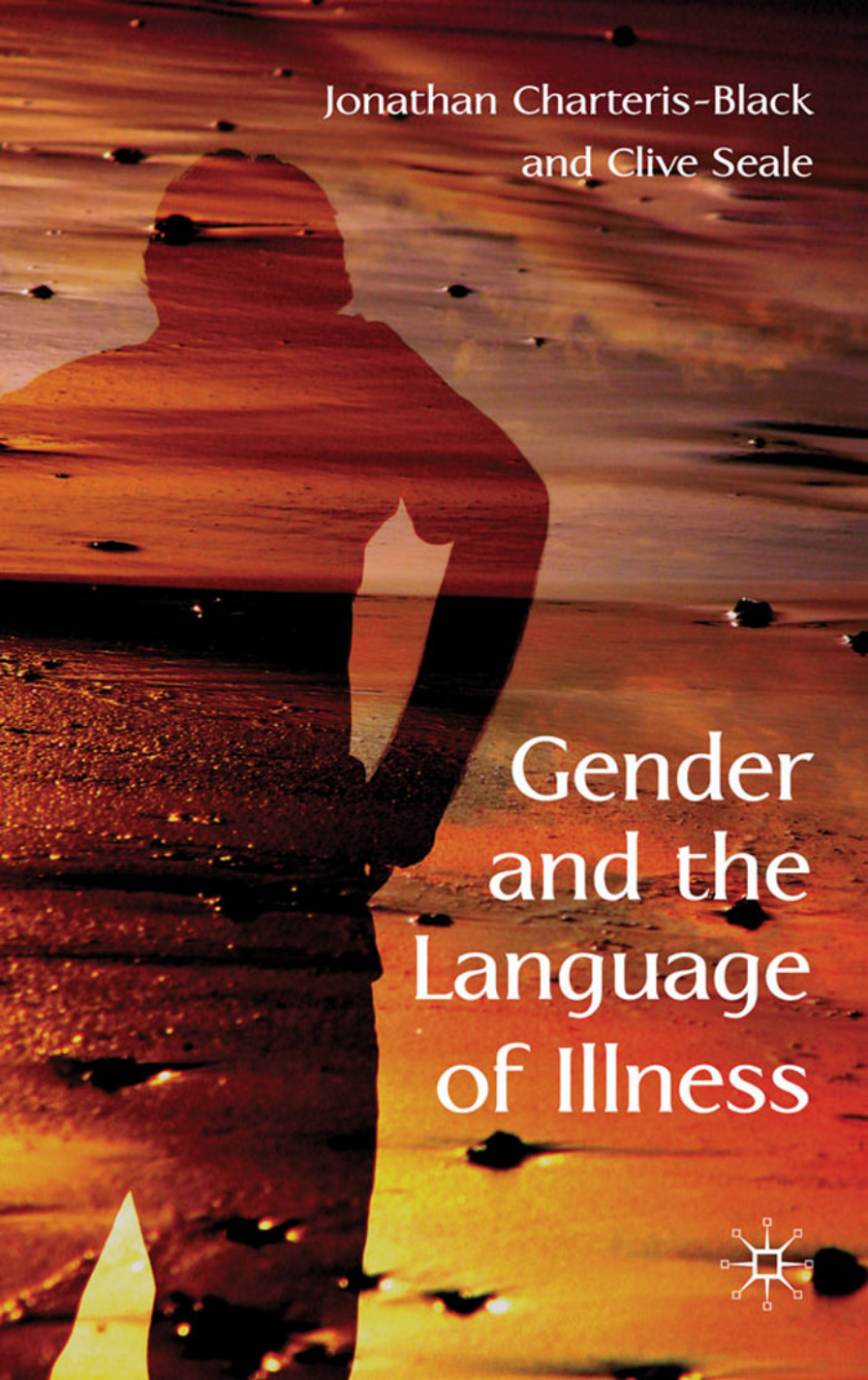

Jonathan Charteris-Black
and Clive Seale
Gender and the Language of Illness

Gender and the Language of Illness

Also by Jonathan Charteris-Black

CORPUS APPROACHES TO CRITICAL METAPHOR ANALYSIS (2004)
POLITICIANS AND RHETORIC: The Persuasive Power of Metaphor (2005 and 2006)
THE COMMUNICATION OF LEADERSHIP: The Design of Leadership Style (2007)

Also by Clive Seale

RESEARCHING SOCIETY AND CULTURE (1998 and 2004)
CONSTRUCTING DEATH: The Sociology of Dying and Bereavement (1998)
THE QUALITY OF QUALITATIVE RESEARCH (1999)
MEDIA AND HEALTH (2003)
QUALITATIVE RESEARCH PRACTICE (2004 and 2007)

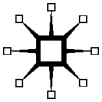
Gender and the Language of Illness

Jonathan Charteris-Black
University of the West of England, UK

and

Clive Seale
Queen Mary University of London, UK

palgrave
macmillan



First published 2010 by
PALGRAVE MACMILLAN

Palgrave Macmillan in the UK is an imprint of Macmillan Publishers Limited, registered in England, company number 785998, of Houndmills, Basingstoke, Hampshire RG21 6XS.

Palgrave Macmillan in the US is a division of St Martin's Press LLC, 175 Fifth Avenue, New York, NY 10010.

Palgrave Macmillan is the global academic imprint of the above companies and has companies and representatives throughout the world.

Palgrave® and Macmillan® are registered trademarks in the United States, the United Kingdom, Europe and other countries.

ISBN: 978–0–230–22235–9 hardback

This book is printed on paper suitable for recycling and made from fully managed and sustained forest sources. Logging, pulping and manufacturing processes are expected to conform to the environmental regulations of the country of origin.

A catalogue record for this book is available from the British Library.

Library of Congress Cataloging-in-Publication Data

Charteris-Black, Jonathan, 1955–
Gender and the language of illness / Jonathan Charteris-Black, Clive Seale.
p. cm.
Includes bibliographical references and index.
ISBN 978–0–230–22235–9 (alk. paper)
1. Sex factors in disease. 2. Language and languages – Sex differences. 3. Sexism in language. 4. Discourse analysis. 5. Medicine – Language. I. Seale, Clive. II. Title.

RB212.C53 2010
306.44—dc22 2010011787

10 9 8 7 6 5 4 3 2 1
19 18 17 16 15 14 13 12 11 10

Printed and bound in Great Britain by
CPI Antony Rowe, Chippenham and Eastbourne

In memory of Christopher Charteris-Black

This page intentionally left blank

Contents

Tables

Acknowledgements

This study was supported by a grant from the UK Economic and Social Research Council (RES-062-23-0130). We are grateful to them, to the people working in the Healthtalkonline organisation who collected the original interviews and to the interviewees who participated.

We would also like to thank Sue Ziebland and Francie Smee and the researchers of the University of Oxford Health Experiences Research Group whose help in making available and organising the interviews analysed for this book was invaluable. Mike Scott (Wordsmith Tools) and Paul Rayson (Wmatrix) have both been very supportive with software issues, and we have benefited considerably from their ingenuity and expertise in creating the software in the first place. The work done for this book uses materials and software tools that all these people have collected and developed, and we thank them for this.

1
Gender and the Language of Illness

1.1 Introduction – sex, gender and identity

One day after taking a new job in the city of Bristol in the West of England, one of the authors, Jonathan Charteris-Black, was purchasing a bicycle when he overheard a conversation between a young male assistant and a female customer in which the customer commented on the assistant being absent the day before when she had come to collect her bicycle; he replied that he had not been well and the customer asked him: 'Was it a case of man flu?' He replied laughingly 'Yes' and that he was feeling better today. The term 'man flu' is ironic and refers to the belief that men exaggerate pain or illness, typically by describing a cold as 'flu'; it originates from a belief (held mainly by some women) that men complain more about their state of health (especially to women), a practice that conflicts with notions of the 'stoical' or tough man. Since the early socialisation of very young males usually involves experiencing their mothers as the first source of comfort, this can create a pattern of expectancy for women to be sources of comfort when experiencing illness. One perspective might be that women do not wish or need to provide sympathy for needy adult men. Another perspective is that the expression 'man flu' is evidence of the trivialisation of men's accounts of health because it implies that men are indulging themselves when they talk about their health. This second perspective suggests that there is evidence in recurrent, everyday language use, or discourse, of how health is a topic which only women really know about. A negative stereotyping of young men's talk about health as trivial may leave them unprepared later in life to discuss serious illness and to delay seeking diagnosis and contribute to the

greater life expectancy of women[1]. The role of gender in how people talk about illness and its implications is therefore an important one and it forms the topic of this book.

We will examine how men and women experiencing a wide range of different types of illness talk about their experiences. We will consider how far individual agency interacts with sex-based classifications as a 'male' or 'female' to produce discourses of illness experience that correspond with, or challenge, sex-based stereotypes for masculinity and femininity. Gender arises from a subtle interaction of how we think of ourselves and how we are viewed by others; it is an issue of identity and self-awareness rather than one of biological sex difference. However, a great deal of confusion about 'sex' and 'gender' pervades our use of these words; we very often use 'gender' as a way of avoiding having to use 'sex' to avoid embarrassment. Consider the following:

> I've never ever ruled out the you know the possibility that if I ever found a female who was attractive that I liked, I mean I see a person I don't see a person of either gender, it just so happens that men I find men attractive and women generally not. Saying that I find women far better friends.

Here the speaker, a young man whose interview about illness is one of the many examined in this book, uses the word 'gender' when he is really talking about biological differences between men and women and his sexual preference for biological men, but because he is talking about sexual attraction he avoids saying 'a person of either sex' and instead refers to 'a person of either gender'. 'Gender' is often used as a euphemism in situations where 'sex' might risk bringing to mind sexual activity – after all common expressions that use the word 'sex' include 'having sex', 'safe sex', 'sex drive' and 'sex exploitation' all of which refer to the physical act of sex rather than the more complex issue of identity. So 'gender' is often substituted for 'sex' – especially in areas such as social policy or intellectual discussion – to avoid bringing to mind a network of meanings that are associated with sexual activity. We see this in expressions such as 'gender testing' which are not really about gender at all but are about sex differences on the basis of classification as 'male' or 'female'; the two words are sometimes used interchangeably as in 'sex or gender' because we do not want to risk

[1] For the period 2005–2010 the world average life expectancy was 65 for men and 69.5 for women; in the UK it was 77.2 for men and 81.6 for men (CIA World Factbook).

bringing to mind inappropriate associations by using 'sex'. 'Gender' is therefore unthreatening while 'sex' is potentially embarrassing.

Contemporary Western views on gender emphasise the freedom of individuals to create, or 'perform', their own identity rather than to accept pre-existing norms for what it means to be a 'woman' or a 'man'. Establishing one's gender may require us to resolve tensions between our sense of self-identity and the identities that others attribute to us. Modern views emphasise individual agency and the influence of local context in the way that individual men or women 'do' gender and distance themselves from traditional accounts that assume that men and women will do gender in the same way for all their lives. Traditional views assumed that an individual is one of two genders, 'male' or 'female', that is decided at birth on the basis of their anatomy and will continue to have a closely related identity as a 'man' or as a 'woman' throughout their lives. Such traditional views promoted discourses about gender founded on stereotypes because they equated the simpler issue of sex difference with the more complex phenomenon of gender.

However, sex-based comparison is not necessarily conservative: huge advances have been made in modern democracies for a more equitable balance of power between the sexes precisely because of the identification of sex differences. Government organisations employ evidence on status and income disparities between 'men' and 'women' (meaning males and females) to produce statistics for the higher status employment and earnings of males, and the lower status and loss of lifetime income of females who may be housewives or mothers in support of arguments for legal changes that discriminate in favour of 'women' – meaning biological females (rather than men who may feel like women); positive discrimination would not be possible if there were no sex-based comparisons of profession, income, candidacy for office in a political party and so on. The legal system differentiates by biological sex (though it may refer to 'gender') and employs such differentiations in issues such as fertility treatment or sperm donation. When it comes to social planning in areas of education, the law, or public housing, predetermined sex-based categories – though binary and presumptive of essential gender – are employed to reduce inequalities where they exist in relation to the public resources relating to these areas. If social categorisation only recognised the self-created individual then this would eliminate all potential for social change on the basis of sex or biological gender. Social change relies on the identification of pre-existent categories and on practices such as collecting social statistics on acts of violence, child abuse, depression, imprisonment or suicide.

In this book we will demonstrate how developments in language analysis through the use of computers can be used to investigate how gender identity arises from an interaction between social variables such as sex, age and social class. Using corpus linguistics methods we will identify the 'key' words – those that occur relatively frequently – of men and women in a large sample of approximately 200 qualitative interviews with people who have experienced a health or illness condition – either as a patient or as a caregiver. The contexts in which these words occur are analysed to produce a detailed understanding of how people from different sexes, social classes and ages verbalise their gender identities. The original interview transcripts, including interventions by the interviewer are inspected for details of context. This approach known as corpus analysis is informed by qualitative analysis to establish features that we think are relevant to an understanding of how gendered identity arises from a range of social variables in the context of illness experience. Our hope is that clinicians, carers and health information providers and promoters will benefit from a deeper understanding of the relationship between gender and illness and that this will improve their capacity to understand and support the needs of people with a variety of illness conditions.

We will compare words and concepts that are used by men and women experiencing illness as a basis for investigating what variation implies about the gendered nature of identity and how this identity may be challenged, modified or changed by the experience. There will be discussion and explanation of words and concepts that are more commonly used by either sex, as well of those that are used with similar frequency, with consideration of variation in performance by particular groups according to age and social class. This will avoid over-extravagant claims about what is done by abstract homogeneous categories of 'males' and 'females' and will recognise how illness experience serves to reinforce or transform senses of personal identity of which sex is one component and personality, age and class are others. Word choices in biographical narratives will be related to other characteristics of expressive style to consider the impact of illness on discourse.

1.2 Difference: Sex, sex roles and comparison

1.2.1 Introduction

In this section we will trace the origin of a view usually described as 'essentialist' that the differences in the language used by men and women can be accounted for initially by their biological sex and later

by their socialisation as boys or girls; we will then discuss some of the findings of sociolinguistic research investigating variation in language use by men and women and the limitations of these approaches. In general we will argue for the insights into gender that can be gained from making comparisons of groups of people according to a range of social variables. While individuals are free to diverge from 'normal' or 'traditional' ways of doing masculinity or femininity – based on their sex – these norms are still as real as other social variables that contribute to identity such as social class or age. We propose that the notion of gender requires an element of 'difference' between masculinity and femininity in order to have any meaning at all. But we will also suggest that comparative approaches based even on pre-existing anatomical classifications as 'male' and 'female' should identify similarities as well as differences. The similarities in the language use of biological males and biological females allow us to challenge traditional stereotypes of masculinity and femininity based on such categories. Binary differences in language between males and females allow us to identify the 'normal' way of being a man or being a woman – we will refer to these as their sex roles – and this is a necessary precondition for investigating variation by individuals in their personal construction of gender.

1.2.2 Sex

A distinction between the male and female *sex* is something that is taken as 'given' by those whose passions and incomes may be intimately concerned with the world of biological nature – whether they are farmers, vets or the breeders of luxury pets, there is a fundamental need to distinguish between the male and female since an inaccurate classification may be embarrassing and expensive. In the natural world sex is conceptualised as something immutable and the physical arrangements for livestock ensure that contact between the sexes takes place in a controlled way. Indeed the very categories of male and female seem to form part of the mental representation through which humans have control over the natural world. There is no particular challenge to these acts of sexual categorisation and it is generally accepted as a necessity to retain one bull while the rest of the males are despatched for slaughter since they produce no milk or that a female kitten may be spayed. There is no consideration of whether this bull really believes himself to be a cow or vice versa since that would be to anthropomorphise by bringing in notions of gender while classification in the natural world is by sexually determined categories. Sex is then fundamental to economic management and the web of relationships between reproduction, resources and

markets and is imposed from without rather than experienced from within. It is something that is so unquestionable that it constitutes the natural order for those involved in the animal or plant world.

One reason for the confusion between 'sex' and 'gender' that we introduced in the previous section is because we find a similar essentially based ordering according to anatomy in the human social world. A distinction is made at birth on an external inspection of the genitalia and a sex is entered on a birth certificate. Approximately 1.8 in 10,000 live births involve inconsistency between chromosomal and phenotypic sex (Sax, 2002). Surgical interventions are sometimes made to ensure that an individual's genitalia conform to normal anatomical requirements for males or females, but these are controversial (Dreger, 1998; Eckert and McConnell-Ginet, 2003). Socialisation, or nurture, soon takes up where nature left off: and the young child is directed towards a toilet or section of the playground that is formally or informally allocated for 'boys' or 'girls'. Very soon the child acquires knowledge of sexual semiotics such as the signs on public conveniences where symbols for iconic human body shapes, or initial letters 'M' and 'F' are used to direct his or her body to a gendered space and encourage him or her to behave accordingly. When children occupy spaces at school, they self-select an engendered space and very different cultures emerge in these spaces – one for girls that is often based on talk and interaction and the other more often in active rough play in more open spaces. In such a way natural sexual differences become socialised. Little consideration is given to boys who would prefer to gather around the mirror and apply make-up or girls who want to leave the margins of the playground and take part in a game of football since society often rides roughshod over issues of identity.

