of male researchers' experiences exist. Drawing on the experiences gained and empirical data collected during a three-year qualitative research project on masculinity and health, this article sets out to provide a critical, reflexive, autobiographical account of masculinity and the research process. During the course of this study it became apparent (although often implicit and hidden rather than explicitly visible) that the researchers' own male gender and gendered practices influenced the research process in its various stages. The article explores how these gendered practices are socially and historically contingent.

Introduction

Emerging from long-standing debates about the impossibility of researcher objectivity within the research process, reflexivity has become an integral part of high-quality qualitative research. It assists with evaluating how intersubjective encounters within research influence data collection and analysis and can increase integrity, trustworthiness, rigor and thereby research quality (Finlay, 2002; Hall and Callery, 2001; Seale, 1999). Given the proximity and influence of feminist theory on our understanding of the need for, and practice of, reflexivity in research (Roberts, 1981; Maynard and Purvis, 1994), it is no surprise that the gendered self has become a particular subject position of reflexive concern. Numerous, often highly nuanced, accounts of the role, influence and effect of female researchers' own gendered identity within specific research projects are readily available (for example: Gair, 2002; Inckle, 2005; Letherby, 2002;

Address for correspondence: Steve Robertson, Department of Nursing, University of Central Lancashire, Preston PR1 2HE, UK; Email: srobertson1@uclan.ac.uk

 10.1177/0967550706ab050oa

McCorkel and Myers, 2003). Yet similar reflexive accounts on the role, influence and effect of male researchers' gendered subject position are largely absent from the literature.

Whilst there has been a significant increase in men's critical, autobiographical writing that problematizes issues of one's masculine subjectivity (for example: Jackson, 1990; Sparkes, 1996; Pringle, 2001), there remains an exceptional paucity of work where men reflect on their masculine subject position as researchers (for notable exceptions, see Gray, 2004; Morgan, 1981). Although texts have begun to emerge that explore the theoretical and practical concerns of undertaking research, including health research, with men (White and Johnson, 1998; Pateman, 2000; Haywood and Mac an Ghaill, 2003; Petersen, 2003), the exhortation within these texts for male researchers to become explicit about their own gender within the research process has not led to the production (or at least not the publication) of such reflexive accounts.

The reasons for this absence of reflexive accounts amongst male researchers are undoubtedly complex. However, I make two suggestions here on why this might be. First, when discussing the historical invisibility of men as problematized, gendered research subjects, Hearn and Morgan (1990: 7) remind us that such invisibility may not be accidental, rather, 'it may serve men's interests, keeping their activities apart from critical scrutiny, by other men as well as by women'. This being the case, there is no reason to think that this might be any different in terms of men's research activities. There are undoubtedly moral and political issues relating to the closer scrutiny, including self-scrutiny, of female researchers, and this does have the advantage of facilitating and encouraging a reflexive, self-aware approach to research that has not yet been developed (or at least rarely made explicit) by male researchers (Gill and Maclean, 2002). Second, it has been postulated that within a western philosophical system, men have become associated with the mind and reason, and women with the body and emotions; this is known as Cartesian dualism or the mind/body distinction. Some argue that, for men, this has led to an inherent feeling of 'wrongness' in spending time with ourselves, particularly emotional self-reflection, which becomes seen as a form of 'self indulgence' (Seidler, 1991: 85). In this sense, the masculine subject position itself may, unconsciously, act to mitigate against research processes that require self-reflection or self-analysis.

It is here that health research may offer some specific hope for developing accounts of male reflexivity. Reflection and reflexivity have become central components of health professional training and practice and have been recognized as facilitating patient-centred encounters (Baarts *et al.*, 2000), as assisting the development of expert practice (Hardy *et al.*, 2002), and as ultimately improving diagnosis and thereby

clinical outcomes (Malterud, 2002). This being the case, men who work as health professionals are, perhaps, more likely to be familiar with such processes of self-reflection than men in general. In addition, for those male health professionals working in roles historically seen as 'feminine' (e.g. nursing), there is an on-going process of reflection about one's gendered identity that has to occur to overcome stereotypes and prejudice, and facilitate successful, intersubjective, therapeutic encounters (Whittock and Leonard, 2003; Evans, 2004; Stott, 2004).

This article aims to provide a reflexive account of my own subject position within a research project that considered the links between lay men's and community health professionals' conceptualizations of 'masculinity' and 'preventative health care'. It does not focus only on the data generated but gives a reflexive account of the totality of the project, thus providing 'a reflection of a researchers location in time and social space' (Bryman, 2001: 500). Emphasis is placed on my own masculine subjectivities and how this positioned me in particular ways at particular stages of the research process. First, in order to contextualize the reflexive account that follows, I provide a brief description of the research undertaken.