1.2.3 Sex roles

An important distinction that we have introduced above and underlies the research approach taken in this book is between sex difference and gender, and we think that the notion of sex roles mediates between the notions of sex and gender. Sex roles may be summarised as follows:

> ... being a man or a woman means enacting a general set of expectations which are attached to one's sex – the 'sex role'. In this approach there are always two sex roles in any cultural context, a male one and a female one. Masculinity and femininity are quite easily interpreted as internalized sex roles, the products of social learning or 'socialization'. (Connell, 1995: 22)

Traditional sex roles assume a simple view of gender as something that corresponds with sex – the way people behave or feel as men or women, their sex role, arises from socialisation as a man or a woman, which is based on their sex. Nature and nurture converge in institutional life – in the office, the hospital or the prison. Generally, the less the institution is oriented to social control the less engendered the allocation of space, so that in universities there is little separation on the basis of sex[2], while in prisons it is taken for granted. Biological sexual classification is imposed if we are taken into a hospital – a men's or a women's ward – or to a psychiatric ward; in prisons issues of personal safety, based on views of men's fundamental nature as being potentially threatening to 'women' – supported by substantial statistical evidence of violence (physical or sexual) by males on females – will present an irresistible case for the separation of 'genders', for safety and protection (usually of women rather than men). Similar separations will take place in relation to other groups perceived as physically vulnerable on the basis of their age – for example, in homes for children or old people. No matter how much individuals reinforce or challenge the social practices that they encounter, there will always be moments in life when the convergence of nature and nurture are reimposed as part of social reality and there will be a requirement to perform according to such essential classifications – these include selecting a school, job interviews and applying for a passport.

A drama-based metaphor (implied by words such as 'perform' and 'roles') is often used for predictable situations where there are clearly established audiences and where the stakes are not too high. Since this work analyses a set of interviews that were designed to be placed on the world wide web, a 'drama' metaphor certainly has some relevance; however, since audiences are not clearly established and the stakes really are very high in the case of illness, we might anticipate some divergence from traditional sex roles and this is where gender becomes relevant. Tensions may arise between a sex role – as a boy/man or as a girl/woman – and the set of beliefs about gender and identity; moreover, the experience of illness may bring on these tensions. An identity for someone experiencing illness may be influenced by resolving tensions between what is anticipated by a sex role and how the experience influences the beliefs that the individual has about his or her gender. Surprisingly, the experience of illness may contribute to, rather than

[2] This is not the case in Islamic universities that are sometimes separated by sex.

detract from this formation of a gendered identity, so that, through illness, individuals may discover more about what it really means to be a man or a woman for themselves rather than what their sex role might have anticipated it as meaning. And in so doing they may come to change, or to reinforce the nature of these sex roles in the society in which they live.

Approaches to gender that are based *exclusively* on identifying differences between the genders – often referred to by the title of a popular work with this theme *Men Are from Mars, Women Are from Venus* – are now seen by many researchers as historically outmoded – although they continue to sell many popular works that advise us on how to understand 'men' and 'women'. The media and fashion industries thrive on creating differences that are tied in with the vast systems of consumption arising from the need to perform according to a stereotyped gender and require the purchase of make-up, hair products, panties and high-heeled shoes. In reality gender is something that is only partially contested in modern society – there are sex roles for 'men' and 'women', but there are individual men and women whose social behaviour – of which language constitutes a vital component – may either reinforce, challenge or remain indifferent to such roles: but the norms are still there, although they may shift in an almost imperceptible way over time through the countless minor actions that challenge a sex-based gender order. These may include acts such as when boys or men wear necklaces, kiss each other in public or wear an elegant bag and women swear in public, commit acts of hooliganism or drive fast cars. Sex roles serve as a backdrop for the performance of a gendered identity: but such a performance will be strongly influenced by what is perceived as acceptable in particular social and work settings.

1.2.4 Comparison of sex and sex roles

Talking about 'women' and 'men' as distinct essences contributes at some level to sustaining a binary dualism that rejects the idea of there being *degrees* of masculinity and femininity. This risks suppressing individual variation within these categories, and ignoring the interaction effects with other variables such as social class or age. A key theme in criticisms of variationist research that we discuss in more detail in Chapter 2, Section 2.2 is that it has assumed the pre-existent reality of the variables that are measured – so it assumed gender could be treated as equivalent to sex, and therefore has reified pre-existent categories

leading to claims about monolithic and unvarying categories of 'men' and of 'women'. As Romaine (2003: 109) comments:

> The standard sociolinguistic account of the relationship between language and society often seems to suggest, even if only implicitly, that language reflects already existing social identities rather than constructs them. This approach has limited explanatory power since it starts with the categories of male and female and social class as fixed and stable givens rather than as varying constructs themselves in need of explanation.

We should be cautious in assuming that the very fact of creating dualisms such as passive/assertive, irrational/rational, emotional/distant and so on gives rise to gender stereotyping. Thinking about gender presupposes a comparative mode of thought that distinguishes between masculine and feminine but does not distinguish between conventional and non-conventional performances of gender. An assumption of sex role norms is a requirement of any social system and if there were not expected ways of *being a certain gender*, or performing a sex role, then there would be no resources *for using gender as a resource for identity formation* in the first place. As we have noted social reforms are often based around improving the situation for people who are classified as 'women'. The idea that there is an identity that precedes the adoption of a masculine or feminine role seems to be at odds with what we know of how identities come into being through social interaction – and indeed, like language, can only exist in a very restricted form without such social influence.

Much of the literature on gender has made the topic rather inaccessible to the non-expert reader; one of the reactions to this has been that conventional sex roles have offered a degree of security in times of uncertainty about gender and sexuality. This is probably why findings about gender differences are much more readily publicised by the media than studies that argue for similarity between the genders – a story based in biology reinforces and naturalises traditional viewpoints of gender and concurs with readily available cultural stereotypes found in folk wisdom such as proverbs and popular sayings that generalise about the verbal behaviour of men and women. Research advances in understanding human psychology have originated in taking 'difference' in sex roles as a starting point, whether in the categories of 'men' or 'women', or the more complex socially and culturally constructed notions of 'masculinity' and 'femininity'. Like other dualities such as

'left' and 'right' in political thought, 'good' and 'evil' in theology, they provide a way of formulating thought about issues that are necessarily complex because they are intertwined with the human sense of who we are – of our identity. While describing a particular individual as 'emotional' or 'distant', 'feminine' or 'masculine' is a matter of personal opinion, such terms can aid our understanding of their discourse.

It is therefore with no apology that the methodology employed in this book, which will be described more fully in Chapter 2, compares the language produced by 'men' experiencing illness with language produced by 'women' experiencing illness. This is not because we believe men and women are predetermined by biological gender to use language in a certain way, but because we believe that social influences predispose them to some uses of language that conform to their normal sex roles and that these are measurable. We may term such predispositions as 'norms' or 'tendencies' for the use of language that originate in socialisation processes to which individuals react differently. These socialising influences will not *determine* how they use language throughout their lives, nor will they be based on sex alone, since there will be an interaction between sex and the other variables of age and class. We believe that quantitative comparison of variables that include sex followed by qualitative analysis enables us to identify a multiple range of language choices by men and women – so that each sex has the option of communicating experiences in what is at the time of speaking a 'masculine' or 'feminine' style – but that we are only able to have the possibility of such stylistic choices with reference to normative notions of conventional sex roles. Without the concept of the 'feminine' we could never have had 'feminists' and without the concept of 'men' we could not have had a 'men's movement'; we believe, therefore, that we can only begin to conceptualise gender at all through predetermined categories that exist because of their relationship to each other; as Connell (1995: 43) writes

> Masculinity and femininity are inherently relational concepts, which have meaning in relation to each other, as a social demarcation and a cultural opposition ... it is gender relations that constitute a coherent object of knowledge for science. Knowledge of masculinity arises within the project of knowing gender relations.

However, we accept, and welcome, the freedom of individuals to *adapt their styles* according to their own expressive purposes in particular circumstances of social practice, to communicate particular experiences

and in ways that correspond with a more individual or personal sense of identity to which their sense of gender contributes. We also believe that over time, when a sufficient number of individuals modify their linguistic style, this will in turn *change our expectations* of how men and women normally speak: sex roles may therefore be changed by doing gender. At this point we should, therefore, move on from discussion of sex and sex roles to a more thorough consideration of gender.

1.3 Gender as performance

1.3.1 Introduction

Since the publication of Butler's *Gender Trouble* (1990) which portrayed gendered identity as a potentially mutable and adaptable 'performance' it has become commonplace amongst sociolinguists (e.g. Cameron, 2003) interested in gender to question the 'gender differences' tradition, in which differences between men and women in their typical use of language are described. For some time, current research has been coming to terms with the reality of gender, rather than just sex or sex roles. Many studies now demonstrate the presence of subcultures that break with the norms of conventional heterosexual gendered expression, or that achieve gendered identification via unexpected means (Holmes and Meyerhoff (2003) and Eckert and McConnell-Ginet (2003) provide comprehensive summaries). The shift towards a performative view of gender has been marked, resulting in studies that emphasise variability, individual agency and the influence of local context. For example, quasi-ethnographic sociolinguistic studies of gay men and women, cross dressers, phone sex workers and drag queens proliferate in the journals; all of these emphasise the mutability of gendered performances and the agency of the people concerned. Contemporary postmodern approaches to gender emphasise it as something that an individual decides for her or himself.

A major criticism of the 'gender difference' tradition is that it left some questionable assumptions unchallenged – in particular that speakers cannot vary their performances of gender because they arise from something inside the person (essences) rather than the responses of active agents to particular social contexts. Thus the 'gender difference' paradigm has variously been characterised as essentialist, deterministic, promoting of gender stereotypes, or lacking in an appreciation of contextual and cultural variability (Speer, 2005; Stokoe and Weatherall, 2002). However, as this book will demonstrate, individuals vary enormously as to how far they utilise traditional constructions of

gender in their projection of an identity when they are experiencing illness. Individuals can accept the normative gender attributions of identity that others give them, or contest such attributions; this may be because they experience a tension between who others tell them they are and who they feel themselves to be. Some individuals will be content to go with the gender flow, while others will feel the need to make choices from a range of available options that are themselves dependent on the social milieu in which they grow up. There is every reason why a social practice should shift over time when a sufficient number of individuals modify their individual practices for being a woman or a man.

1.3.2 Communities of practice

The communities of practice (e.g. Bergvall, 1999) approach to the study of language has arisen in contrast to the tendency of variationist research towards essentialism (see Chapter 2) and proposes that there are ascribed social roles against which any performance of gender may be accepted or resisted. A community of practice 'is an aggregate of people who come together around mutual engagement in an endeavour. Ways of doing things, ways of talking, beliefs, values, power relations – in short practices – emerge in the course of this mutual endeavour' (Eckert and McConnell-Ginet, 1992: 464). This ethnographically based approach rejects the oversimplifications implied by the monolithic categories of 'men' and 'women' by arguing for a much more localised or community-focused view of language use to which other identities, professional, or age-related, contribute, such as doctors talking about pregnant women or adolescents talking about sexual health issues. It recognises that in specific settings it is normal rather than deviant for men to talk in a way that is more 'feminine' – say, when they are discussing illness – or for women to employ a more 'masculine' style – say, when they are talking about finance or football. The communities of practice approach leads to studies of particular local instances of language use and seeks to avoid over-generalisation.

Holmes (1996) argues that ethnographic study needs to be contextualised within larger quantitative studies and Bergvall (1999: 280) proposes that 'Large-scale quantitative studies collected across a broad population can contextualize the individual communities' usage, and augur the direction of change in the use of linguistic variables'; in this book we will be report on an analysis of approximately 200 transcribed interviews that reveal the practices of people who have experienced illness – though not very large, this is nonetheless larger than many samples of language in existing gender studies. This brings together

Holmes' search for a larger quantitative study with one that collects together several communities of practice (e.g. people diagnosed as suffering from depression, pregnant women, cancer patients etc.). We employ computer software to make comparisons between different groups that are arranged by variables of sex, age and social class (also referred to as 'socio-economic classification' or 'SEC' in this book). This methodology allows us to examine how 'communities cohere into larger aggregates through broadly held social and cultural values, involved and reified in the national and international media' (ibid.: 289). We are not seeking to reify gender stereotypes, but where there is quantitative evidence of norms of language use that vary according to sex, we are not going to sweep this under the carpet. We identify normative or stereotyped sex roles as the basis for identifying variation in practice because we think that it is only possible to describe how some men might discuss illness in a more 'feminine' way, or how some women may discuss illness in a more 'masculine' one, if we have linguistic evidence for what might be normal in how women and men talk about illness.

Behind the communities of practice approach is an assumption that underlies modern approaches to gender: individuals make language choices, and these choices reflect their ideologies, their outlook on the world and potentially change the world. Language therefore provides evidence on how an identity is developed that mediates between an inner belief system and an outer social world. It is here that a notion of 'style' is relevant:

> Inasmuch as people feel that their way of speaking defines them, the development to linguistic style is a central part of identity work. Style is about creating distinctions (Irvine 2001), and how people talk expresses their affiliations with some and their distancing from others. It expresses their embrace of certain social practices and their rejection of others – their claim to membership (and to particular forms of membership) in certain communities of practice and not in others. And within communities of practice, the continual modification of common ways of speaking provides a touchstone for the process of construction of forms of group identity – of the meaning of belonging to a group (as a certain kind of member). (Eckert and McConnell-Ginet, 2003: 315)

In many advanced liberal democracies there has been a challenge to a social order based on the natural order – because it is seen as oppressing the individual identity that is valued so highly. Contemporary views

on gender do not take it as something, like sex, that is given at birth and which the individual has to live with for the rest of their lives, but as something that may be created by individuals according to whether they feel more psychologically themselves when they adopt masculine or feminine identities.

1.3.3 Discourse

'Linguistic style' or 'how people talk' is what we understand by 'discourse' and is a way of using language that contributes to the formation of identities. In modern societies individuals seek to behave according to their sense of who they are and who they want to be may alter over their life course. So-called postmodern perspectives attribute a significant role to discourse, in the creation of a gendered identity:

> While structuralists believed that people's identities determine how they speak, post-structuralist accounts of language and identities argue that the reverse is the case – that language (among other things) helps to shape gender (or sexuality or race, etc.). Therefore gender becomes associated with ways of *doing* rather than ways of *being*. People are who they are because of the way that they talk, rather than the way they talk being due to who they are. (Baker, 2005: 10)

Nonetheless, we should remind ourselves that presuppositions about what is 'normal' in gender are often based on prior expectations of sex roles rather than on whom people feel themselves to be. Without some knowledge of the assumptions that underlie normal 'ways of being' there would be no system of 'signing' or 'indexing' a particular group identity: it is precisely for this reason that some gay men can 'do' gender by adopting a higher voice pitch and employing make-up and eye-shadow – and transvestite men can draw on the stylistic resources of women's clothing to mediate their identity in the world. Their stylistic repertoire relies on the availability of a set of semiotic resources, or discourses, that convey meaning only because they are historically associated with women. Their communicative repertoire would be completely curtailed if *all* men had always done this – gender-crossing assumes that there is a boundary to cross and without it there would be no ways for creating meaning through transgression. 'Doing gender' relies on choices about ways of behaving and relies on pre-existing sex roles as a crucial resource for doing identity. This means that gender as well as being performed is also

socially constituted. Consider the following summary of a possible postmodern research approach:

> By looking at men and women's crossover into spheres and spaces often predominantly associated with the other we begin to get a sense of how boundaries between those spheres are actively maintained, how gender is policed, how people resist these boundaries, and perhaps what transformation requires. (McElhinny, 2003: 26)

We should note that there is still an assumption of 'predominant' associations and of 'boundaries'; without this assumption of what is normal, it would not be possible to have a concept such as a 'crossover': in order for rules to be broken, there have to be rules in the first place. We believe that our approach accords with Giddens' (1986) view of the relationship between human agency and social structure: each action by an individual reproduces the structure which in turn shapes the individual action. Semantic theory itself relies on divergence and contrast of meaning as well as on convergence and similarity. Ways of doing gender can only exist within a context of expectations of how gender is to be done, and for this reason views on gender and language that deny any possibility of differentiation by gender allegiance are like throwing out the baby with the bathwater. So to build on Baker's (2005) claim: people are the way they are because of an interaction between who they are, how they talk – their discourse – and their beliefs about how others talk about them – dominant discourses.

Cameron (2003) notes that variationist representations of gender and language are often used to provide support for the popular view, promoted in mass media folk linguistics, that gender differences exist and are natural. Cameron marks the ideological status of these beliefs by noting that the content of such popular stereotypes differs across cultures and across historical periods and while at one time it may have disadvantaged women, in the post-industrial contexts it may be disadvantaging men. The language ideology current in the USA and UK holds that men (particularly if working class) are 'inarticulate, linguistically unskilled' (ibid.: 454) because of their assumed inability to participate in a public discourse that nowadays emphasises the need for informality, personal intimacy, self-revelation, admission of vulnerability – all characteristics that were shown by variationist research to be associated with women. This view has also been influential in sociology, with Giddens observing that 'women have prepared the way for an expansion of the domain of intimacy in their role as the emotional revolutionaries

of modernity' (1994: 30). The widespread belief that associates these characteristics with women paradoxically allows male politicians (like Tony Blair or Bill Clinton) to exploit this mode of discourse quite effectively in the interests of power, producing 'women's language' in public settings as a way of marking their sensitivity and ordinariness. As Whitehead (2002: 110) argues

> For men, the question is not whether they take up masculine discourses as practices of self-signification, but rather which masculine discourses to engage in. And here, whatever choice is available is heavily localized and thus constrained by numerous variables such as age, cultural capital, body, health, ethnicity, geography, nationality and, not least, the unique history of the subject as individual.

We should notice that the plural 'masculine discourses' implies a range of sex roles but also admits that not everyone will have equal access to gender discourses.

Although recent approaches demonstrate the increased opportunities that exist nowadays for performing gender identities, they have to be interpreted against the background of empirical studies that demonstrate the influence of norms for gender. In this book we present an account of gendered performance in illness narratives that draws on a postmodern, discourse or performative perspective, but which, for the reasons given above, recognises the continuing relevance of elements of the gender difference model, though modified by an appreciation of a range of other variables – in particular age and social class – that interact with gender and that we will consider later in Sections 1.4.3 and 1.4.4. In this study we place greater emphasis on recognition of the importance of both individual agency and the local context in which accounts are produced. We also agree with Stubbs' view that

> Speakers are free, but only within constraints. Individual speakers intend to communicate with one another in the process of moment to moment interaction. The reproduction of the system is the unintended produce of their routine behaviour. (Stubbs, 1996: 56)

We believe that the notion of gender arising from entirely free language choices remains to some extent a luxury of those in occupations such as higher education or other symbolic elites who often reside in metropolitan settings and who risk generalising from privileged liberal environments such as academia to making claims about society

as a whole. For many, gender identity is much less of a choice than for others – it may, for example, be easier for a young upper-class gay man in Bristol to develop a feminine sexual identity than for a working-class gay man in a Welsh valley. This is because the working-class man is more exposed to the constraining influence of traditional masculine sex roles than the upper-class gay man because of the very different attitudes towards sexual identity in their respective communities. Age, social class and social constructions of gender in specific communities all influence how it is performed in discourse.

1.4 Illness, language and social variables

1.4.1 Illness and language

The experience of serious illness necessarily entails a break in the life story since it interferes with the 'normal' performance of social roles and requires a complete re-evaluation of the 'self'. Life-threatening illness raises questions about the purpose of life, values, relationships and the place of the individual in the world. Illness is usually experienced as out of the normal and is likely to endanger the sense of individuality and independence that characterises the construction of a self. The person becomes dependent – to a greater or lesser degree – on carers, whether family or friends, on health support workers and professionals – and forms a new web of social relationships. There may be a daily routine which is centred on visits to hospitals and clinics for medical examinations, tests, collection of test results, medication, meetings with other patients and support groups – whether online or face to face. Such biographical disruption (Bury, 1982) requires a concomitant narrative reconstruction of the self (Riessman, 1990; Williams, 1984) and it is likely that language plays a significant role in such a reconstruction. Individuals will vary in the extent to which they require meaningful explanations of illness, but it is likely that they will develop stories around their experience that differ from those they told previously about themselves.

Frank (1995), for example, identifies four different narrative types as a response to illness: the restitution narrative, the chaos narrative, the quest narrative and testimony; the restitution narrative has the following pattern:

> 'Yesterday I was healthy, today I am sick, but tomorrow I'll be healthy again'. This storyline is filled out with talk of tests and their interpretation, treatments and their possible outcomes, the competence

> of physicians, and alternative treatments. These events are real, but also they are metaphors in Schafer's sense of enacting the storyline of restoring health. Metaphoric phrases like 'as good as new' are the core of the restitution narrative. Such phrases are reflexive reminders of what the story is about: health. (Ibid.: 77)

The restitution narrative is characterised by a contrast between life before and life after successful treatment – with images of the enjoyment of pastimes such as sport and gardening. The emphasis in the restitution narrative is on the control offered by expertise and medicine that contributes to restitution and this contrasts with the chaos narrative characterised by both the individual's lack of control and medicine's inability to control the disease. In the quest story the person accepts illness and becomes a proactive narrative agent – rather than a patient dependent on expert knowledge or on medicine – who is able to overcome the chaos through his or her own efforts (ibid.: 115). Mythological and narrative approaches such as these find a similar therapeutic role for language to that proposed by cognitive therapies and assume a reciprocal relationship between interdependent systems of thought and language.

Storytelling therefore contributes to the social construction of illness – taking it out of the private world of the body into that of the self that lives in a social world and relies on others. Illness offers individuals a watershed to which they can respond either by clinging to familiar language styles – that for example may reinforce dominant narratives, and clichés taken, perhaps, from experience of TV medical soaps such as ER or Casualty – or be characterised by stoicism or humour or whatever other elements of language style are part of a continuing sense of self. Alternatively, they may reconstruct themselves by finding a new identity, possibly one that is more self-revelatory, more prepared to reveal areas of experience and of feeling that were previously concealed. Such a narrative of change may have implications for gender and illness experience provides a rich source of insight into how pre-existent gender identities are either continued, reinforced – if they are seen as offering security – or dispensed with, if they are inadequate to the challenges presented by illness. Dominant gendered identities based on normative sex roles may be challenged and rejected if they do not satisfactorily accommodate the experience of illness. The struggle for health may therefore be taken as an opportunity to embrace a changed sense of identity.

1.4.2 Illness and gender

Illness has been identified by health sociologists as an area of experience in which women's style predominates since the nurturing characteristics of 'feminine' styles are likely to be especially appropriate in the case of sickness, where people may benefit from expressing their feelings about their situation:

> ...men are often portrayed as reliant on female partners (or other female relatives) in health matters, and women are said to encourage awareness of health issues, to assist men in interpreting symptoms, and to play a key role in persuading men to seek help. (O'Brien, Kate and Graham, 2005: 504)

The claimed dependency of men on women regarding discussion of health issues is ironic in that gender stereotypes within the health care system often allocate higher status to men because of their knowledge-based expertise and constraint on emotion:

> Thus the surgeon (stereotypically rational, reasoned, unemotional and distant) must be male, while the nurse (stereotypically caring, compassionate, maternal and emotive) must be female. (Whitehead, 2002: 18)

While economic resources in the health system may be distributed in favour of male health professionals, the emotional and linguistic resources for dealing with the ill self may be distributed in favour of women. If illness is considered a 'feminine' domain in popular language ideology the question arises of whether this disables some men in their development of new narratives of self? An expectation that men will be 'in control' of themselves may lead either to avoidance of illness as a topic, or – when they discuss illness – a focus on trivial health issues as implied by the ironic term 'man flu' which we discussed at the start of this chapter.

Health sociologists have therefore followed popular language ideology in identifying a lack of expressiveness as a problem in relation to men's health issues. The heroic and solitary performance of masculinity has been associated by health sociologists as being linked with reluctance by men to seek help and

> A large body of empirical research supports the popular belief that men are reluctant to seek help from health professionals. (Addis and Mahalik, 2003: 5)

Health sociologists have been concerned with improving men's help-seeking behaviour when ill, and argued that challenging the 'hegemonic' masculine norms of silence in response to illness may be beneficial to their health by, for example, enabling men to seek medical help at the first sign of symptoms. In a study of men experiencing depression Emslie et al. (2006) find support from Warren (1983), who claimed that depression in particular is incompatible with conventional masculine identities. Developing men's ability to talk about health issues can therefore be seen as potentially life-extending for them. A typical example of masculine deficiency is given by O'Brien, Kate and Graham (2005) who find evidence of male avoidance in a focus group study of men talking about health concerns and behaviour:

> It was clear from the accounts provided that there was a widespread reluctance to seek help (or to be seen seeking help) as such behaviour was seen as challenging to conventional notions of masculinity ... It was apparent that to many participants to (be seen to) endure pain and to be 'strong and silent' about 'trivial' symptoms, and especially about mental health or emotional problems was a key practice of masculinity ... (Ibid.: 514)

A version stressing men's own involvement in this conspiracy of silence is supplied by Courteney (2000) who argues that dismissing concern for their health is a typical way in which men construct themselves as traditionally masculine. We have found evidence of such dismissal in the popular phrase 'man flu'.

It may also be the case that the gendered performance of illness may differ regarding physical and mental illness, and that gender norms for how to talk about illness are based on the notion that it is primarily based around bodies rather than minds. As Whitehead (2002: 12) notes

> Women and men have a biological dimension to their sense of reality and formation of subjectivity; not least ... through their experience of being embodied agent/actors in the social world.

Part of this bodily based experience is for girls at the age of puberty to experience menstruation and for this embodied experience to continue through their lives until the menopause. The experiences of pregnancy and childbirth and subsequent close involvement with children – along with that of menstruation – are ones which may bring women into closer

contact with the realities of the human body and to develop a language for talking about illness. Part of women's socialisation involves intimate discussions about the body's needs and how they may be responded to most effectively. Men on the other hand perhaps view health as a constant state of embodiment less heavily affected by the biological cycle of their bodies, or by close physical involvement with those of others, and, as a result

> Dominant notions of embodied masculinity speak of force, hardness, toughness, physical competence ... Moreover, masculine bodily existence suggests the occupation of space, the capacity to define space, the ability to exercise control over space, or to place his body in aggressive motion within it, in so doing posturing to self and others the assuredness of his masculinity. (Ibid.: 189)

Men's bodies are not supposed to change and are not entities where issues of loss of control – and the associated feelings that this may cause – are at stake. Men experience embodied loss of control when they experience sexual desire, but to display an erection is to break a taboo. What may be for many men the most important part of their body is, perhaps like their feelings in relation to illness, supposed to be sheathed.

1.4.3 Language and age

Linguistic studies of ageing and language have been less studied than those of younger people, as Eckert (1997: 165) points out 'in sharp contrast to the year-by-year studies of [the language of] children and adolescents, adults have been treated as a more or less homogeneous age mass'. Russell (2007) comments on the absence of studies of how older men and women 'do' gender, and we agree with Macaulay's claim that '... drawing conclusions about gender differences without taking age and social class into consideration may give a misleading picture' (2005: 156); in his variationist study of Scottish speakers he found that more significant differences were accounted for by the age variable than by the gender variable. Therefore, in designing the research we describe in the next chapter we believe that the interpretation of accounts of illness experience should consider how people set about doing age, as well as how they do gender in their use of language.

Coupland (1997) summarises a small research tradition on language and age. Early research focused on establishing whether ageing brought a decline in communicative competence, with inconclusive results and,

as Coupland summarises, is 'certainly not altogether bad news for the old' (ibid.: 29). Such research suffers from a lack of consistency about what age to count as 'old' and a lack of specificity about the social contexts in which the studies have been done. Remedying this latter problem is a strand of linguistic research which focuses particularly on what Coupland calls the setting of 'geriatric medicine' (ibid.: 39), showing that the language of older people in this context reflects low expectations of both medical benefit and of the desirability of becoming involved in medical and health decision-making (see also Coupland 1991). However, gender has not been a variable in these studies and it appears likely, given the nature of the older population in such care settings, that these findings are more likely to apply to older women than men.

Coupland also comments on the role of age in contributing to language ideologies: stereotypes of age-appropriate language circulate in contemporary culture and are at times reproduced by older people themselves when they discursively reflect on their own linguistic performances. Such stereotypes, for example, may claim that older people are likely to 'lose the thread' of an argument, or express themselves in terms that represent them as 'grumpy' or 'grouchy'. We think that, unlike the field of gender and language where there has been a campaign to overturn popular stereotypes, self-representations based on age that reference popular stereotypes have been under-researched; therefore in this study we have sought to investigate how uses of language may be attributed to the interaction of age with gender.

1.4.4 Language and social class

The issue of social class in relation to language has been a highly controversial one since Bernstein first proposed a distinction between an 'elaborated' middle-class code and a 'restricted' working-class one. Much early sociolinguistic research into language considered social class to be an especially important influence on language use (e.g. Labov, 1966 and Trudgill, 1974). As Romaine (2003: 99–100) explains:

> Analysis of certain key variable speech forms showed that when variation in the speech of and between individuals was viewed against the background of the community as a whole, it was not random, but rather conditioned by social factors such as social class, age, sex and style in predictable ways. Thus, while ideolects (or the speech of individuals) considered in isolation might seem randomly variable, the speech community as a whole behaved regularly.

Macaulay (2005) provides a valuable overview of the literature that we will not repeat here. There has been a suspicion that much early sociolinguistic work on gender has placed excessive reliance on the linguistic behaviour of upper- and middle-class men and women, so that these elite individuals have been made to stand for all classes (Eckert, 1990; Freed, 1992). For example, an early claim made by Lakoff (1975) was that women were more likely to use 'empty' adjectives for emotional emphasis. Lakoff's two key examples are 'divine' and 'charming', clearly words that even in the 1960s and 1970s would have been associated with elite cultures. Ironically, and against his intentions, it may have been the reaction to the fall-out caused by Bernstein's characterising working-class language as 'restricted' that led to a decline of research in class and language. However, some more recent studies have shown that working-class men swear more (Rayson, Leech and Hodges, 1997). However, McEnery and Xiao (2004) note that the overall tendency for working-class men to swear more in fact masks a more complicated relationship since as they explain: 'those in authority flout their seniority through the use of swear words' (2004: 245); this implies that higher social class people may gain covert prestige through swearing. In our own study of social class and gender in illness narratives we (Seale and Charteris-Black, 2008a) found that high social class men perform gender in more varied ways than low social class men and speculate that their more varied repertoire, including the use of what was once termed 'women's language', is linked to their capacity to maintain social distinction and authority.

We think that understanding how social class interacts with gender for people experiencing illness is important for gaining an understanding of how cultural capital is deployed in the interests of social advantage and the maintenance of distinction. Social class has become associated with a perspective that emphasises how an individual's life chances and identity is determined by the social structure; this is a perspective that has fallen out of favour because of a growing interest in the influence of other variables such as race/ethnicity, gender and sexuality on the formation of identity through discourse (Savage, 2000). This is surprising – particularly in relation to health – given that social inequalities of income, education and occupation actually play an even greater role than they did 30 years ago in determining the life chances of people in the UK and the USA. There is growing evidence of widening discrepancies of income and life expectancy since the 1980s in both countries (ibid.). Paradoxically, because of apparent obligations to understand personal identity as a reflexive personal project, people

increasingly *resist self-identification with a class position*. Thus, class is often, in the popular imagination, pronounced to be 'dead' and class-based politics rejected. This has formed part of the discourse of the 'Third Way' that has been implemented by centralist parties such as New Labour in Britain that has sought to eliminate an earlier class-based discourse through concepts such as 'hard-working families'. As a result, public and political awareness of the objective importance of social and income inequality has declined. As Savage argues, drawing on Bourdieu's idea of social capital (1986), social class deserves to be put back into sociocultural and sociolinguistic analysis if sociologists are to contribute to the demystification of inequalities in modern societies. We have therefore sought to include discussion of the interaction of class with gender in the research described here.

1.5 Summary

The purpose of this book is to investigate how the language used to describe experiences of illness and biographical disruption reinforces or challenges British cultural norms for performing a gendered identity. We will study the way identities are revealed by language use through considering how far interviews about illness experience show evidence of a discourse that conforms with, or resists, gender stereotypes. We have also sought to include as part of an explanation of such variation from language norms reference to social class and age as well as to gender. Conformity with traditional sex roles is revealed by a discourse of elaborate expressiveness in relation to illness by women and lack of such expressiveness by men who are ill; more contemporary discourses are revealed by men who attempt a redefinition of their gender identity by using 'feminine' language contributing therefore to a redefinition of what a 'masculine' sex role might be like. We will show how some men tell stories about illness that perform stereotypically masculine identities, but others do so in ways that reveal different kinds of masculine performance and we will explore the relevance of age and social class for these other kinds of performance. Some men construct their masculine identity and re-establish control over illness around traditional masculinity by being 'one of the boys', while others emphasise their difference from, and possible superiority to, this version of masculinity by displaying themselves as more intelligent or emotionally sensitive – more 'feminine'. The language through which illness experience is described, therefore, provides a rich source of insight into how gender identities are reinforced or challenged and changed in discourse.

2
Methods for Investigating Gender and Language

2.1 Introduction

In this chapter we hope to raise some of the methodological issues in researching gender, language and illness experience as well as explaining the particular methods we employed in our studies. By examining both earlier and more recent methods, we hope to be able to evaluate whether a research approach is more oriented to providing insight into the influence of biological sex, into traditional sex roles or into the more self-creating aspects of gender identity – or into all of these. We will first consider the types of methods employed in variationist sociolinguistics that characterised earlier approaches to investigating gender. We introduce a discussion of some general issues in corpus linguistic approaches to research before going on to explain some concepts that are employed in corpus research in general as well as in the research described here. We then explain how these concepts relate to the discourse(s) of gender and illness experience that form the topic of this book, and how we see gender as one of a range of interacting variables that account for language use, or discourse; finally, we will outline the specific corpus and procedures for the analysis that is described in the following chapters and complete the chapter with a brief outline of these.

2.2 Variationist sociolinguistics

An approach in sociolinguistics that is known as 'variationist' involves counting a range of linguistic features – typically the pronunciation of pre-selected sounds, or the use of pre-selected grammatical forms – produced by speakers from different social backgrounds. This has

involved allocating speakers to groups that were predetermined by social variables such as sex, social class or age, identifying variation between these groups and making inferences and generalisations about the relationship between language and society. It is worth noting some assumptions that lie behind this methodology and the sorts of knowledge claims that it makes. It assumes that individuals can readily be allocated to meaningful categories on the basis of biological factors such as their sex or age and social factors such as their class. These categories are therefore assumed to be valid *prior to* the research and could be taken to imply a belief that these factors will potentially influence their use of language. In other research approaches, such as conversation analysis (see Hutchby and Wooffitt (2008) for an explanation of this method) categories only emerge from the data examined rather than being presumed to pre-exist in this way. We should also note that while sex appears fixed by biology and is relatively stable over time, the other categories of age and social class have shifting boundaries – when does one cease to be 'young' or stop being 'working class'? Indeed in the case of age, it will of course be part of the natural life progression that an individual shifts over time from one category (e.g. 'young') to another (e.g. 'middle aged'). It may also be the case that people move up or down their social class over a period of time. When investigating gender we should recall that although continuing to be classified as 'male' or 'female' an individual may stop performing a traditional sex role by adopting the one traditional for the 'opposite' sex. Such longitudinal variation can only be captured by methods of data collection that take this into account.