THE RESEARCH PROJECT

Within the United Kingdom (UK), there are continued concerns regarding men's higher mortality rates and reduced longevity compared to that of women. Explanations for this vary, but are often based around ideas that the practices associated with 'masculinity' lead men to be both at greater risk of illness and injury, and less likely to seek help when health may start to deteriorate (Banks, 2001; White, 2001; Peate, 2004). Yet, despite a growing body of research looking at men's experiences of chronic and acute illness, little empirical work exists that considers how men understand 'health' and practise preventative health care, and how this is influenced by issues of 'masculinity' (for notable exceptions, see Mullen, 1993; O'Brien *et al.*, 2005; Watson, 2000). In addition, others have pointed out how the conceptualizations that health professionals themselves hold about masculinity, and how these become embedded in health service delivery, will also affect the opportunities and experiences men have for engaging with health-promoting activities (Robertson, 1998; Seymour-Smith *et al.*, 2002).

This research, undertaken in the north-west of England, aimed to provide empirical data concerning the links between lay men's and health professionals' conceptualizations of 'masculinity' and 'preventative health care'. Taking as its starting point the complex and contradictory nature of 'masculinity', a series of focus groups (n = 4) and in-depth interviews were carried out with lay men (n = 20) and community health

professionals (n = 7). The focus groups were undertaken at the start of the fieldwork in order to generate sensitizing concepts that then guided the semi-structured interview schedules (Morgan, 1997).

Informed by Connell's (1995) theoretical work on the patterning of contemporary masculinities (Table I), the lay men included sub-samples of gay men (n = 7) and disabled men (n = 6) as well as men who did not present themselves as gay or disabled (n = 7). This was in recognition of the fact that men are not a homogenous group and that varied configurations of masculinity are likely to result in different health experiences and practices. Each of the men was interviewed on two occasions with interviews lasting from 30 minutes to three hours. The health professionals included two general practitioners (one male, one female), three practice nurses (one male, two female), a health visitor (female) and a community psychiatric

TABLE I The patterning of contemporary masculinity (Connell, 1995)

Hegemonic masculinity	'Hegemony' refers to the cultural dynamic by which a group claims and sustains a leading position in social life. Hegemonic masculinity is the configuration of practice that embodies the currently accepted answer to the problem of the legitimacy of patriarchy, which guarantees the dominant position of men. Hegemony is usually established through a correspondence between cultural ideals (such as exemplars in film, e.g. Sylvester Stallone) and collective institutional power. So for example we can talk of the health service as being a 'masculine' structure (Davies, 1995).
Subordinated masculinity	In clarifying what constitutes hegemonic masculinity, it is clear that other expressions of masculinity must be subordinate to this 'leading' position. Gay masculinity is perhaps the most conspicuous example of this and Connell makes it clear that the subordination is not just about cultural stigmatization but is also about material practices. Thus gay men often encounter cultural exclusion, abuse, violence and economic discrimination.
Marginalized masculinity	In addition to being subordinated to the 'leading' position, some expressions become marginalized from this position. There may be no direct, overt threat or attempt to exclude some expressions of masculinity (unlike gay masculinity) but they nevertheless become marginalized from full participation in society by material practices. Such a situation may arise for men with a physical impairment.
Complicit masculinity	Few men meet the normative standards of hegemonic masculinity, yet this does not stop these men benefiting from the general effect of this hegemony. The majority of men gain from the overall effect of the subordination of women and the subordination and marginalization of some men (as above) and thus share in what Connell terms the patriarchal dividend. This Connell terms complicit masculinity.

nurse (male). Each was interviewed once with interviews lasting from 30 minutes to one hour. All interviews were tape recorded and transcribed.

The overall design within this project was broadly interpretivist in nature and followed a process of abductive reasoning where theory, data generation and data analysis were dialectically related (Blaikie, 1993; Mason, 1996: 142). Preliminary data analysis was completed following each group of three to four interviews through a process of iterative reading and listening and identification of emerging themes. Further analysis was completed after all the participants had been interviewed. Each emerging theme was sub-coded and analytical links made between these sub-codes and between emerging themes. This constituted an adapted form of the 'constant comparative method' (Glaser and Strauss, 1967) of analysis with the adaptation coming through the inclusion of Connell's (1995) theoretical work into the continual motion between larger and smaller data sets. The appropriateness of utilizing the constant comparative method of analysis in this way has been noted by Mason (1996: 142).

Reflexive account

In order to provide this reflexive account, I have drawn on two main sources. First, using field notes (reflective diary, interview notes) made throughout the research journey, I reflected on how my own subject position(s) had influenced decisions made at key stages. Second, I re-examined, and recoded, the transcribed interviews looking specifically at how issues of gendered and professional identity were created and sustained, or rejected within these interviews. Assisted by Connell's (1995) theoretical work outlined above, I then made analytical links between the emerging reflections and codes and considered their utility as explanatory frameworks for the actions and/or subject positions I took.[1]

Why this research topic?