Earlier quantitative work on gender in the variationist tradition focused on phonological variation (e.g. Eckert, 2000; Labov, 1966; Macaulay, 1977; Milroy, 1980; Trudgill, 1974) and related this to issues of social class with women having a tendency both to use and over-report using more standard phonological and grammatical forms and men showing the opposite tendencies. This was explained as arising from women's greater concern for politeness and need for a symbolic means for gaining social status and power by their children moving socially upwards to compensate for men's greater occupational status and concomitant financial resources. More recent work has analysed discourse features in relation to gender (e.g. Holmes, 1996; Macaulay, 2005). Following this tradition, sociolinguistic research within a 'gender difference' paradigm has produced a considerable body of evidence documenting and promoting the idea of male/female difference (Bergvall, 1999); however, much of this work is really telling us about

sex roles rather than about gender. Coates (2004) reviews studies done from 'variationist' sociolinguistics which show that 'women' express feelings, intimacy and mutual support more readily than 'men', who prefer to discuss impersonal topics like sport or current affairs, albeit sometimes in a manner that generates emotions of male solidarity. An important agenda in 'men's language', for writers like Coates, is the assertion of male heterosexual identity. Variationist research has documented men's quantitative dominance of mixed sex speech situations, their tendency to interrupt or exclude women and their desire to assert their status as knowledge experts or successful achievers. What it has not always done in our view is to distinguish sufficiently between sex, sex roles and gender – with a tendency in the worse cases to conflate all three of these.

An epistemological assumption behind variationist approaches is that counting linguistic features produces meaningful knowledge – this requires adequate attention to issues of sampling and representation, consideration of how to establish meaningful categories to count and then larger epistemological issues regarding the significance of numbers implied by quantitative methodologies. These approaches make assumptions about an independent or objective researcher who knows what to count and why it is worth counting these things. Aggregation of data from several individuals conceals the identity of particular people who may not seek to be typical members of a group that is being studied – for example, one who challenges a pre-existing stereotype, as when a man is speaking in a feminine style and vice versa. In this work, we will be drawing on the enormous power of computers to count word forms according to pre-existing sex classifications, but we will also consider how far aggregation on the basis of predetermined groups conceals individual variation, and how both norms, and variation from them, are vital in understanding the relation between language and gender.

There is a risk in variationist sociolinguistics that by pre-assigning categories sex will readily be equated with gender. As we have seen in the previous chapter, 'sex' refers to a biological fact in which people are divided into two categories according to their salient visible features, while 'gender' refers to an identity that is socially performed or constructed according to individual preference, as individuals select from a range of gender styles available in their culture. They may behave either according to a conventional sex role for being masculine or feminine in their culture, or in ways that have not yet become the conventional sex roles for doing masculinity or femininity. While

people are *born* as male or female, they *perform* socially according to the extent to which they accept or reject the range of masculine and feminine sex roles available. In this respect, while biological sex is fixed by nature, gender arises through identity work that involves choosing from a range of socially and culturally available options. However, as mentioned in Chapter 1, in defence of variationist approaches it is worth noting that the notion of gender as 'chosen' is probably only freely applicable to those in positions of social power that permit them to choose a gendered identity as they would other resources for the expression of style. For many, choice is ruled out and conformity to conventional sex roles may be enforced. This is why the variationist methods will not, and should not, simply disappear. Rebellion remains the privilege of a few and the majority are often trapped in a world of social constraint. The only consolation is that as Baker (2005: 15) notes (citing Foucault, 1976): 'A dominant or hegemonic discourse is also likely to produce a reverse discourse – wherever there is power, there is also resistance'.

2.3 Corpus-based research

In this section we will first describe what a corpus is before considering some of the general reasons for using a corpus in linguistic analysis and the sort of questions that it can assist in answering. We will consider the merits of both quantitative and qualitative approaches, how they impact on this study and how corpus research does not necessarily assume the superiority of either approach. We will argue that corpus research overcomes some of the limitations of postmodern research methods that risk reinforcing pre-existing researcher intuitions rather than discovering anything new.

A corpus is any large collection of naturally occurring language and is in contrast to other types of language invented specifically for illustrating a point about language. One of the underlying principles of corpus linguistics is that theoretical claims should be based on proven instances of language use and so intuitions about language are measured against attested linguistic evidence. There is therefore a separation between data and intuition, and hypotheses about language may be modified according to the extent to which linguistic features recur in the corpus. An assumption that motivates the work of corpus linguists (e.g. Charteris-Black, 2004; Channell, 2000; Hunston and Thompson, 2000; Sinclair, 1987, 1991; Stubbs, 1996, 2001) is that analysis of word frequencies in a large corpus of language reveals

aspects of language of which we would not otherwise be aware. For this reason a basic assumption is that word frequencies can potentially tell us about norms; for example, if men use more words relating to sports and women use more words relating to feelings, this enables us to claim that it is normal for men to talk about sports and for women to talk about feelings. It does not tell us what all men or women will do, but it does tell us about tendencies in how language is used and therefore allows us to identify discourses which involve conformity with, or resistance to, these tendencies.

Corpus-based analysis implies the use of electronic searches of a corpus using automatic and interactive techniques that employ quantitative and qualitative modes of analysis (cf. Biber, Conrad and Reppen, 1998: 4). It is particularly important in corpus-based research to find the right balance between these two modes of analysis: qualitative analysis is necessary in the choice of research questions since these determine what it is that will be searched for in the corpus. Quantitative analysis is essential because it provides the basis for judging norms of language use. Without quantitative analysis we would not be able to demonstrate whether the use of language was typical since these notions depend on quantitative findings as to what is regular in language use. Qualitative analysis is necessary to interpret discourse value, or prosody, for example, whether words communicate a positive or a negative evaluation. In this respect corpus-based analysis is most effective when qualitative and quantitative analysis are involved in a dialogue – each asking questions of the other. In addition to identifying word frequencies, corpus methods allow us to identify where words occur in texts and their collocations; these are the other words that they typically occur with or whose company they keep (see Baker, 2005: 27–33 for a discussion of 'collocation' and related concepts such as 'semantic preference' and 'discourse prosody').

The methodology of the research described in the following chapters is developed through comparisons of the language produced in interviews with people who have undergone prior classification – following variationist methods – as 'men' or as 'women'. As with much research into gender and language this approach *initially* relies on the sex given on their birth certificate, rather than on, say, the sex roles they have adopted or the gender they have sought to become. And as Baker (2005) notes

> Corpus research, then, with its emphasis on comparing differences through counting, and creating rather than deconstructing

> categories, could therefore be viewed as somewhat retrograde and incomparable with post-structuralist thinking. (11)

However, like Baker, we believe that a fully explanatory qualitative account of gender is enhanced by a prior quantitative analysis. This is because quantitative analysis of a large sample of interviews enables us to identify underlying norms of language – whether according to the variables of sex, social class (SEC) or age (the three variables which our corpus permitted us to measure). These norms provide the backdrop for a qualitative analysis that allows us to investigate both compliance with and rejection of these norms. We readily accept the freedom of individuals to 'do' illness in the way that is the most expressive in providing a biographical account of the type and nature of the disruption that it caused, and how they responded to such disruption. We therefore agree with Baker (2005: 13) who – in a comparison of quantitative and qualitative methodologies – argues that

> ...both forms of thinking are dependent on each other. A post-structuralist analysis requires a pre-existing structuralist counterpart, whereas a structure that is not subjected to deconstructionist principles is in danger of reification. The two processes are therefore linked components of a way of making knowledge.

The personal psycho-emotional experience of gender provides a strong case for engaging in corpus-based research into gender and language because it distances researchers from their own gender ideologies and resulting expectations about language. The danger with the rich and detailed analyses of incidences of language use that characterise some research into gender is that we never know the criteria for the samples of language selected for analysis. A sceptic might say that selections are made because they demonstrate a particular point that researchers believe in as part of their own experience – prior to examining any data at all – and are therefore intuitive. This may be especially so in the case of gender, since no researchers come to the field of gender without prior experiences of gender ideologies and a research interest in gender could imply holding prior beliefs that it is a highly significant social variable. The selection of gender as an area of research in the first place might be determined by a belief, or intuition, that it holds the key to psychological tensions experienced by the researcher who chooses this area. Beliefs about their own gender identity may have originated in experience of issues related to gender – such as relationships with

parents, or with siblings; possibly physical, mental or sexual abuse; sexual relationships with others in mixed or same-sex educational environments or relationships with members of the opposite or same sex that have lead to marriage or divorce with their profound emotional and financial consequences. All such experiences may have contributed to very firm beliefs and ideologies that influence the selection of research topic and data samples. The use of a corpus that is collected according to principles such as random sampling and analysed, at least initially, by machine is to *delay inference* for longer than in conventional qualitative social research, and to approximate closer to the ethnomethodological ideal of 'unmotivated' inspection of data.

Like conversation analysis, corpus-based research avoids making premature generalisations about what will occur in language by giving prior significance to the data – although, like variationist sociolinguistics, it does require the assignment of pre-existing categories to compare. However, corpus enquiry need not exclude awareness of a range of possible external influences on language, including but not limited to gender, or the potential for an individual to perform a unique identity. This is because a corpus does not in itself conceal the identity of speakers – it is still possible to know the age, gender and social class of someone whose language has entered a corpus. One of the principles of corpus-based research is that it goes beyond the researcher's intuitions and provides empirical insight into how language is employed in ways that may challenge our own intuitions or beliefs – corpus-based research is therefore not solipsistic. It accepts that any single individual cannot know a great deal about the use of language in actual social contexts because of their limited experience of these contexts. It proposes that any claims about how language works should be substantiated by analysis and comparison of samples of language that can be demonstrated as representative of more general use – while retaining records on individual use – only in this way can we protect against the intrusion of our own intuitions, while retaining the advantages of more finely tuned context-based approaches.

In spite of the apparent honesty in bringing the perspective of the lived self to the centre of research, there seems to be a difficulty in some approaches (see, e.g., Denzin and Lincoln, 2005) that the personal world of the researcher's intuitions may impinge rather too greatly on the topic of research. If there are no truths other than those lived by the individual researcher, there is a risk of solipsism and a sort of research free for all in which *any* individual can claim their own experiences to be somehow more salient or insightful that those of others. How can

we ever measure the validity of an individual's experiences unless we have a principled way of generalising from a multiplicity of individuals? Corpus approaches allow us to claim something as more true precisely because more people have verbalised a similar experience. It is the potential for such generalisation that is offered here by corpus-based research.

2.4 Concepts related to corpus research

2.4.1 Keywords

The notion of keywords originated in Firth (1935: 41) who described these as 'sociologically important words' and was later developed by Williams (1976) to refer to words of social and cultural importance. Though insightful, Williams' qualitative understanding of 'keywords' was not produced by empirical linguistic analysis about how words are actually used, but reflected his orientation towards cultural studies. Williams' selection of salient keywords thus depended heavily on his own beliefs, values and ideology. So, as a Marxist, for Williams these were often words that had significant political meanings such as 'trade' or 'labour'. With the emergence of corpus linguistics, it became feasible to have a more empirical and inductive approach to the identification of keywords, which at the most mundane level may be defined as words which occur in a text or body of texts more often than would be expected by chance alone. This purely statistical definition misses, of course, any variability in the semiotic and cultural significance of words, but is a starting point on which a more qualitative investigation of this significance can be based.

The most commonly used software for identifying keywords in this statistical sense is Wordsmith Tools (Scott, 2005) and that is what we employed for the research described in the following chapters. Scott's (2005) method for identifying keywords is, we reiterate, purely statistical, so that they are simply words that occur *significantly more frequently in the vocabulary choices of one group as compared with the other.* Keywords are identified by using a statistical test (such as the log-likelihood test, for which see Appendix 3, to compare the word frequencies in a text or corpus against their expected frequencies derived from a much larger 'reference corpus' that is representative of general language use (such as the British National Corpus)). Alternatively, the analyst may be interested in comparing and contrasting two texts or corpora, and will wish to identify either 'positive' keywords (words that occur more frequently in corpus *x* than in corpus *y*) or 'negative' ones (words that occur more

frequently in corpus *y* than in corpus *x*). In this case, we can say that the analyst is carrying out a comparative keyword analysis, a method which we have found particularly helpful in our studies (see, e.g., Seale, Charteris-Black and Ziebland, 2006). We have used the method on a number of investigations of the Healthtalkonline corpora that we report in this book (Charteris-Black and Seale, 2009; Seale, 2006; Seale and Charteris-Black, 2008a,b; Seale, Charteris-Black and Ziebland, 2006; Seale et al., 2008; Seale et al., 2010) as well as other corpora (Seale, 2008; Seale et al., 2007), and a chapter describing the method appears elsewhere (Seale and Charteris-Black, 2010).

But a keyword analysis that stopped at this would probably be uninteresting. The mind of the analyst now takes over from the computer to investigate and build up a picture of the semiotic significance of particular keywords. First, lists of statistically identified keywords can be analysed for patterns – for example, keywords that are semantically related to each other in some way. In the case of illness experience we find that keywords can be grouped into semantic categories such as words that refer to people (pronouns, the lexical field for family relations, sister, mum etc.); or around medical terminology (such as amniocentesis, radiography, angina, or menopause) or 'time and measurement' (words such as 'Monday', 'thousand' or 'o'clock'). They can also be classified according to grammatical categories that describe their role in a sentence: for example, verbs, nouns or adjectives. Such cases where a word co-occurs with a particular grammatical pattern are known as 'colligations'. We can also examine clusters around keywords, to establish whether the keywords are used in similar contexts. All of these things are facilitated in softwares such as Wordsmith Tools.

Our development of comparative keyword analysis (reported in Seale, Charteris-Black and Ziebland, 2006), in which one corpus of texts is compared with another (rather than with a reference corpus) in order to identify positive and negative keywords provides evidence of measurable differences between the lexis of *any* two bodies of texts – for example, two that are differentiated by a variable such as sex or age. Though it assumes a predetermined dualism because keywords can only be established through comparisons, we reiterate that only through comparison can social variables be indexed in the first place. In the case of gender, we first have to classify on the basis of biological sex as our respondents are 'men' and 'women' based on their pre-existent status as males or females. Subsequent qualitative exploration of the corpus then permits more sophisticated investigation into masculinity and femininity by exploring whether actual women or men choose to use

the language that quantitative analysis has demonstrated to be typical of their sex or to use language that is typical of the opposite sex. In this respect keywords can provide insight into masculine and feminine discourses, and into some of the variability with which gender identities are performed.

2.4.2 Key concepts

Once we engage in semantic categorisation another important idea we employ in this work is that of 'key concepts' (Rayson, 2009). Identification of a key concept presupposes that groups of words are semantically related in some way, so that they may be grouped into semantic fields. For example, a semantic field for 'sports' might include words such as 'exercising'; 'gym'; 'golf'; 'rugby'; 'goal'; 'cricket'; 'swimming'; 'tennis' and so on. The identification of such word groups depends on the knowledge which we all share about what particular words, in general, mean. Some words, of course, are likely to have several different meanings according to their context (e.g. 'goal'); this is known as 'polysemy', others are less likely to produce such variability (e.g. 'rugby'). Having constructed a dictionary of common meanings of words, software can be employed to process texts and perform automatic categorisation of words into semantic groups. The software we employed for doing this (and subsequently identifying key concepts) is Wmatrix (ibid.), whose pre-categorisation of semantic fields is particularly sophisticated. Clearly, this categorisation process is subject to error, particularly where words with several different meanings are concerned, but as long as a large majority of words are accurately categorised, we have found that the analytic insights that can subsequently be derived are substantial.

We define a 'key concept', then, as a category of semantically related words that occur more frequently in one body of texts as compared with another body of texts (such as a reference corpus). As with our adaptation of keyword analysis to produce comparative keyword analysis, it is also possible to compare any two bodies of texts in order to identify groups of semantically related words (key concepts) that occur with statistically different levels of frequency. We have found that this provides a useful additional analytical tool that can identify differences between two bodies of text at a higher level of abstraction than keywords alone. For example, in one analysis done for this study a key concept for speech produced by men as compared with women was coded by Wmatrix as belonging to the A12 semantic category, whose label is 'Difficult'; Table 2.1 shows the word types that were classified for this key concept

Table 2.1 Semantic field A12 'Difficulty'

Types	Men's tokens	Tokens per 10,000 words	Women's tokens	Tokens per 10,000 words	p < *
Problem	878	71.12	578	24.63	.0001
Difficult	672	54.43	605	25.78	.0001
Problems	540	43.74	431	18.37	.0001
Difficulty	51	4.13	24	1.02	.0001
Difficulties	40	3.24	27	1.11	.0001
Burden	28	2.27	31	1.32	.05
Awkward	21	1.70	27	1.11	n.s.
Complications	20	1.62	6	0.26	.0001
All tokens in A12 category	2,250	182.25	1,729	73.68	.0001

Note: *based on log-likelihood test.

which occurred more than 20 times in 99 interviews with men and 99 with women.

This table shows us that a group of words that are semantically related to 'Difficulty' are used with different frequencies in men and women's speech. First, it can be seen that men use word tokens (particular instances of a word) that relate to the idea of 'Difficulty' at a rate of 182.25 per 10,000 words, as compared with only 73.68 times per 10,000 words in the interviews with women. The p value of < .0001 for 'all tokens in the A12 category' shows that this is highly statistically significant. Most of the differences for individual words types are also highly significant, except for 'awkward'. In a Wordsmith Tools analysis, which focuses on individual words rather than groupings of words, these words would also have been identified as 'keywords', with the exception of 'awkward', whose potential importance for this analysis would then have been missed. Note that the raw frequencies of word tokens are not a good guide. The word 'burden', for example, is used 28 times by men and 31 by women, which does not appear very different until one compares the rate per 10,000 words, at which point the difference can be perceived.