Mason (1996: 9) outlines several reasons for the choice of topic area by social researchers:

- gaps in current knowledge concerning that topic area;
- it is particularly timely to research a given topic area;
- research may be commissioned to evaluate a social programme relating to that topic area;
- the topic area is of particular, substantive interest to the researcher's own experiences.

Of these, the last reason is very rarely written in to subsequent funding proposals or talked about in final project reports. Indeed, in the account provided above, sub-titled 'the research project', attention is focused much more on the timeliness and gaps in the current knowledge base than it is on the significance of this topic area to myself as the researcher.

My journey, my own experiences, that led me to identify this topic area (which I shall broadly term 'men's health promotion'), began seven years before the research actually commenced. In the early 1990s, my partner commenced a degree in Women's Studies at a local university. During this course, she began to question many of the core values that she held and processes of renegotiation began in our relationship concerning many aspects of our life, including divisions of labour – in practical terms, who washed, cleaned, prepared food, entertained and helped educate our (young) children and so on. This inevitably led to (and is still requiring) a (re)negotiation of my own core values and recognition of how these were/are developed with reference to expected standards, or norms, of 'male' behaviour. I had/have contradictory feelings (experienced by other men in similar circumstances) of wishing to be supportive of a feminist standpoint, and recognizing the need for personal change, yet fearing where this change may lead (see Cohen, 1990; Morgan, 1992; Segal, 1997: 279ff). Of particular on-going concern is which expected male 'norms' I could or should sustain, which I could or should reject, and how any subsequent changes in core values (and the practices that these would invoke) would be viewed by family, friends, colleagues and others.

This coincided with a professional career move for me. Although being in nursing had required some consideration of my own male subject position, like many male nurses, I had gravitated into the relatively safe 'male' area of critical and intensive care nursing practice, following qualification. However, my own degree experiences around this time developed an understanding and appreciation of health in much broader terms and generated a concomitant desire to move more into health promotion work. It seemed a logical move to consider and commence my health visitor training as I had been advised that these were the health professionals most likely to be participating in health promotion work in the UK. However, I was not prepared for how less traditionally 'male', and more 'feminized', the whole area of health visiting was, still being dominated by work with mothers and babies, at least in the localities I trained and worked in. As well as being professionally disappointing, this undoubtedly generated some gender-strain within my working experiences and necessitated additional consideration of my personal and professional male subject position (Egeland and Brown, 1989).

Combined, these two simultaneous experiences shook the 'taken-for-granted' status of my male gender. I became increasingly sensitized to issues of gender, and found myself considering how particular events and circumstances might differentially impact on men and women. On moving into health visiting practice, I was struck by the lack of involvement that my colleagues had with men as a client group, despite the rhetoric that health visitors are 'family visitors' (see also Chalmers, 1992). I was further struck by how the interactions I did witness, and those that I participated in, were likely to influence men's future engagement (or not) with health services (Williams and Robertson, 1999). It became apparent, as others have noted, that barriers to accessing health promotion services and activity for men is as much about stereotypes held by health professionals, and the 'masculine' gendered nature of the health services, as it is about men's own beliefs and behaviours (Williams, 1997; Robertson, 1998; Seymour-Smith *et al.*, 2002). I was also aware that many of the stereotypes attributed to men, and reinforced by colleagues, did not adequately reflect my own experiences or those of many of my male friends. It is this combination of personal and professional experiences that initially drove the move into the 'men's health promotion' research project.

The influence on 'sampling'

Growing up as a physically small man made me aware of the various ways that categories of 'men' are constructed and how individual men 'jockey' for position to try to enter or maintain themselves in particular categories or groups. As also noted in empirical work by Edley and Wetherell (1997), and Frosh *et al.* (2002), this often entailed buying (back) into values (at least rhetorically) associated with hegemonic masculinity. In line with autobiographical accounts from other 'small men', I found (find) ways to compensate, sometimes to overcompensate, in order to gain acceptance within particular, often dominant, groups when I was at school and later on (Jackson, 1990: 171). Yet, this often creates contradictory feelings as the following research reflective diary entry highlights:

> I know I'm different with different people and in different places, but what does this mean, who is the 'real' me? I don't feel fake in any of these situations although I'm sometimes surprised by my own actions; disappointed at times, impressed at other times! I feel as comfortable in a pub as I do in the school yard [picking up my children]. Yet, somehow, I also don't seem to fully 'fit' as a 'male' in either place.
>
> (Brackets added)

This alerted me to the fact that my different ways of 'being' a man were not only a matter of individual choice, the ability to choose an identity from 'free-floating signs and signifiers' in the post-modern sense. Rather, 'being' a man is something that is predicated on gender relations that are also embedded in social structures. For example, our attempts at home to develop more equitable divisions of labour were/are often thwarted by established social structures that act to favour traditional gender divisions. The most obvious expression of this is how gendered inequalities in financial recompense for paid employment make it difficult to alter the balance of paid employment/domestic labour arrangements within our family unit.

It was important, therefore, for me within the research project to locate an adequate theoretical model that could account for such personal contradictions in (my) male experience and that also recognized the importance of the socially embedded nature of inequitable power relations between men and women that result in male privilege; that is a model that could encompass issues of agency and structure in relation to masculine identity, position and practices.

Connell's (1987; 1995) work provided such a model. The ability to think about my own (and other men's) activity as 'configurations of practice' that become embedded in, and in turn replicated through, existing social structures suggests a patterning of masculinities (see Table I) that encompasses hierarchical power relations, but further suggests some room for manoeuvre between different configurations in different sets of social circumstance. This model has strong resonance with my own thoughts and experiences as a man; at times marginalized, subordinated and complicit with, but always the beneficiary of (and sometimes the perpetrator of), embedded hegemonic masculine practices.

It became clear therefore that my research sample needed to be able to provide accounts and examples of marginalized, subordinated, complicit and hegemonic masculinities; hence the specific theoretical sampling that included gay and disabled men as well as men who presented as not gay and not disabled.

Data analysis and abductive reasoning

It is often perceived by junior researchers that 'data analysis' is a matter of acquiring the right 'how to' book or paper and applying it. Even methods of qualitative analysis are seemingly chosen in objective isolation from the researcher's own background and experiences; though they (hopefully) reflect the methodological position taken by the researcher. For me, the abductive reasoning approach that underpinned this project emerged through subjective processes; at personal cost and out of personal (gendered) experiences.

My academic journey began in a patriarchal household where scientific reason was highly valued. The historical connection made between science and technology and the realm of the 'masculine' (Connell, 1995: 164ff), associating men with the mind, reason and rationality (Seidler, 1994), was (and still is) played out daily within my father's house. My own early education reflected this association, and a desire to please my dad, with my post-compulsory college subjects being three 'hard (male) science' subjects. Yet, the movement into the more 'feminized' arena of nursing challenged this base. As Hicks (1996; 1999) has pointed out, the association of nursing with care, compassion, intuition and empathy, the values that attracted me toward nursing, is almost antithetical to deductive (scientific) approaches based on detachment, distance, impartiality and objectivity. Taken-for-granted, gendered assumptions about what knowledge should be valued were brought into question for me as new modes of enquiry were opened. On commencing the research, I therefore found myself confused and torn about the process of reasoning that was directing my approach to the project. I lived the feeling that there was something wrong with me, with my professional and gendered identity, that made me unable to accept one of (what I initially thought were) the only two forms of reasoning; as a reflective diary entry from the time highlights:

> I've now spent over a month restraining myself from completing more interviews until I'm sure of how data analysis will proceed and why it'll proceed in that way. I'm getting increasingly frustrated and anxious as time goes on. Others seem to have no difficulty in placing their work on particular forms of 'reasoning'. I know I'm not 'theory testing' but also think that developing theory from data is pure nonsense; anyone who says they come to data without *some* theory is fooling themselves.
>
> (Emphasis in original)

Unable and unwilling to reject my (male) roots on the importance of the scientific process, yet wanting to embrace (feminine) approaches that can accept and welcome uncertainty, and that value interpersonal relationships, created seemingly untenable tensions that led to months of frustration, internal and external dialogue, tears and desk-thumping – these last two themselves perhaps being the embodied, physical representation of a contradictory gendered identity.

It was only when I was a third of the way into the research that I encountered the concept of abductive reasoning. This described almost perfectly the analytical process I had already become engaged in, being associated as it is with dialectical movement between everyday concepts and meanings and more theoretical social science explanations (Blaikie, 1993). In doing so, it provided a safe place for me, a place that offered the thorough rigour I demanded in terms of process, but that could also cope

with ambiguity, and that valued subjective expression without reducing it to that which is incorrigible.

Data collection

In considering issues of reflexivity, others have highlighted how the concept of 'positioning' has resonance for their own research experiences. Hamberg and Johansson (1999) explore how they positioned themselves, and were positioned by the research participants, in different ways (as 'doctors', as 'women' and as 'researchers') in the interviews they completed and that such positionings triggered different responses and reactions and therefore generated different 'data'. In this section, I briefly explore in similar fashion some of the various gender positions I experienced in the interviews and critically explore how the interviews reflected ways of 'doing' my (male) identity. To facilitate this process, I use Connell's (1995) patterning of contemporary masculinities (Table I) as a framework.