This semantic field contains word types corresponding with indirect responses to illness since viewing illness as a 'problem' or as 'difficult' gives an objective point of view on the condition – it is 'a problem' rather than 'my problem'. Key concepts are related to the notion of semantic preference; this is the relation between a word and a set of semantically related words, so that, for example, 'illness' might co-occur with a set

of words relating to 'difficulty' to contribute to a style that might be described as 'traditionally masculine'.

Quantitative distributions of word usages such as these were a helpful preliminary to more detailed qualitative analysis that allowed exploration of individual variations within genders that might not have been visible with an overall gender comparison. For example, sometimes we found that women employed this more objective, indirect or 'masculine' style, just as some men employed a more direct emotional or 'feminine' style. The original interview transcripts, including interventions by the interviewer, were inspected for further details of context. This has facilitated a context-sensitive, targeted and systematic comparative analysis of the language features used in the interviews.

2.4.3 Keywords and key concepts compared

There are a number of advantages of using two corpus-based tools (Wordsmith Tools to identify keywords; Wmatrix to identify key concepts). The first of these is triangulation: it is preferable to have a separate source of insight into a particular variable because it validates the findings. For example, Wordsmith Tools shows that there are a large number of nouns that refer to family members as keywords for women as compared with men; Wmatrix also shows that 'Kin' is a key concept for women as compared with men. It also quickly shows us a list of all the words that were used by women and were classified as belonging to this key concept; the ones that occurred more than ten times were: 'husband/s'; 'family/ies'; 'mum'; 'mother/s'; 'daughter/s'; 'son/s'; 'sister'; 'parent/s'; 'dad'; 'father'; 'sisters'; 'brother'; 'wed'; 'married'; 'wife'; 'relatives'; 'marriage'; 'grandchildren'; 'brothers'; 'got married' (Wmatrix sometimes includes two-word terms). The key concept sometimes detects words that did not show as keywords; for example, a key concept identified by Wmatrix for men as compared with women respondents is 'People: Male'. Yet when we use our own semantic organisation of lists of words relating to men identified as keywords by Wordsmith Tools we find that there are many omissions from those classified by Wmatrix, as Table 2.2 shows.

Here the identification using Wmatrix of a key concept 'People: Male' revealed 36 different word types whereas the Wordsmith Tools analysis identified only 5 word types that refer to people who are male; as a result, overall, Wmatrix identified more than twice as many occurrences of words (or 'word tokens') in the lexical field relating to 'People: Male' compared with Wordsmith. Wmatrix includes words that are not themselves keywords (e.g. 'man' and 'boy' were not keywords but relate to the concept of people who are male) and this creates the

Table 2.2 Comparison of findings for keywords and key concepts: 'People: Male' (men compared with women)

Keywords identified by Wordsmith Tools that are synonyms for male people		**Key concept: 'People: Male' identified by Wmatrix**	
Word types	**Tokens in men's interviews**	**Word types**	**Tokens in men's interviews**
Guy	141	Man	178
Men	103	Guy	141
Chap	59	Men	103
Bloke	23	Boy	59
Mates	19	Chap	59
		Guys	54
		Mr	31
		Bloke	23
		Male	20
		Boys	16
		Gentlemen	16
		Blokes	11
		Macho	11
		Chaps	8
		Lad	7
		Lads	6
		Other words < 5	35
Total	346	**Total**	778

possibility of a more finely tuned analysis of gender ideologies. For example, 'lads' is not a keyword yet it is related to the key concept 'People: Male'. When we examine the contexts in which 'lads' is found we find the following:

> And on the day of, during the second year of exams which were fairly important because you've got to pass those to get to the final part of two years, I crashed out in the dining hall. And *one of the lads* said to me at the end of the last exam, a law exam, we were walking down the steps, 'Well,' he said 'we were actually betting on whether you were gonna make it right the way through'. And they all knew about it. So my friends were aware that I had epilepsy. (EP34SP4, male, 52, epilepsy)

The word 'lads' leads us to the expression 'one of the lads' which implies a sense of belonging to a group. 'Mate' is not classified by Wmatrix

under the concept of People: Male, this is probably because it also implies friendship; however, we included it as a keyword because it implies maleness; and the use of a plural form (as with 'lads') is consistent with the view that men talk more about their 'mates' rather than a particular 'mate'; for example:

> No, they've, the, the thing with *my mates* is that I've always told em if, if anything [er] actually happened with this, [um] if it did go for they'd just treat me as normal. And that's what they have done. (YPC16, male, 23, teenage cancer)

As we will see in Chapter 3, we argue that this provides evidence of a wider discourse style by which men experiencing illness distance themselves from the experience through the use of a general term – in this case referring to a group of 'mates'; a more emotionally involved strategy might be to name individual friends. The presence of both singular and plural forms of semantically significant words is important – the fact that 'mates' is more frequent than 'mate' can be contrasted with 'guy' and 'bloke' where the singular form is more frequent; this is because with these words the reference is to a particular, though unnamed, individual. Women respondents in the interviews that were analysed for the statistics in Table 2.2 only used 'mates' three times and do not use 'mate' at all. Although neither 'mate' nor 'mates' shows under the key concept 'People: Male' because it also implies friendship, by using more than one software package we are able to identify a pattern that would not have been identified by a single one alone. So there are qualitative insights as well as quantitative gain from undertaking analyses using more than one computational tool.

Identification of lower frequency items with the capacity of Wmatrix to identify these as belonging to key concepts can also provide rich insights; for example, a word that only occurs twice is 'chappie'; here is one of the contexts:

> So we were the last in so we got out and I stupidly said, 'Oh look, the stairs aren't bad, let's get up them'. But I was heaving my case up and I got to the top bit and there was *a steward chappie* – he was quite *a young boy* to be quite honest – and he said, 'What cabin number are you, sir?' and I told him and I was puffing along taking my case and I was so out of breath by the time I got to the cabin door but he fled! [laughs]. I think he thought I was going to die on him and he

> didn't want to be left with *this old codger* dead! (HF28, male, 74, heart failure)

Here, the labelling of a man as 'steward chappie' reflects an interaction between gender and age: the use of the compound form seems to qualify the status of 'steward' and profile his youthfulness compared with the respondent who self-deprecatingly refers to himself as an 'old codger'. Further evidence of the influence of age occurs with the expression 'young boy' – clearly a relative term since the speaker is strong enough to carry a heavy case up some stairs. Although age is the topic here, the way that age is linguistically articulated characterises the traditional masculine style of an older man.

Key concepts are also related to Hoey's (2005) notion of semantic priming:

> The notion of semantic priming is used to discuss the way a 'priming' word may provoke a particular 'target' word. For example, a listener, previously given the word *body*, will recognise the target word *heart* more quickly than if they had previously been given an unrelated word such as *trick*; in this sense, *body* primes the listener for *heart*. (Ibid.: 8 our italics)

In the case of illness experience it is very likely that words will prime each other and it is significant that the example here is potentially medical; illness and its treatment arouses whole networks of associations arising from concepts such as illness, symptoms, treatment, emotional responses, medical experts, hospital locations and so on so that the use of a word from one of these concepts activates a set of associations leading to the use of a semantically related word. Many of these associations are likely to override the influence of social variables such as gender and age; however, this does not mean that they will all be overridden in a way that could be anticipated by intuition alone.

For example, keyword analysis alone would show that men have more keywords relating to 'Sports' while women have more keywords relating to 'Family'. However, something that would have been difficult to identify from analysis of individual keywords is that men also have a key concept (when compared with women) 'Belonging to a group'[1].

[1] The words classified by Wmatrix software as belonging to this concept included: Group; together; unit; team; association; society; community; member; club; organisation; public; gather; joint; network; units.

Conversely, traditional gender stereotypes might lead us to expect women in general to have the key concept 'Fear/shock'[2] more than men. These stereotypes might *not* lead us to expect them also to have a key concept 'Knowledgeable'[3]. Indeed given gender stereotypes we might have expected men to be concerned with 'knowledge' and women with 'emotion'. The identification of key concepts with Wmatrix provides a fresh and insightful discourse-based approach to texts, because it organises systematic and recurrent use of semantically related words into readily identifiable patterns that would not be evident from examination of individual cases. This is precisely the motivation behind computationally based language analysis: to go *beyond* stereotypes (that are in reality sets of mental expectations) and find out about patterns of language use in a way that is not available through introspection of individual cases alone. In this respect computational analysis using both keywords and key concepts resists stereotyping by going outside of pre-existing experience and cognitive expectation. It is therefore inductive, empirical and relatively free from the ideological lens of the analyst.

Comparative keyword analysis has enabled us to examine a very large quantity of text for promising features identifying interesting and somewhat unexpected phenomena. As later chapters will reveal, contrary to expectations that an emphasis on 'difference' would result in a stereotyped and 'essentialised' picture of gender it has in fact led to a discovery of people 'doing gender' in a variety of ways – including, but not restricted to, the conventional – in response to biographical circumstances and social context. In addition, because the method is backed up by counts of keywords, the classic problem of anecdotalism that affects much qualitative social research on illness experience (this problem involves only showing quotations that support the writer's argument at the expense of negative or deviant cases) is avoided. In this respect, comparative keyword analysis fulfils the benefits of counting in qualitative research perceived by Silverman (2004) and the advantages of mixed-method research outlined by Bryman (1988). (See also Seale (1999) for a discussion of counting in qualitative research and its potential for improving the quality of reporting.)

[2] The words identified by Wmatrix as belonging to this concept included: frightening; scared; shocked; fear; terrifying; afraid; panic; horrified; shy; petrified.

[3] The words for this concept included: know/knew; knowledge; remember; information; aware; news; looking back; conscious; informed; heard of; recognise; recall; warning; expert.

The constraints on corpus-based research are quite well known. A major one is usually the fact that a corpus provides evidence of uses of language by unknown users in instances in time rather than the development of language by particular known individuals over time. Although our work does not overcome the time problem, it does not suffer from the problem that language users are unknown. All of the material that we analyse was collected by Healthtalkonline researchers whose purpose was to post extracts from videotaped interviews on a publicly accessible educational web site (www.healthtalkonline.org). The code numbers which we have placed at the end of the quotations from speakers in this book correspond to those on the web site, so that readers may identify, see and hear the individuals who produced these words by visiting the site.

We also need to govern against skewing effects such as when a high number of frequencies arise from their over-use by a particular speaker – however, this is possible to do through the dispersion plots that are provided by Wordsmith Tools; these show where in a text a word occurs, so that we can see, for example, that a word might cluster in very small number of texts while another word disperses itself much widely over a larger number of texts. However, because comparative keyword analysis can manage very large quantities of text it is possible to construct samples, as we have done, that are more representative of a broad variety of experiences than in small-scale qualitative studies. This then enhances the capacity for empirical generalisation, something which has traditionally been a problem in qualitative social research (ibid.). Reliability and replicability is enhanced by the fact that inference is relatively more delayed than in conventional qualitative work, which relies from the start on interpretive identification of phenomena by the analyst. Validity, in the sense of the capacity for sensitivity to nuances of meaning and context, is then provided by the qualitative element of keyword analysis whereby individual keywords are examined in their context. However, we accept that the method is limited in its capacity to examine interaction, which is more appropriately investigated by methods such as conversation analysis which also provide insight into discourse.

2.5 Deriving discourses from keywords and key concepts

The identification of keywords and key concepts is therefore a starting point for an exploration of *discourse(s)* – how groups of people go about constructing their identity in relation to their experiences of illness

when invited to talk about it to others. Analysis of language enables us to identify a discourse. Deciding which keywords, key concepts or other language patterns to report, or to analyse further, is not done on purely statistical grounds. Some keywords and key concepts are highly statistically significant but may be of trivial importance for the research questions being pursued. Choosing the keywords, key concepts or language patterns that best bring out the characteristics of a particular text is, then, a qualitative judgement, informed by examination of patterns of keywords and key concepts and the meanings that these words and words belonging to these concepts have in the texts concerned, and relating this to the purpose of the analysis. Thus, although inference is delayed using this method, so that the analysts' own ideas are left in the background for as long as possible, inevitably intuitions are eventually deployed, as they must be in all scientific endeavour.

> Keywords will therefore not reveal discourses, but will direct the researcher to important concepts in a text (in relation to other texts) which may help to signpost the process of eliciting discourse. (Baker, 2005: 27)

The patterns that occur around keywords and words belonging to key concepts are known as collocates and concordance lines allow us to see the distribution of frequencies of words that occur in a pre-specified number of places prior to or after the keywords themselves. Lists of keywords and key concepts that initially suggest gender difference may, after more detailed exploration of their collocations, provide evidence of similar discourses by men and women implying a discourse of illness that is not constructed through gender.

Deriving discourses from lexical frequency patterns requires detailed qualitative analysis that seeks to elucidate the patterns of keywords and identify deviations from them. We need to be aware of *how* keywords contribute to the performance of an identity. We can also look for what *does not* occur in a corpus (but which might have been anticipated as occurring from intuition) as well as what *does* occur; this is done by examining negative keywords – these are words that occur significantly less frequently in a sub-corpus than in a control corpus. So, for example, we found that when compared with high SEC men the word 'shit' was a negative keyword for low SEC men – it is a word they avoid. As we will see in Chapter 3, words in the lexical field for swearing show that high SEC men use 'crap', 'shit' and 'fucking' a total of 53 times, whereas low SEC men only use a single instance of one of these swear words in

similar sample sizes of language. This is not to say that low SEC men do not swear in settings other than an interview with a researcher but we can infer that low SEC men *avoid* swear words in this context – perhaps because they perceive the researcher as coming from a different social group or perhaps because they prefer not to perform a traditional class masculinity in a public forum such as the world wide web. The comparison permits us to identify that swearing is done by *some* men in *some* settings – here higher SEC men in interview settings – even though (or perhaps because) they knew that they might be shown doing this on the web. Performing a gendered identity should include variation according to setting; we therefore explain empirically confirmed lexical patterns in the data by proposing that 'men' have a range of repertoires, or discourses, but that it will be an interaction between class and gender that influences *which ones they select* in particular situations.

In order to investigate discourse we need multiple comparison groups; for example, when in the following chapters we compare *all women* with *all men*, we find that 'baby' is a woman's keyword – occurring over one and half times more frequently; however, when we compare high and low SEC men, we find that 'baby' is also a keyword for *low SEC men* who use it around three times more frequently than higher SEC men; around half of the total uses of low SEC men are in the phrase 'the baby was'– a phrase often used by high SEC women and one that does not occur at all in the sample of high SEC men (and only occurs three times among the low SEC women). Such multiple comparisons enable us to undertake a more finely tuned analysis that explains discourses that are more closely attributed to class influence, but which might – had a less discourse-oriented approach been employed – have led to making excessive claims for gender as an overriding variable. Here, through the use of multiple comparisons that our data set allows, we have seen a similarity in the frequency with which low SEC men and high SEC women talk about babies and a difference in the frequency with which high and low SEC men talk about the same topic.

In seeking to provide an explanation that goes beyond the reporting of statistical patterns we believe in the value of a highly critical examination of frequencies. For example, forms of language may be used ironically, or in quotation marks, so that they do not readily demonstrate the beliefs of the speaker but of those they are seeking to reject or challenge. High frequencies might also arise from transcription conventions. For example, in our corpus any names of particular people mentioned in the interviews were removed to preserve their anonymity, and this was indicated in the transcript with the expression

'name removed' – therefore these two words, along with others such as 'sighs' or 'laughs' showed as key, although they are not relevant to our interpretation. Another example is that a key concept for all men compared with all women is 'location and direction' and 'close to' was classified under this concept; however, once we consider the following contexts, through inspection of concordance lines, we find that only the first four related to 'location and direction':

> which is why I chose somewhere close to me here, so that I could visit he
>
> moved have a look around at homes close to where I've moved to, to decide when
>
> It that if she was living with or close to one of us it would be easier from
>
> because I could not go anywhere close to food at all, particularly the

However, the next four are extended meanings and mean 'emotionally close':

> share this news with the people close to me, my family, my close friends
>
> so that I would really get close to this and really be able to monitor
>
> are often touched by it by someone close to them having it. Try not to be scared
>
> trees, and you depend on people close to you to point the things out that

A simplistic analysis of key concepts might have accorded with a gender stereotype for men – that they are primarily concerned with location and direction; however, closer analysis of the context of particular words in this concept shows that men are also concerned with emotional proximity.

To investigate discourse we have examined sub-corpora in relation to the social variables of gender, age and social class; this allows us to identify how these variables interact with each other, so that we are able, for example, to make claims for the discourse of an upper-class older woman and to compare this (should we wish) with that of a low-class younger man. This is known in critical linguistics as re-contextualising language: this means linking a language pattern identified from lexical

use in a corpus to the social variables of the person who originally uttered it and to other aspects of the social setting in which it occurred:

> ... corpus analysis shares much in common with forms of analysis thought to be qualitative, and at least with corpus analysis the researcher has to provide explanations for results and language patterns that have been discovered in a relatively neutral manner. Unlike more qualitative forms of analysis, the corpus linguist does not act as judge and jury over the process ... corpus data therefore can frame explanations, setting the parameters by which they can exist. (Ibid.: 36).

To investigate discourse we need to provide explanations of patterns of language use through detailed analysis of language samples in context. But such analysis should also provide evidence of how language is used that go beyond *beliefs about how it is used* – beliefs that may themselves arise from quite fixed ideological perspectives.