Hegemonic positioning

As outlined above, the research was predicated on a personal and academic commitment to pro-feminist values; therefore explicit examples of hegemonic positioning within the focus group or interview narratives are generally absent (though 'complicity' with this position is not, as will be seen shortly). However, my post-interview field notes tell a different story in respect to the presence and possible influence/effects of hegemonic positioning. Several entries following interviews with the gay men refer to the men having 'difficulty understanding what I was asking' or 'talking around subjects rather than directly about them' and covering topics 'that are not related to the current project'. Likewise, three entries following interviews with the disabled men talk of the men being 'very focused on disability'. The construction of my masculinity as white, able-bodied and heterosexual – in line with current hegemonic norms (Petersen 1998: 41ff.) – creates 'others' out of that which is not. This 'othering' is not just about 'differences' but results in material processes through which the views and expressions of 'others' become less; are devalued. It therefore becomes easy (though not consciously) for me to interpret these 'other' men's narratives in my reflections as not relevant, not direct, or as the men experiencing difficulty in understanding or not focusing 'correctly' on the topic at hand. These binary oppositions (in this case able-bodied/disabled, straight/gay), therefore exist as unequal sets of power relations, and map also onto the researcher/researched oppositions. My (subconscious) creation of parts of these men's narratives as 'other', as less relevant

(demonstrated in the field note entries), creates the potential for these narratives to be marginalized within the analysis and/or presentation of results.

Yet it is only in the writing of this paper that I have fully recognized, or admitted, this potentially destructive possibility. I feel shamed (again) by my own elitist, hegemonic, male position yet have also been quite happy to use it to achieve an end, *and* to leave this level of personal reflection until that end has been achieved (perhaps in order to achieve a further end?). In this way, there is perhaps a degree of complicity with current hegemonic masculinity and it is to this that I now turn.

Complicit positioning

As Connell (1995) outlines, complicit configurations of masculinity realize the patriarchal dividend (the advantages men gain from the overall subordination of women and particular 'other' groups of men) without the risks attached to 'being the frontline troops of patriarchy' (p. 79); that is, without having to necessarily enter into situations of direct conflict. As such, complicity is often achieved by following rather than taking a lead and language plays a key role in facilitating such 'turn-taking' and in reproducing established gendered sets of relations (see also Coates, 2003; Gough and Edwards, 1998). Within the interview narratives, I commonly engaged in banter around football, drinking and sex:

> I: How come, if you're disabled, you can't move from the waist down, you've just got to sit in one position for 24 hours, you can't move your legs, so how do you not get a deep vein thrombosis? Does someone come along and start massaging you?
> R: It would be nice wouldn't it on the NHS? [laugh]
> I: Yeah, 6 foot 2 blonde, Swedish you know [laugh] yeah.

and

> I: I remember being able to stay up all night drinking and then go to work the next day [laugh]. [R: Yeah.] Yeah and regularly. That's the kind of thing that makes you feel old. When you go out and you're knackered by 11 o'clock and you wanna come home [laugh].
> R: Yeah. The other thing I've noticed is the length of time it takes to get over hangovers. [laugh]
> I: I just stay in bed. I don't really suffer from hangovers, unless I drink cider. That blows me head off. [R: Lethal.]

Whilst such conversations could be seen simply as ways of establishing a rapport (numerous other examples exist of me trying to identify common ground with participants on non-'macho' topics) they also construct, and

thereby possibly expect from participants, particular ways of 'doing' masculinity. Given that health is often seen by men as a feminized issue (see Robertson, 2003), and that men researching gender are often viewed with suspicion in terms of their sexuality (Frosh *et al.*, 2002: 62ff.), it seems that at least part of my motivation behind such exchanges was to show that, although I was a researcher of gender and health ('feminine') issues, I was still a 'real' (that is heterosexual, and/or hegemonic) man. This analysis is reinforced by the fact that I mention my own children in many of the interviews (although only in a couple of the interviews with the gay men), a strategy that I have since discovered has been utilized by other male researchers to 'reassure' curious participants concerning their sexual identity (Wight, 1994).

However, I also participated in narratives that constructed a masculinity positioned outside such 'macho' stereotypes that seem to suggest a rejection of complicity:

> I: We've got a steamer now [pointing] so … [R: It's the same as ours.] It's brilliant. The difference, we were so surprised because of the food now. I mean, like with the kids as well. What we eat basically, like we eat the veg, so they get a good balanced diet, and we get a good balanced diet. And since we've had the steamer the taste in the food has been unbelievable.
> R: Its brilliant innit? We've had ours probably just a year … [Interruption, participant's wife comes in]. Sorry we're talking steamers here …
> W: Oh right [laugh].
> R: Very 'blokey' conversation [laugh].

Such positioning could be seen as representative of my remodelled, renegotiated 'new' male identity, deliberately *not* complicit with hegemonic masculine 'norms' and values. Yet, care needs to be taken as constructions of this type of 'new man' may merely be modern representations of what is now hegemonic. Wetherell and Edley (1999) point out in their work how modern hegemonic masculinity is constructed in part through opposition to previous 'macho' stereotypes. This being the case, such conversations could merely represent my being complicit with new hegemonic male 'norms' rather than representing alternative ways of 'doing' my masculinity. The embarrassed apology about the conversation around steamers given to the participant's wife speaks of a contradiction and oscillation between 'old' and 'new' hegemonic masculine forms that I experience.