2.6 Corpus and sub-corpora

The larger corpus of interviews from which we selected several sub-corpora consisted of 1035 qualitative interviews with people who had experienced a health or illness condition (either as a patient or as a caregiver) that were collected by the Healthtalkonline Health Experiences Research Group, part of the Oxford University Department of Primary Health Care. Access to transcripts of the 1035 interviews were purchased by the authors of this book with the aid of a grant from the UK Economic and Social Research Council. The Healthtalkonline organisation hosts two web sites, www.healthtalkonline.org and www. youthhealthtalk.org on which extracts of these interviews are shown. Interviews are audio and video-recorded and for the most part the respondents agree to be shown talking about their experiences on these publicly accessible websites, although some opt for an actor to speak their words for them in order to mask their identity.

Healthtalkonline has created a unique database of personal and patient experiences through in-depth qualitative research into a wide range of illnesses and health conditions. The web sites that Healthtalkonline hosts are aimed at patients, their carers, family and friends, doctors, nurses and other health professionals. The original purpose of these interviews was to make information about illness experiences publicly available to help those wanting to know. In this book, we present many

quotes from respondents to Healthtalkonline interviews. In most cases, it is possible to locate the web location where the speaker is shown. For example, the quotation at the start of the next chapter is from 'DP04'. This is a 31-year-old man interviewed about his experience of depression who opted for an actor to speak his words for him. You can see the actor at: www.healthtalkonline.org/mental_health/Depression/People/Interview/671/Category/29.

A detailed description of the research methods involved in collecting the interviews can be found at www.healthtalkonline.org/Overview/Research but a brief summary based on this source is provided here.

Respondents are volunteers recruited through a range of channels that include GPs, hospital consultants, support groups, newsletters and advertising in the press, on websites and by word of mouth. Healthtalkonline researchers use a method called purposive (or maximum variation) sampling (Coyne, 1997) to ensure that a wide range of experiences and views are included. This involves continuing to collect interviews until they are convinced that they have represented the main experiences and views of people within the UK. Interviews usually take place in the respondent's home and are recorded on audio tape, and also, where consent is offered, on digital videotape. In the first part of the interview people are asked to describe their own personal story regarding their illness from when they first suspected there was a health problem. The researcher does not interrupt the person while they are telling their story but, when they have finished, asks additional questions, which may have been prompted by issues the respondent raised or from the health experience literature. The interview tapes are fully transcribed and the transcript is returned to the respondent for review. Participants sometimes decide that there are sections of the interview they would rather did not appear on the website, in which case the researcher removes them from the final version. Some Healthtalkonline studies concern both the patient's perspective and the impact of an illness on those who care for the patient; this is the case, for example, for carers of people with dementia.

Once the interviews have been analysed extracts are selected for inclusion on the Healthtalkonline web site. Respondents are aware that their accounts will be made publicly available in this way. Awareness of this context is important in understanding our study as an investigation of a particular 'community of practice' (Eckert and McConnell-Ginet, 2003). Our investigation is not one of a face-to-face community of the sort which a traditional ethnographer might study, but one in which participants can be thought of as participating in a 'virtual' community

(Hine, 2000) in which adjustments of performance will have taken place in response both to knowledge of research interview dynamics and of the eventual public use to which the interaction would be put. The participants in the interviews examined here were able to view the narratives of other participants on the Healthtalkonline web site and were informed that they were contributing to education about health issues through providing information on their own experience.

The analysis reported in this book draws on four sub-samples, or sub-corpora, of interviews carefully selected so that particular comparisons can be made between groupings of interviews while controlling for factors that might otherwise confound the validity of inferences we draw from these comparisons. Thus our organisation of the corpora follows a quasi-experimental design (Campbell and Stanley, 1966).

2.6.1 The full matched sample

In order to make valid comparisons between male and female respondents, a matched sub-sample of interviews which controlled for age, socio-economic classification (SEC), type of illness and the gender of the interviewer[4] were drawn up. This involved the identification of 99 pairs of male and female respondents (198 respondents in all) in which each member of the pair shared the same age band, SEC, type of illness experience and gender of interviewer. Interviewer speech and male and female respondent speech were separated into different files using Word macros in preparation for quantitative comparisons of word usage. The total size of the sub-corpus for the 99 interviews with men was 983,085 words and for the 99 interviews with women was 1,094,912 words (respondents' speech only). Table 2.3 shows the characteristics of the full matched sample.

All respondents were categorised by socio-economic category (SEC) according to a three-point version of the UK Office for National Statistics scheme (Rose and Pevalin, 2005) that has now replaced an older (Registrar General's) scheme for dividing the population by occupational status. Table 2.3 shows that the majority of the interviews selected for the full matched sample were with people categorised as high SEC (professional and managerial). This reflects a preponderance of high SEC people in the Healthtalkonline collection which meant that it was hard to find low SEC matches.

[4] The interviewers were all women, except for interviews with people with depression and of the carers of people with dementia for which the interviewers were men.

Table 2.3 Characteristics of the full matched sample

Illness condition	Men	Women
Breast cancer	1	1
Colorectal cancer	10	10
Lung cancer	13	13
Teenage cancer	6	6
Epilepsy	8	8
Chronic pain	9	9
Rheumatoid arthritis	3	3
High blood pressure	1	1
Heart failure	7	7
Heart attack	3	3
Sexual health of young people	3	3
Pregnancy	1	1
Ending a pregnancy	4	4
Immunisation	2	2
Depression	11	11
Carers of dementia	3	3
Living with dying	10	10
Age group		
0–25	13	13
26–35	11	11
36–45	15	15
46–55	25	25
56–65	18	18
66–75	12	12
76–87	5	5
SEC*		
Managerial professional	66	66
Intermediate	14	14
Routine and manual	19	19
Interviewer gender		
Male	14	14
Female	85	85
Total interviews	99	99
Total words	983,085	1,094,912

Note: *SEC = socio-economic classification.

Source: Rose and Pevalin, 2005.

2.6.2 The social class (SEC) matched sample

For this sub-sample 96 interviews were selected and divided into 4 subgroups of 24 each by SEC and gender, matched with each other

by age, type of health/illness condition and gender of interviewer. The sizes of the social class sample may be summarised as follows:

Men		**Women**	
High SEC	Low SEC	High SEC	Low SEC
249,423 words	199,091 words	241,225 words	271,541 words

High SEC interviewees included higher and lower managerial and professional occupations. Low SEC interviewees included intermediate, routine and manual SEC groups. The mean ages for each of the 4 groups were similar, falling between 50 and 52 years, with a range between 16 and 81. Each group of 24 contained interviews with people speaking about their chronic pain (2 interviewees in each group), colorectal cancer (2), depression (4), termination of pregnancy (1), epilepsy (2), heart attack (1), heart failure (3), receiving intensive care (2), lung cancer (4), terminal illness (2), teenage cancer (1). All interviewers were women, except for those concerning depression.

2.6.3 The age matched sample

For this sub-sample 80 interviews with people talking about their experiences with cancer were selected and divided into 4 subgroups of 20 by age and gender, controlling for type of illness. It was not feasible to match the four groups by SEC. Table 2.4 shows the characteristics of this sub-sample.

2.6.4 The specific illness sample

For the investigation reported in Chapter 7 where we investigate language variation between illness types we grouped together closely related illness experiences – initially combining interviews with men and with women to produce four separate sub-corpora:

1. Heart disease (heart attack and heart failure)
2. Cancer (breast, prostate, lung and colorectal cancer)
3. Depression
4. Carers of people with dementia

We refer to these corpora as the 'Specific illness corpora', profiled in Table 2.5.

Table 2.4 Characteristics of the age matched sample

	Women		Men	
Health condition	**Older**	**Young**	**Older**	**Young**
Carers of dementia	1	1	1	1
Chronic pain	3	3	3	3
Depression	2	2	2	2
Ending a pregnancy	1	1	1	1
Epilepsy	4	4	4	4
Heart attack	2	2	2	2
Intensive care	4	4	4	4
Living with dying	2	2	2	2
Rheumatoid arthritis	1	1	1	1
Total	20	20	20	20
Average age at interview	63	35	66	35
Age range	46–84	16–45	49–84	17–45
Total words	194,753	234,373	192,033	207,737

Table 2.5 Specific illness corpora

Illness sub corpus	**Number of interviews**	**Number of word tokens**	**Percentage**
Heart disease	75	747,495	21
Depression	39	483,994	14
Carers of dementia	31	686,714	19
Cancer*	180	1,650,361	46
Total	325	3,568,471	100

*Cancer types

	Men	**Women**	**Word tokens**
Breast	1	44	403,356
Prostate	51	0	396,137
Lung	28	18	418,911
Colorectal cancer	19	19	431,957
Total	99	81	1,650,361

In Chapter 7 we refer to these by the name of the condition, for example, the 'heart corpus' and the 'cancer corpus'. These are not matched by age and SEC and it should be noted that people experiencing depression are likely to be younger than those who are caring for people with dementia, and people with heart disease are usually older. In Chapter 7 we largely focus on heart disease, exploring the lexical choices of people experiencing this condition and how these interact with the variable of gender. In the specific illness sample, unlike the other sub-samples, we did not remove the interviewers' contributions when we analysed the tests. These contributions comprised up to 15 per cent of the total words of these interviews and clearly contributed to the co-construction of this illness discourse.

2.7 Summary

This chapter establishes that the availability of the large corpus of interview material, and the developments associated with computational corpus linguistics that we have developed in order to analyse this, represents an exceptional opportunity to investigate gender, language and illness. We have explained the contribution and limitations of variationist sociolinguistics to this field, and the place of corpus-based research within this. Keywords, though initially developed in relation to cultural studies, in the hands of corpus linguists become a powerful tool for investigating texts in a manner that is relatively free from early inference by the researcher thereby maximising the possibilities for discovery. Our particular variation of keyword analysis using Wordsmith Tools software to compare two bodies of texts with each other, rather than one body of text with a 'reference corpus', (thus 'comparative keyword analysis') has been explained and illustrated. The related use of key concept analysis using the web-based software Wmatrix has been similarly illustrated and explained. These techniques allow discourses to be derived, allowing us to show how a variety of gendered identities – some of them patterned by age and socio-economic position – are brought into being through linguistic choices made by speakers. Finally, in this chapter we have described the four sub-corpora used for the investigations reported in the chapters that follow. The account of the ways in which these sub-corpora have been constructed makes it clear that a quasi-experimental design in which key variables are controlled for as particular comparisons are made lies at the heart of our investigative logic.

3
Men's Traditional Discourse of Illness: Distancing and Avoidance

3.1 Introduction: Men and discourses of illness

We referred in Chapter 1 to research from medical sociology that supports the view that men are reluctant to express feelings regarding their health[1]; one explanation of this may be that men are unsure about what might be a normal way of talking about illness. The disrupting effect of illness experience on men's life stories offers possible discursive styles and this choice may create the sort of tensions voiced by this young man:

> I mean I think one of the problems is that you sort of lack a kind of middle ground between being kind of really macho and emotionless, and kind of tough for want of a better word, or kind of emotionally constipated which I kind of put together, do you know what I mean? And then the other thing you don't want to be is a kind of wet bugger, you know you don't want to be kind of, you know the kind of world I came from was pretty, you know I went to a boys' school it was pretty rough [laughs]. (DP04, male, 31, depression)

It is the *range* of discourse options that creates conflicts for some men, especially perhaps younger men who are experiencing illness: how to *embrace* more feminine and contemporary identities while *retaining* an identity that is still in some way 'masculine' – expressed here as not being a 'kind of wet bugger', since presumably this would be associated in this speaker's mind with femininity. Use of a discourse through

[1] For example, Emslie et al. (2006), O'Brien, Kate and Graham (2005) and Warren (1983).

which men can express their ill selves may contribute to the creation of new masculine identities. Such men are balancing on an expressive tightrope with fear of getting it wrong – either by being *too* emotional or *not* being emotional *enough* and coming over as cold and detached from the inevitable emotions aroused by illness experience. Pursuing this idea we might take the view that for many men in late modern society, fears of ideologically unacceptable ways of expressing themselves inhibit the adequate expression of feelings and this may especially be the case when experiencing illness.

In this chapter we focus on the traditional discourse styles employed by many men to cope with the biographical disruptions arising from their experience of illness. We illustrate how some men adhere to traditional masculine sex identification by demonstrating their control over the experience through a range of linguistic strategies and discursive styles. A discursive style is one that permeates the use of language, whereas a linguistic strategy is one that can be linked to specific language uses. For example, some men's expression is characterised by the frequent use of swear words and so swearing is a discursive style because it is a way of talking, whereas the replacement of verbs by nouns (known as 'nominalisation') would be a linguistic strategy because it is realised by an identifiable linguistic pattern. The combined effect of linguistic strategies also contributes to discursive style. We have found three linguistic strategies to be of especial importance to a masculine style: the use of *reification*, of *deictic distancing* through pronoun choice and of *abstractions*. We suggest that these strategies contribute to a discourse style of describing personal experience *from an external or supposedly objective viewpoint* – as if it were happening to *someone else* rather than to the speaker. We will see in Chapter 5 how this traditional masculine style contrasts with that of other men who use a style that positions themselves as the *subjects* rather than as the *objects* of illness experience and who attempt a redefinition of their gender identity by using 'feminine' language thereby contributing to a rejection of a traditional masculine sex role. But the risk for men who feminise their emotional expression is that they lose a masculine identity altogether – which may explain why some men sustain a traditional style for masculine identity.

We will refer to the traditional masculine style as 'a discourse of distancing and avoidance'; this has some similarities with notions of 'face' and 'face-saving' (Goffman, 1967), and with the traditional politeness norms for British English – in particular negative politeness, that is avoiding a threat to the integrity and independence of others

as compared with the more solidarity-oriented positive politeness that invites others to share the experience. For some men it is possible that illness may be a private matter and not an appropriate topic for everyday conversation because illness threatens the normal performance of self. Indeed, it is likely that men who strictly adhered to this point of view would not have agreed to be interviewed about their illness experience anyway – let alone have their experiences put on global view via the world wide web. However, for those of whom we know about, our findings support those of Galasiński (2004) who in a study of 26 interviews with white middle-class men found evidence of emotional distancing. His work is based on content analysis, whereas ours is based initially on keyword analysis of a much larger body of data, followed by qualitative analysis. Our use of keyword analysis allows us to distinguish between linguistic strategies that are specifically identified at the surface level of text and discursive style that is not necessarily measurable at the surface level of language, although there is some evidence of it there.

Our findings also accord well with Kiesling's (2005) study of fraternity culture which finds that young American men, in order to establish solidarity with other men without being interpreted as homosexual, develop a set of indirect strategies that avoid personal topics such as love, relationships and friendships. He refers to this phenomenon as 'homosociality' and identifies tensions between appearance and substance in men's discourse. Rather than express their feelings through explicit verbalisation, conventional sex roles encourage men to 'do friendship' by drawing on various discourse activities that include talk about sporting events. He proposes that this is a type of 'deflection' or displacement that leads men to 'rely on socially indirect speech genres, acts, and stances, such as insults, boasts and other forms to create homosociality' (ibid. 721). Galasiński (2004) and Kiesling (2005), along with other researchers, emphasise that masculinity is not unitary and that such traditional or conventional forms of expression are not necessarily 'hegemonic' but contribute to 'multiple, sometimes conflicting cultural discourses ... Much of such interpretation depends on the cultural discourse dominant in a group of people, and on the norms of the speech activity in which the strategy is situated' (Kiesling, 2005: 722). The difficulty for men experiencing illness is that in late modernity there is such widespread questioning of traditional masculinity that there are no longer any norms; however, a discourse of distance and avoidance is one way of dealing with the experience.

Given traditional gender norms we might have expected men experiencing illness to present themselves as heroic survivors or fighters against life-threatening conditions, and to conceal their feelings from the interviewer in order to sustain a 'masculine' presentation of self. However, we will show that many men are overwhelmed by the difficulties that are brought on by the experience of illness and find it very difficult to adopt such heroic attitudes. They often encounter – at least initially – feelings of loss of control because the experience of illness contrasts so dramatically with previous feelings of being in control when in good health. In this respect it may be that the crisis of masculinity in late modernity (cf. Connell, 1995; Giddens, 1991) may have more relevance for men who are experiencing illness – or other extremely challenging biographical disruption such as divorce or estrangement from children. As Galasiński (2004: 144) illustrates

> ... I also showed that men talk about their emotions, and in a variety of ways, contexts, constructions, presumably depending on who they are, what they want to say, and a host of other reasons that, perhaps, do not concern the fact that they are men at all.

In this chapter we show men reacting to illness by distancing themselves from the experience as they struggle to find a discourse that is adequate for a weakened and ailing body. But in Chapter 5 we illustrate how some other men explicitly *reject* such materialising and externalising strategies in which the body is treated as an object to be viewed from without. Such men realise that focusing only on the message-level of talk, by treating the body or the mind as something to be 'fixed', is inadequate because it limits opportunities for the expression of emotion. We will suggest that such men undergo a degree of personal transformation as illness forces them to discover more about themselves and to accept their vulnerability. Adopting more feminine styles may threaten the distinctiveness of the men described in this chapter because a distancing and avoidance discourse retains some of the conventional 'strength' and 'stoicism' that are culturally established ways for men to do illness. A traditional masculine identity requires men to demonstrate that they can deal with the challenge of illness in a similar way to how they deal with other challenges of the material world – as another problem to be 'fixed'. We will now consider first the linguistic strategies of reification, deictic distancing and use of abstractions. We then discuss the discursive styles of sports talk and swearing; these together characterise a discourse of distancing and avoidance.

3.2 Linguistic strategy: Reification

Reification generally means treating something that is abstract or intangible, such as an idea or a feeling, as if it were a material object; as a strategy for responding to illness experience, it implies treating either the ailing body or psycho-emotional responses to the ailing body as material entities rather than as part of a lived experience. In this section we propose that this is a characteristic of traditional masculine discourse when talking about illness.

The software programme Wmatrix identified groups of words with related meanings that were used differently by men and women across a range of comparison groups. There were a total of 37 key concepts for men ($p < 0.0001$) and some of these are shown in Appendix 1. However, we will illustrate and discuss in detail one named 'Difficult' – summarised in Table 3.1 – which is based on the full matched sample of interviews, as is all of the analyses in this section unless otherwise stated.

This key concept encapsulates a group of words conceptually related to 'difficulty' that are used differently by the sexes, since they hold across comparisons that controlled for the variables of illness type, age and socio-economic classification (SEC). 'Difficult' was a key concept for men in the full matched sample, amongst low SEC men in the social class matched sample, and for men compared with women whether old or young in the age matched sample. There is, however, some interaction with social class, since 'difficult' is not a key concept when comparing only high SEC men and women. So discourses of illness potentially arise from an interaction of gender, age and social class and possibly other variables such as sexual orientation and ethnicity that are not examined in our research.

A frequent phrase involving a word that contributes to this key concept in the interviews with men is 'one of the problems'; this occurs 20 times (as compared with only 3 times in the women's interviews). It indicates that men following traditional masculine styles experience the disruption of illness as a linear sequence of problems that challenge the normal way in which they are used to dealing with life: illness – whether their own or that of others for whom they are caring – does not simply present *a* problem it presents *a whole host* of problems. This expression can be treated as a hyperbole that is typical of traditional masculinity; consider the following:

> So we were referred by the doctor at our local hospital to [um] a specialist to a, to a heart specialist to, to another hospital. We went along there, [um] which was where they, they told us actually what

> *the problems* were. And the heart wasn't forming properly, there were *problems* with the stomach, they couldn't see the aorta forming properly. So there were, it *wasn't just one problem* that might be able to be fixed at some point, it was you know, *one problem on top of another, on top of another, on top of another,* and that's what they could tell at, at that stage and they said that, you know, 'It maybe that there are *other problems* that we can't even see yet'. (EAP35, male, 38, ending a pregnancy)

The speaker, who is with his wife who has had termination of a pregnancy contrasts a single problem that might be 'fixed' and a multitude of 'problems' that seem to stretch into an infinite future of as yet unknown problems. While the repetition suggests considerable potential for emotional impact, the speaker restrains himself from a more transformational attitude in which feelings are expressed directly. For many men reducing a health condition to an objective physical 'problem', or reifying it, is one way of responding to an illness.

Using Wmatrix it is possible to establish all the words that are classified under a key concept. Table 3.1 shows the frequencies for

Table 3.1 Key concept 'Difficult' identified by Wmatrix in the full matched sample (men compared with women)

	Men		Women		
Types	**Tokens (> 5)**	**Tokens per 10,000 words**	**Tokens (> 5)**	**Tokens per 10,000 words**	**p < ***
Problem/s	1,418	14.42	1,009	9.23	.0001
Difficult/y/ies	765	7.78	657	6.00	.0001
Burden	28	0.28	31	0.28	n.s.
Awkward	21	0.21	27	0.25	n.s.
Complications	20	0.20	6	0.05	.01
Fix	22	0.22	8	0.07	.01
Complicated	17	0.17	21	0.19	n.s.
Crisis	16	0.16	12	0.11	n.s.
Inconvenience	13	0.13	4	0.03	.05
Hard work	11	0.11	15	0.14	n.s.
Challenge	19	0.19	17	0.15	n.s.
Challenging	14	0.14	11	0.10	n.s.
Demanding	13	0.13	16	0.15	n.s.
Others < 6	107	1.08	119	1.10	n.s.
Total	2,484	25.3	1,955	17.9	.0001

Note: *based on log-likelihood test.

words included in the key concept 'Difficult' that occurred more than the 5 times in the 99 interviews with men and their corresponding frequencies for the 99 interviews with women in the full matched sample.

The table shows that men experiencing illness used the word 'problem/s' approximately 14 times per 10,000 words while women used it around 9 times, so that men use this word more than 50 per cent more frequently than women. When we measure this difference statistically, the results are highly significant ($p < 0.0001$). As well as 'problem' and 'difficult', lower frequency items such as 'complications', 'inconvenience' and 'fix' are used much more by men; however, other words such as 'awkward', 'complicated', 'hard work' and 'demanding' are used with similar frequency; key concepts show a *lexical pattern*, rather than predicting *exactly which words* are used more or less frequently by particular groups. It is through such lexical patterns that discourse emerges out of linguistic strategies.

To interpret semantic tendencies such as these we need to examine the verbal contexts of high frequency items and a method of doing this is to identify their collocation patterns – that is, the other words that occur in the vicinity of a particular word. Using corpus-based methods it can be insightful to identify clusters of words around a particular word and explore the typical ways in which these clusters are used. By doing this we identify how particular words nest within clusters of other words that themselves are nested within wider linguistic patterns. This 'Russian doll' approach permits us gradually to expand our focus from the word itself to these wider linguistic patterns and to arrive at a strategy – although we cannot claim that it is necessarily one of which the speaker is aware. Corpus-based approaches are intended to provide insights into language that are not based on intuitive knowledge on the part of the researcher or of the researched.

Through collocational analysis we established that the most common noun following 'serious' is 'problem'; 'major' and 'serious' were analysed together because another common collocation was 'major problem'. This suggests that a traditional masculine strategy for dealing with illness is to activate a problem-solving mental frame; those following the resulting traditional styles of expression conceptualise an illness diagnosis as a 'problem' for which they need to devise solutions. Table 3.2 presents an analysis of the entities that men and women referred to as 'major problems'.

Table 3.2 Comparison of entities referred to as 'major/serious problem/s' in the full matched sample (men compared with women)

	Men	**Women**
General physical condition	24	5
Performing a physical task	6	0
Negative 'no major problem'	6	0
Psychological state (e.g. depression)	6	0
Financial	2	0
Relationship related	2	0
Other	3	3
Total	49	8

Men evaluated their physical condition as a 'major problem' and described the effects of having an illness on their ability to perform physical tasks:

> ...and to have an upset stomach and bad bowels is in itself a *very major problem*, never mind having a chronic pain problem behind that. So that is a level which is incredibly important. (CP 27, male, 54, chronic pain)

> My biggest bug bear are stairs. Getting up them is quite painful. But believe it or not *the major problem comes in coming downstairs*. The pain's a lot worse. (CP32, male, 57, chronic pain)

These findings provide empirical evidence that men using a traditional masculine discursive style describe their situation as being 'problematic' or potentially problematic (since this is implied even when the existence of a 'problem' is denied). Such men view themselves from an external viewpoint, considering their bodies as things to be examined from the outside, in much the same way as they might face problems in the material world such as fixing a faulty tap or a leaking roof. The reification involved in this suggests that these men may be distancing themselves from inner states related to their illness conditions.

The frustration involved in serious illness can lead to restrictions that threaten the continuation of a lifestyle hitherto experienced as normal and unproblematic. Thus one man said:

> You know, [er] or any of the enjoyable things that I used to do. They're way beyond my reach now. So I've really got to put them out of my

> mind and start afresh. *And that was a major problem* at the beginning with me. It took me two years, at least two years, to come to terms with that. ... *I must admit. [er] I was getting angry with myself* for not being able to do simple things. (CP32, male, 57, chronic pain)

For some men, then, the suffering experienced as a result of illness creates feelings of frustration because *it is a problem for which a solution may not be to hand*. We have already noted in Chapter 1 a popular gender ideology in the ironic expression 'man flu' – implying that men exaggerate issues relating to their health and we have argued that this ideology contributes to the finding of medical sociology that men are reluctant to seek health support (e.g. O'Brien, Hunt and Hart, 2005). However, one reason why some men resist talking about their health is because personal revelation is not part of traditional masculine discourse. In the following extract a man is keen to stress the health difficulties he encountered:

> I've got no qualms about the operation and I'd have no qualms about doing that again, but then it led *to whole lot of complications*. I had been out to two months and I had a terrible pain just under my heart at the side, couldn't sleep at night, couldn't breathe, I didn't attend the rehab classes at this point. (HF14, male, 56, heart failure)

This man uses 'complications' (a word that men use three times more than women) as a way of distancing by avoiding detail. 'I had a terrible pain' can be understood as an alternative to the more general 'I felt awful'. The use of reifications often occurs in medical terms and is an indirect expressive strategy: it may well be easier for men using 'traditional' masculine discourses to express strong anxieties and negative emotions by materialising them as this is less threatening to a traditional identity than an overt account of an emotional state – which as Kiesling (2005) has argued may be interpreted as homosexual.

Men convey intensity of feeling through expressions such as 'extremely difficult' for which there are 12 occurrences in the full matched sample interviews with men (3 times more than those with women). The sort of things that are described as 'extremely difficult' include concentrating because of pain, running a house when his wife has fallen ill, and dealing with issues such as retirement, the social services, and the urge to commit suicide. Interestingly, the only experiences that women refer to as 'extremely difficult' are physical events such as changing the bed, menstruation, standing and walking. It does, therefore, seem to be the

more psychological aspects of illness experience, such as stress, that are perceived by men to be 'extremely difficult' rather than the physical constraints of illness; this may support the view that many men are poorly equipped psychologically to deal with illness and encounter it as a potentially overwhelming experience. It may be this lack of psychological preparedness that leads some men to respond by treating it as just another external problem of the material world – similar to the world of work and do-it-yourself.

A question we may ask ourselves is were men able to talk about illness differently, how far might this bring about greater psychological ease in acceptance? We cannot be sure about the answer; however, as Tannen (1992: 52) points out, 'Trying to solve or fix a trouble focuses on the message level of talk'. For many of the men in this study, problems are objectified – rather than experienced as part of a subjective self – and if their health cannot be 'fixed', their self-respect as successful (masculine) problem-solvers is endangered. Although 'fix' does not show as a keyword for men in a matched sample comparison of genders (where the significance level for a word to be counted as 'key' is $p < .001$) it often occurs in the vicinity of other words that *are* identified by the key concept 'difficult' as we saw in the extract from a man who saw medical problems as something 'to be fixed'; a particular expression that seems to encapsulate the linguistic strategy of reification or 'materialisation' is the expression 'quick fix' as in the following extract:

> Yes it's like a liquid, it tastes awful mind but, it tastes absolute awful but it certainly works but it's *a quick fix*. If I hurt my side, you know if I stretch or anything and it does hurt then I can just have *a quick fix* of Oramorph and that then gets you over the first bit of the pain. (LC18, male, 55, lung cancer)

The phrase indicates that whatever is referred to is not a permanent solution to the particular problem but is one that may be necessary in some circumstances (such as extreme pain) – even though it is ultimately unsatisfactory because of its temporary nature.

Interestingly, a number of men demonstrate that they are aware of the limitations of an approach that treats their bodies as something that are distant from the 'selves' waiting to be dealt with by an array of medical experts; for example:

> So that took about eight to ten weeks to go along to see the physiotherapist and I think I had about six, six treatments, but I was

> on that thinking really that they was going *to fix me* and I didn't realise I had to actually take part and [um] and do things as well. I suppose, I suppose in a way, most people as myself have been brought up that, when something goes wrong with your body, you go along to see your GP, they give you a pill, give you a t..., I dunno, do something to you and hey presto you're cured and you get back on with your life. (CP46, male, 49, chronic pain)

Here the speaker interprets the notion of 'fixing' as something that is performed by medical magicians on a passive audience without requiring active participation. In the following extract, the speaker contrasts a psychological attitude towards illness that is based on 'fixing' an illness condition, with an alternative – perhaps less traditionally masculine – attitude of acceptance towards the condition that is based on 'managing' rather than 'fixing' it.

> [um] Yeah. Yeah ... *manageable* ... that's an interesting word because sometimes *manageable* means I can do things and *manageable* sometimes means this is where I am at the moment, I'm not actually gonna to try and *fix* anything, just accept this is what's going on, and relax rather than struggling against it, or *try to fix things* or trying to be dynamic when its not there. (DP38, male, 45, depression)

There seem, then, to be *discourses* for men experiencing illness; one of these discourses adopts views of medicine as 'fixing' the bodily 'problem' – this is an impersonal discourse of distancing and avoidance. Another, that we have briefly introduced here, is a less traditionally masculine discourse that *rejects* the language of the 'quick-fix solution' and takes on greater personal acceptance for managing the condition. We will now seek to gain a clearer picture of the traditional masculine discourse of distancing and avoidance by considering the second linguistic strategy revealed by keyword analysis – deictic distancing.

3.3 Linguistic strategy: Deictic distancing

An important choice for communicating a perspective towards something or someone is through the use of the pronoun system. There is a distinction between 'personal' pronouns – such as 'I', 'he', or 'she' – that refer to a specific person and other types of pronoun – such as

'it' or 'you' – that are often impersonal ways of referring because they are vague as to whom they actually refer. There are very significant implications for discourse style arising from how pronouns are employed since some pronouns distance the speaker from the entity discussed and contribute to a more 'objective' or impersonal discursive style. The choice by the speaker of the first person pronoun 'I' conveys the world from the speaker's lived perspective, the choice of second person and impersonal pronouns, 'you' or 'it', represent the world from the perspective of another. For example, 'you' is often used to mean 'people in general' rather than the person who is addressed and 'it' is a way of representing something to avoid reference to human agency; 'it' is often used when the speaker wishes to speak 'objectively' or in such a way as to distance him or herself from a subject that experiences a particular illness. We will refer to this use of pronouns as deictic distancing.

Consider how a man uses second person pronouns in the following:

> *Interviewer*: And did *you say* the Macmillan's also have small grants that can also *help you?*
>
> *Respondent*: Yes they will, they will give *you* a one off grant *to help you* to catch up or to *help you in your quality of life*. For example one of the consequences of cancer can be enormous weight changes and *your* wardrobe is inappropriate so they will *help you* to restock *your* wardrobe. (LC10, male, 48, lung cancer)

Although the phrase 'help you' is in response to the use of the same phrase by the interviewer, there is still a choice between first and second person pronouns; this also occurs in the following:

> A pain clinic is where they'll give *you* medication, injections, all sorts of you know interventions I suppose. Whereas a pain management programme won't give *you* that, any medication. Their main primary purpose is to help *you* take more control of *your* pain. (CP46, male, 49, chronic pain)

Here the speaker employs the impersonal 'you' in speaking about advances in pain management and avoids direct reference to himself as the subject who is actually experiencing pain – this is deictic distancing. Compare

this with the following account in which a woman describes technical appliances that are available to assist her in performing daily tasks:

> *Interviewer*: [Um] In terms of around home, you mentioned having somebody help you with your ironing, [um] do you have any sort of equipment around the house *to help you*?
> *Respondent*: [cough] I've got a little bits [um] *my, my* biggest god send somebody bought *me* was an electric tin opener 'cos *I* couldn't open tins and that is amazing, and *I* know it, it's not a specific one for people with arthritis but [uh] it's really great and things to help *me* open jars. I recently purchased [um] something to help *me* get my tights on, stockings on which *I* couldn't get on before. Somebody actually had to put them on for *me* so [um] *I've* got that. *I* think that's all *I* have. *I* haven't got any special pots or pans or kettles or anything like that, *I* haven't found a need yet to actually get that and *I'm* going to get a button, something to help *me* do buttons up, that's another thing which is a very simple little thing *I* can get. (RA14JC, female, 43, rheumatoid arthritis)

In response to a question phrased in the same 'you' style as was presented to the man earlier the woman switches to use of first person pronouns (shown in italics). The association of women with first person pronouns contrasts with the findings of a study of same-sex conversations in the International Corpus of English; Schmid and Fauth (2003) that found that females used more third person pronouns. However, our findings are consistent with Galasiński's (2004: 50) finding that identifies the use of the generic 'you' by men as a distancing strategy by which men 'constructed emotions as experienced by unspecified emoters'.

Plural pronouns can also be imprecise forms of reference; for example, 'they' is a way of avoiding referring to anyone in particular – and also one way that we avoid specifying someone's gender – and 'we' is similarly imprecise because it is not always clear who 'we' refers to. Pronouns therefore reflect important speaker perspectives and how speakers want to represent the way that they experience the world, as close or distant, as personal or impersonal.

Table 3.3 shows the keywords identified at the $p < 0.001$ level in gender comparisons in all of the three samples thus far considered. We include subject, object and reflexive pronouns (e.g. I, me, myself) and contracted forms (e.g. I'm).

Table 3.3 Pronoun keywords – gender, SEC and age comparisons

	Men	**Women**
Full matched	Our Itself, its, it's	I, I'd, I'm, me, my She, she's, he, he'd, her, it, him
High SEC	Your It's	I, I'd, we'd, me She, she'll, he, her, him They, they'd
Low SEC	Its, itself	I, I'm, I'd, I'll, me, my He, he's, she, her, him They'd
Older	We	I, I'd, me, my Your, you, you've She, him, it They
Younger	You Her, it's, its, itself	I, I'd, me, my He

The table shows that women generally use more pronouns for each of the comparison groups (except for the younger age group). When men do use pronouns, their tendency, as compared with women, is to use impersonal pronouns. Women use first person singular pronouns (I, my, me) much more frequently as these are 'key' for women irrespective of class and age. This is because women are more likely than men to place themselves subjectively at the centre of the lived experience of illness. However, men use the first person plural pronoun 'we' and 'our' more than women (except in the high SEC comparison where women use 'we'd' more often), suggesting that some men often defer to the notion of a conjoined identity – rather than an individual one – when talking about illness.