Subordinated/marginalized positioning

The interviews with the gay men posed particular challenges for me. I was unsure whether banter such as that above would be an appropriate way to

relate or present myself to the gay male participants, indicative as it is of hegemonic male conversation (Coates, 2003). I was concerned about causing offence but at the same time was also aware that I did not want to misrepresent myself, or be positioned, as a gay man within the interviews. The deeply embedded nature of homophobia within the construction of hegemonic male identity led me to be cautious when relating to these men. Despite having several gay friends, I was unsure what the rules of (my male) engagement with this group could or should be within this research context. In practice this led to my asking a health service colleague who had a specific remit to work with gay men to facilitate this focus group although I was also present. This most likely represented a combination of my wishing to be sensitive but also a fear of how I might be perceived and treated by the group as the following indicates:

> Why am I so concerned about taking the focus group of gay men? I've run loads of groups with men, women and mixed groups in work. I'd like to think it's because I want to be sensitive to particular health issues that may arise but I half think I'd be out of my depth if the conversation became too loudly camp, that I might lose control in the group and even get laughed at for not understanding terms, innuendo etc?
>
> (Reflective diary entry)

Despite (rhetorical) commitment to emancipatory, pro-feminist research approaches, I find it difficult to relinquish control with this particular group. I find it difficult to allow myself to be subordinated to a 'gay hegemony' that I fear would predominate, preferring to allow myself to be marginalized in order to achieve the research outcomes; in this case the collection of adequate, 'good-quality' data.

I remained committed to completing the in-depth interviews with the gay men myself. Here I found myself co-constructing a form of masculinity that showed itself open to engaging with alternative ways of 'being male', yet at the same time showed elements of complicity with other aspects of hegemonic masculine values:

> I: I think guys feel a lot better just going out casual wear, just decide 'right I'm going out in an hour' and they're off in an hour, without having to spend three or four hours like a girl would normally spend tarting themselves up with make-up and glossy stuff and whatever [R: laughs]. Although some fellas do that [laughs].
> R: Yeah, yeah, I've got some friends that do! [both laugh].

Here the positioning (demeaning) of women as 'girls' and 'tarts' is (albeit subconsciously) endorsed by my laughing at the end of that sentence. I make clear my engagement with alternative forms of 'doing' masculinity

by making comments about my gay friends, yet also position myself (along with the interviewee) in opposition to that which is female.[2]

Clearly, other positionings not directly related to gender also played out in the process of data collection. These also often operate as sets of binary opposition, such as professional/non-professional, that are contextualized within pre-established power relations that become played out in the co-construction of interview narratives. However, there is insufficient space to consider all these within this paper and it would detract from its focus.

Discussion

Despite recognizing its importance, questions have been raised about the primacy given to reflexivity in social science research and the need to avoid approaches that are too introverted and that act to reproduce ego identity at the expense of exploring and understanding social life (May, 1998). However, the work presented here suggests that good critical reflexive accounts can and do act to illuminate issues around masculinity, gender and men's practices and, in this sense, they represent *one* means of understanding *particular* aspects of social life.

What is important to remember is that 'reflexivity as a critical practice may be far from neutral and in particular may have a hidden politics of gender' (Adkins, 2002: 345). Thus, even in presenting this account here, gender politics is being played out. On one level, my account presents a challenge to hegemonic male 'norms'. Given the paucity of male reflexive accounts, even the process of producing this article could be seen as a symbolic resistance to current hegemonic practices that give precedence to objective (male) research accounts that rely on researcher neutrality and distance. Likewise, the dissection of my own research practices, and motivations behind these, within this article allows some insight into how, when, where and why hegemonic practices are (re)produced or resisted within the research context.

Yet, on another level, this account could be said to be a representative example of the current gender order. The move since the 1970s for men to become more at home with their emotions and feelings, not afraid to consider who they are, has not, as Segal (1997: 282ff.) points out, shifted the cultural, social and political domination of men over women. In this sense, this reflexive piece could be seen as a contribution to a new hegemonic masculinity that expresses a rhetorical commitment to rejecting previous male stereotypes, yet that contributes nothing to changing actual material practices; that is it does nothing to affect the 'patriarchal dividend', the advantages that accrue to men through current gendered structural inequalities.

The important point here is not to become concerned with the 'truth' of such contradictory explanations but rather to recognize that the process of reflexivity itself allows for, and indeed demands, the consideration of such issues that may not otherwise be thought about within a research project. In doing so, it facilitates, as Frank (1997) points out, 'a focus for a more intense insight'. Within this 'men's health promotion' project, on-going reflexive practice helped guide the way that issues of masculinity, or more accurately masculinities, were to be understood. In particular, it facilitated a movement away from intrapsychic approaches to understanding men's health practices (that is understanding these practices as the product of individual motivation and behaviour) and towards understanding these practices as being socially embedded and contingent.

Acknowledgement

This work was supported through an ESRC/MRC Postdoctoral award.

Notes

1 As a methodological point, I am not arguing that this account necessarily provides a factual and/or truthful explanation of why particular decisions were made and/or subject positions adopted. Rather, with the help of sociological insights into 'masculinity' and professional identity, and with the advantage (?) of hindsight, I am providing what now appear, to me, to be the most likely explanations.

2 That some gay men, despite their often subordinated and marginalized position, still choose to construct their male identity in opposition to that which is female is not surprising given the historical investment that all men have in maintaining (even subconsciously) the current structure of gender order that privileges men's position (see Connell, 1992).

References

Adkins, L. 2002: Reflexivity and the politics of qualitative research. In May, T., editor, *Qualitative research in action*. Sage, 332–48.

Baarts, C., Tulinius, C. and Reventlow, S. 2000: Reflexivity – a strategy for a patient centred approach in general practice. *Family Practice* 17, 430–34.

Banks, I. 2001: No man's land: men, illness and the NHS. *British Medical Journal* 323, 1058–60.

Blaikie, N. 1993: *Approaches to social enquiry.* Cambridge.

Bryman, A. 2001: *Social research methods*, second edition. Oxford University Press.

Chalmers, K. 1992: Working with men: an analysis of health visiting practice in families with young children. *International Journal of Nursing Studies* 29, 3–16.

Coates, J. 2003: *Men talk.* Blackwell.

Cohen, D. 1990: *Being a man.* Routledge.

Connell, R.W. 1987: *Gender and power.* Polity Press.
——— 1992: A very straight gay: masculinity, homosexual experience and the dynamics of gender. *American Sociological Review* 57, 735–51.
——— 1995: *Masculinities.* Polity Press.
Davies, C. 1995: *Gender and the professional predicament in nursing*. Open University Press.
Edley, N. and Wetherell, M. 1997: Jockeying for position: the construction of masculine identities. *Discourse and Society* 8, 203–17.
Egeland, J.W. and Brown, J.S. 1989: Men in nursing: their fields of employment, preferred fields of practice and role strain. *Health Services Research* 24, 693–707.
Evans, J. 2004: Men nurses: a historical and feminist perspective. *Journal of Advanced Nursing* 47, 321–28.
Finlay, L. 2002: 'Outing' the researcher: the provenance, process and practice of reflexivity. *Qualitative Health Research* 1, 531–45.
Frank, G. 1997: Is there life after categories? Reflexivity in qualitative research. *Occupational Therapy Journal of Research* 17, 84–98.
Frosh, S., Phoenix, A. and Pattman, R. 2002: *Young masculinities.* Palgrave.
Gair, S. 2002: In the thick of it: a reflective tale from an Australian social worker/qualitative researcher. *Qualitative Health Research* 12, 130–39.
Gill, F. and Maclean, C. 2002: 'Knowing your place': gender and reflexivity in two ethnographies. *Sociological Research Online* 7, http://www.socresonline.org.uk/7/2/gill.html (last accessed 8 June 2006).
Glaser, B. and Strauss, A. 1967: *The discovery of grounded theory.* Aldine.
Gough, B. and Edwards, G. 1998: The beer talking: four lads, a carry out and the reproduction of masculinities. *The Sociological Review* 46, 409–35.
Gray, R. 2004: No longer a man: using ethnographic fiction to represent life history research. *Auto/Biography* 12, 44–61.
Hall, W.A. and Callery, P. 2001: Enhancing the rigor of grounded theory: incorporating reflexivity and relationality. *Qualitative Health Research* 11, 257–72.
Hamberg, K. and Johansson, E.E. 1999: Practitioner, researcher and gender conflict in a qualitative study. *Qualitative Health Research* 9, 455–67.
Hardy, S., Garbett, R., Titchen, A. and Manley, K. 2002: Exploring nursing expertise: nurses talk nursing. *Nursing Inquiry* 9, 196–202.
Haywood, C. and Mac an Ghaill, M. 2003: *Men and masculinities*. Open University Press.
Hearn, J. and Morgan, D.H.J., editors, 1990: *Men, masculinities and social theory.* Unwin Hyman, 1–18.
Hicks, C. 1996: The potential impact of gender stereotypes for nursing research. *Journal of Advanced Nursing* 24, 1006–13.
——— 1999: Incompatible skills and ideologies: the impediment of gender attributions on nursing research. *Journal of Advanced Nursing* 30, 129–39.
Inckle, K. 2005: Who's hurting who? The ethics of engaging the marked body. *Auto/Biography* 13, 227–48.
Jackson, D. 1990: *Unmasking masculinity: a critical autobiography.* Unwin Hyman.
Letherby, G. 2002: Claims and disclaimers: knowledge, reflexivity and representation in feminist research. *Sociological Research Online* 6, http://www.socresonline.org.uk/6/4/letherby.html (last accessed 8 June 2006).

Malterud, K. 2002: Reflexivity and metapositions: strategies for appraisal of clinical evidence. *Journal of Evaluation in Clinical Practice* 8, 121–34.

Mason, J. 1996: *Qualitative researching.* Sage.

May, T. 1998: Reflexivity in the age of reconstructive social science. *International Journal of Social Research Methodology* 1, 7–24.

Maynard, M. and Purvis, J. 1994: *Researching women's lives from a feminist perspective.* Taylor & Francis.

McCorkel, J.A. and Myers, K. 2003: What difference does difference make? Position and privilege in the field. *Qualitative Sociology* 26, 199–232.

Morgan, D.H.J. 1981: *Men, masculinity and the process of sociological enquiry.* In Roberts, H., editor, *Doing feminist research.* Routledge, 83–113.

——— 1992: *Discovering men.* Routledge.

——— 1997: *Focus groups as qualitative research*, second edition. Sage.

Mullen, K. 1993: *A healthy balance: Glaswegian men talking about health, tobacco and alcohol.* Avebury.

O'Brien, R., Hunt, K. and Hart, G. 2005: 'It's caveman stuff, but that is to a certain extent how guys still operate': men's accounts of masculinity and help seeking. *Social Science & Medicine* 61, 503–16.

Pateman, B. 2000: Feminist research or humanist research? Experiences of studying prostatectomy. *Journal of Clinical Nursing* 9, 310–16.

Peate, I. 2004: Men's attitudes towards health and the implications for nursing care. *British Journal of Nursing* 13, 540–45.

Petersen, A. 1998: *Unmasking the masculine.* Sage.

——— 2003: Research on men and masculinities: some implications of recent theory for future work. *Men and Masculinities* 6, 54–69.

Pringle, R. 2001: Competing discourses: narratives of a fragmented self, manliness and Rugby Union. *International Review for the Sociology of Sport* 36, 425–39.

Roberts, H., editor, 1981: *Doing feminist research.* Routledge.

Robertson, S. 1998: Men's health: present practice and future hope. *British Journal of Community Nursing* 3, 45–49.

——— 2003: Men managing health. *Men's Health Journal* 20, 111–13.

Seale, C. 1999: *The quality of qualitative research.* Sage.

Segal, L. 1997: *Slow motion: changing masculinities, changing men*, second edition. Virago Press.

Seidler, V. 1991: *Recreating sexual politics.* Routledge.

——— 1994: *Unreasonable men: masculinity and social theory.* Routledge.

Seymour-Smith, S., Wetherell, M. and Phoenix, A. 2002: 'My wife ordered me to come': A discursive analysis of doctors' and nurses' accounts of men's use of general practitioners. *Journal of Health Psychology* 7, 253–67.

Sparkes, A.C. 1996: The fatal flaw: a narrative of the fragile body-self. *Qualitative Inquiry* 2, 463–94.

Stott, A. 2004: Issues in the socialisation process of the male student nurse: implications for retention in undergraduate nursing courses. *Nurse Education Today* 24, 91–97.

Watson, J. 2000: *Male bodies: health, culture and identity.* Open University Press.

Wetherell, M. and Edley, N. 1999: Negotiating hegemonic masculinity: imaginary positions and psycho-discursive practices. *Feminism & Psychology* 9, 335–56.
White, A. 2001: How men respond to illness. *Men's Health Journal* 1, 18–19.
White, A. and Johnson, M. 1998: The complexities of nursing research with men. *International Journal of Nursing Studies* 35, 41–48.
Whittock, M. and Leonard, L. 2003: Steeping outside the stereotype: a pilot study of the motivation and experiences of males in the nursing profession. *Journal of Nursing Management* 11, 242–49.
Wight, D. 1994: 'Boys' thoughts and talk about sex in a working class locality of Glasgow. *The Sociological Review* 42, 703–38.
Williams, R. 1997: Health visitors ideologies regarding health promotion for men. *British Journal of Community Health Nursing* 2, 238–48.
Williams, R. and Robertson, S. 1999: Fathers and health visitors: 'it's a secret agent thing'. *Community Practitioner* 72, 56–58.

NOTE ON CONTRIBUTOR

STEVE ROBERTSON is a Post-doctoral Research Fellow at the University of Central Lancashire. A nurse and health visitor by background, he has been writing and researching issues related to men and health for over 10 years and has recently completed an ESRC/MRC Interdisciplinary Award looking at 'Understanding masculinity and gender in health and illness'. He also undertakes voluntary work as co-director on the board of the European Men's Health Development Foundation.