The greater use of first person pronouns by women experiencing illness is highly evident in these accounts of illness experience; one way to explore this further is to consider the verbs that occur either before the pronoun 'me' or verbs that follow the pronoun 'I'. What is most noticeable is what we will call deictic centring – literally, pointing towards the self – *is much more common overall in the sample of women's language*. For example, the phrase 'say to me' occurs 5.94 times per 10,000 words in the matched female sample but only 2.95 times per 10,000 words in the matched male sample ($p < 0.0001$); the phrases

'said to me' and 'told me' occur 5.85 times per 10,000 words for women as compared with 3.46 times per 10,000 words for men ($p < 0.0001$). These findings indicate both that the women in these interviews report conversations with others much more frequently than do men (at a level that is statistically significant) and we may infer from this that they perceive themselves as being at the deictic centre of such discourse – which is the corollary of the deictic distancing by men.

There is an interesting comparison between the clauses 'to help you' and 'to help me'; men and women use the clause 'to help you' with similar frequency – they both use it approximately 3.5 times per 10,000 words; however, 'to help me' occurs 6.61 times per 10,000 words for women as compared with 3.38 times per 10,000 words for men ($p < 0.0001$); so there is quantitative evidence that women prefer the direction of reference to be towards the self. This is especially relevant in the case of the verb 'help' as it clearly implies a sense of need on the part of the person experiencing illness, so, in keeping with traditional gender ideologies, expressions of need are more frequent for women whereas men are more reluctant to represent themselves as being in need of help.

Analysis of the word 'helpless' provided further insight into the contrast between deictic distancing and deictic centring. Women tended to position themselves as the subject that is experiencing helplessness as a result of an illness condition while men tended to use the word to describe how they feel in relation to their partner's illness. Women therefore represent themselves from the perspective of people who are in need of help, while men following traditional masculinity represent themselves from the perspective of people who provide help for others. Consider the following concordance lines from the men's corpus:

1. But you do become totally *helpless* and you do rely on someone solely [um] for helping you.
2. It's almost, it's almost like you're *helpless* – you can't do anything so the only thing you can do is
3. and just, just feeling, feeling quite *helpless* as well, because although I'm there to support her,
4. And that's when I felt most *helpless* I think, because there was nothing I could do
5. wanted to get someone's attention, I would take that off just because you felt so *helpless*.
6. you glance over and you could see how *helpless* she felt and that was quite upsetting,

In only one of these does a man use a first person pronoun as the subject of 'helpless'. Compare them with those from the women's corpus:

1. so I think it's quite frustrating for a man to [um] try and help a partner and being totally *helpless*.
2. I think what's scary is feeling *helpless* and I think I'm always better when I feel I have a measure
3. Yes I think because your whole of your future and your life is in somebody else's hands, obviously the medical profession, and I just felt so *helpless*.
4. whereas if it's somebody else it's, you're very *helpless*, so that was a very tough time for me.
5. really tough I just found it, oh I just felt so *helpless* and I just really wanted to be able to help.

There is more focus on the self with the first person pronoun occurring in all except one of these lines. This indicates influence of the quite traditional sex roles – with men as providers of help and women as receivers of help from others. Women often invite others to share in their emotion, while men often ask others to imagine how they would feel if you were in their situation – rather than how they actually feel from their own point of view. Consider this account of a shared daughter/mother experience:

> It, I, it was very tough, really tough I just found it, oh I just felt *so helpless* and I just really wanted to be able to help [em] but [em] I think, I mean we're very lucky, we're very close and there's, there's, you know, we'd be happy to chat about anything and, we're, we were able to share our feelings and I mean I was immensely lucky to have her around during all of my treatment because she's a nurse and she's a specialist in gynaecological cancer so she really knew everything and I'd sort of be like, 'Mum what's this? What am I taking? What are these pills? What?'. [Laughs], you know, [laughs] even down to simple things as when I was having my surgery, when I'd have my surgery she was there, and she stayed with me and, you know, she could pass me the sick bowl and [laughs] hold my hand, you know? So [em] I think, you know, we have a strong relationship anyway, but then when she was ill it was sort of, you know, it made it even stronger because we were able to share, share things [laughs] yeah. (YPC22, female, 23, teenage cancer, dancer)

There is ubiquitous use of first person pronouns (a total of 23 instances of 'I', 'my', 'we' or 'our'), and construction of jointly shared experience – even the reiteration of the third person pronoun 'she' emphasises the ubiquitous presence of her mother and so avoids creating distance. Another interesting way that the experience is shared is by inviting the interviewer to share the evaluative perspective of the speaker by the repetition of the phrase 'you know' five times[2]. There is a similar uninhibited expression of emotion through repetition in the following:

> But its scary lying in machines, very scary and you can see all the technicians buzzing about, looking at their monitors and you don't know what they're seeing and it's uh, it's scary. I think what's scary is *feeling helpless* and I think I'm always better when I feel I have a measure of control over something. (CRC21, female, 54, teacher, colorectal cancer)

Even though the impersonal 'it' is used three times, the speaker repeats 'scary' three times and expresses feelings arising from of a sense of losing control. In both these extracts it is also very clear that the experience is happening to the actual speaker rather than a hypothetical abstract person; consider how a man expresses feelings of being 'helpless':

> At the time when I, when I had the pain [um] from the prolapsed disc, [um] it affects your life in as much as you can't do anything and it kind of dominates your life. Because it's such a large area to hurt, [um] and have problems with, it does [um] cause problems with everything else like walking or dressing or washing because you're just so sort of fairly immobile. So fortunately at the time I was, I'm, I'm married and so I was able to have someone around to help. But you do become *totally helpless* and you do rely on someone solely [um] for helping you. And you, again you, you ... or in my situation, you tend to rely on, on the painkillers to help you through the day. But if you take too many of them you then, the pain goes but the condition hasn't. And so that's when you need to be careful you don't do more damage because you haven't got the pain although the problem's still there. So yes it's hard and it, it's, I suppose, looking back on it now, it's just something that you have to get through. You can't do anything about it otherwise. There's no point in just sitting there doing nothing, or lying there doing nothing, it doesn't get you

[2] We will analyse the expression 'you know' in Chapter 4.

> anywhere. So you just have to try and continue as much as you can. (CP29, male, 43, chronic pain, nurse, professional)

In this passage the speaker uses a second person pronoun ('you' or 'your') a total of 21 times; the impersonal third person pronoun ('it') 11 times and the first person pronoun ('I') only 7 times. The emotion is deictically distanced from the speaker and it is no longer him who is in a dependent, 'feminine' role but a hypothetical other.

Analysis of pronoun collocations with 'helpless' has shown that some men position their perspective from the point of view of *another* rather than from the perspective of their own lived experience of being physically helpless. It seems that helplessness is a stereotypically feminine experience and that women are permitted to feel helpless, while men following traditional paradigms only feel helpless in relation to *their lack of ability to support others*. The strategy of deictic distancing may bring tensions between traditional masculine roles that require men to be pillars of support and an experience that places limitations on their emotional ability to provide such support. While in some instances the retention of traditional masculine notions of supporting weaker females is important in providing an emotional stability, there is also an indication of the difficulty that men have in dealing with their own feelings of helplessness because they challenge a traditional role for masculinity. For this reason illness is especially challenging for some men's sense of identity that may manifest itself in their being over-supportive, when in the role of carer, to over-reacting when themselves experiencing illness – and contributing to ideological stereotypes such as 'man flu'. Keyword analysis of pronouns provides us with evidence of deictic distancing – in which gender, regardless of SEC or age, is influential. Since pronouns are typically ways of referring directly – or avoiding direct reference – this provides us with interesting and potentially important insights into how a particular linguistic strategy has a wider ideological aspect that explains gendered aspects of talking about illness.

3.4 Linguistic strategy: Distancing through abstractions

3.4.1 Introduction

Another linguistic strategy for men to express conventional gender ideologies when they are discussing their experience of illness is to do so using language characterised by abstractions. This is indicated by a predominance of nouns in men's keywords; when we consider the 100 most significant keywords in the full matched sample we find that 57 per cent of men's keywords are nouns as compared with only

35 per cent of women's (see Table 3.4); many of these nouns that are used more frequently by men are abstract nouns (words that refer to things with which one cannot physically interact). Even when age and SEC are controlled for, men experiencing illness use over ten times more keywords that can be classified as abstract. Thus men adhering to traditional masculine styles use more nouns relating to time and measurement – such as numbers, dates and descriptions of stages or sequences of events in time or the methods and means for doing things (see Appendix 1).

In the passage below a man suffering from cancer demonstrates a traditional masculine style by interpreting an oncologist's communication skills when informing him of his imminent death as 'techniques':

> Yes we were told in a very, the way that the oncologist told me that I was about to die it was handled in such a sympathetic manner that I was actually sitting there watching the process, divorced on one level from the fact that he was talking about me and my imminent death, and I was sitting there thinking this guy is so good I must remember this *technique* so that if ever I have to fire somebody I can use this *technique* because it's so gentle. And it really was very good and I mean you know I was really impressed by it. We subsequently have become very good friends but at the time I thought that it was really very practised delivery, very sympathetic, very caring, much more caring than I'd received up until then from my GP. (LC02, male, 53, lung cancer)

This man expresses a desire to learn the language skills demonstrated by his doctor and what is referred to as his 'manner'. What could have been attributed to the oncologist's humanity is analysed at a distance, by someone who is 'watching' rather than living the process, who understands the communication in terms of techniques. In traditional masculinity men see themselves as being able to evaluate techniques, as in the following:

> And uh explained that they uh were very, very good in this field and they had sort of a professor there who had developed a certain *technique* which was [um] very, very successful. (CRC22, male, 73, colorectal cancer)

This is in contrast to disappointment with those who are unskilled in their 'techniques' – in this case of a bereavement midwife who is dismissed by a man as 'old-fashioned' in the following:

> I mean the, the hospital has a [um] a bereavement midwife – she's a, a specialist in bereavement, that's meant to be a specialist in – [um]

> and to be honest she annoyed the hell out of us. Because [sighs] she used what I consider to be very old-fashioned *techniques*, [um] in trying to help us deal with the situation, and trying to hug my wife and say, 'Come on there, there dear, let it all out'. And I was think, I was just thinking, 'I don't, I don't want you here, because you aren't doing anything to help the situation.' [um] Yeah ... that was interesting [laughs]. (EAP35, male, 38, ending a pregnancy)

We can relate this perhaps to gender ideologies and men's need to be 'experts' – even as here in the field of emotional support – because they see expertise as the mastery of a set of techniques that can be applied in any situation with the likelihood of success. They are perhaps integrating a workplace discourse in which particular jobs are treated as sets of skills, so this seems to be latching into the discourse of appraisal management, knowledge transfer and training. As we shall see in the next chapter, this is in contrast to more feminine modes that are based more on improvisation according to the requirements of the immediate situation.

The findings for some abstract key concepts that are significant for men in a Wmatrix comparison of genders in the full matched sample are summarised in Table 3.4.

Men following traditional masculine styles have a discursive orientation to measuring and counting entities and processes rather than talking directly about what is happening to their own bodies. To give some specific examples, men in a matched sample comparison use the word 'thousand' over ten times more frequently than women to

Table 3.4 Key concepts referring to abstractions in the full matched sample (men compared with women*)

Conceptual key	**Lexical items**
Numbers	One; two; three; four; six; five; ten; seven; twenty; eight; twelve; nine; thirty; hundred; fifteen; forty; eighteen; fourteen; fifty; fifth
Mental object: Means, method	Way/s; system/s; somehow; procedure/s; pattern/s; approach; technique/s; solution; method/s
Time: Period	Year/s; day/s; month/s; week/s; night; hour/s; morning; minutes; period; secs; wait; Monday; while; Friday
Location and direction	This; there; where; here; in; out; back; on; end; away; off; around; course; somewhere; position; left; anywhere; away from; top; outside

Note: *at $p < .0001$ level.

quantify entities such as money, people or dates. The finding for the key concept 'numbers' is in line with Rayson, Leech and Hodges (1997) who found that male speakers in the British National Corpus used numbers more than female speakers. Measurement of time is also salient for men, for example 'Monday' is used with a much higher frequency by men in expressions such as 'Monday to Friday' which is not used at all in the interviews with women but occurs 16 times in 6 different interviews with men. A salient feature of the language of men experiencing illness is that it is concerned with description of events occurring in a time sequence, the reporting of events and other strategies for creating a psychological 'distance' from the lived experience of their proximate bodies. Evidence for this is found in the findings for 'mental objects: means and methods' shown in Table 3.5.

There is quite a wide variation of frequency of use by each gender. 'Method/s', 'procedure/s', 'somehow' and 'approaches' are used with similar frequency whereas others – such as 'way/s', 'system/s', 'pattern', 'technique' and 'solution' – are used more by men, some considerably so. Although we see gender as offering a range of performance options, we find evidence here of the influence of normative uses that create the possibility of engendered performance; for example, a woman would be more likely to perform a masculine style successfully if she were to select lexis such as 'technique' and 'solution' since these are words that characterise the discourse of traditional masculinity.

Table 3.5 Key concept: 'Mental objects: means and methods' by gender in the full matched sample (men compared with women)

	Men		**Women**		
Types	**Tokens (> 5)**	**Tokens per 10,000 words**	**Tokens (> 5)**	**Tokens per 10,000 words**	**p <**
Way/s	1,668	16.97	1,589	14.52	.0001
System/s	194	1.98	98	0.89	.0001
Somehow	63	0.64	83	0.76	n.s.
Procedure/s	53	0.54	45	0.41	n.s.
Pattern/s	49	0.50	27	0.25	.01
Approach/es	53	0.54	68	0.62	n.s.
Technique/s	40	0.41	22	0.20	.01
Solution/s	25	0.25	7	0.06	.001
Method/s	24	0.24	19	0.17	n.s.
Total	2,169	22.06	1,958	17.88	.0001

3.4.2 'Solution/s'

In understanding the discursive styles of illness we should be equally concerned with *how* these words are used as well as with statistical evidence of their use – performance of gender is concerned with selecting from a range of options those that fit with the particular identity that is communicated in a specific context. Men use 'solution/s' around four times more frequently than women and it is the counterpart of 'problems' that we analysed earlier in this chapter – since solutions arise in response to the problem-solving mentality that is characteristic of a traditionally masculine discursive style. As with the analysis of 'system' the use of 'solution/s' reflects, perhaps surprisingly, a positive orientation to an illness scenario since it implies (usually) some sort of prospect of an improved health condition:

> All my life, I've been able to get out of situations by working. I've never been work shy. Every bit of problem I've ever had, all I've ever done is work harder and I've *solved* it. If you work hard [er] and longer, then, in the end, there's *a solution* because 90% of the problems are cash generated. So, if you've got the cash, you can *solve* the problems. (LD06, male, 53, living with dying, multiple system atrophy)

The positive orientation by men who seek 'solutions' is found with a collocation that is only used by men in the interviews: 'best solution':

> What we discovered is *the best solution* for people who hear about a close friend or relative who's, who's in a similar situation is for them to send a postcard, and the postcard says 'I'm really sorry to hear about this, if you want to call me, call me whenever you want, you know, I'd like to give you as much support as possible.' And this, I've now realised is actually *the best solution* because then um, the cancer patient can decide either to call or not to call and in his or her own time. (CRC14, male, 53, colorectal cancer)

The framing of issues as 'problems' frequently leads to expectations of there being 'solutions', but it is still part of a masculine orientation that is based on a view of the world as objective and reducible to 'problems' and possible 'solutions' that are to be evaluated.

3.4.3 'System/s'

The findings for the key concept 'mental object: means and method' also included 'system/s' as a word showing a large overall gender difference

in distribution. People experiencing illness typically use it with the medical sense of bodily processes as in the 'immune system'; 'system' often occurs in regular grammatical patterns such as after a possessive pronoun – as in 'my system'; 'your system' – or following 'the' to refer to the institutionalisation of medical care in the phrase 'the system'. A higher proportion of women's uses referred to some aspect of their body or health as for example in 'my system': this sense accounted for 62 per cent of the uses by women compared with 44 per cent of those by men. In relation to institutionalised medical care there is an interesting divergence between genders with men giving positive evaluations of the medical health 'system':

> Excellent, yes they were, they were excellent, all the way through. *I'm personally happy with the whole system* since day one, I cannot I can't fault them may be. They've got a horrendous job to do, I don't what these people, what makes these people want to be doctors, especially dealing with people like myself and sorry make you croak and that, I mean how do you tell people that? I think you've got to a certain type of person. But they are just generally very, very nice, kind, understanding, helpful, I cannot fault them. (LC22, male, 59, lung cancer)

In contrast, women's use of 'the system' to refer to institutionalised medical care has exclusively negative evaluations:

> Nobody had done any, any research into whether there was any back up at home. I just phoned a friend in desperation, and she got her ex. to come and tear bunk beds apart and dragged me a bed downstairs and she stayed the night. Ghastly. Ghastly. *Complete failure of the whole health system* there – doctors, nurses, social workers, everybody completely failed. (RA04JC, female, 53, rheumatoid arthritis)
>
> You know, and it is, it is quite difficult you know you rely on somebody else and they let you down. In this case *I was let down by the system*. (LD13, female, 50, living with dying, breast cancer)
>
> It's just how I feel. I was going to say I feel that *the system has completely let me down* I really do. (LD02, female, 62, living with dying, breast cancer)

This is a difference that requires some explanation because it seems that men are generally comfortable with 'systems' whereas for women the negative connotations of 'system' – originating perhaps in 1960s

ideologies – are retained. Women in these interviews take a generally critical attitude in relation to institutional providers, with a stronger sense of their rights in relation to health care:

> ... my professor of rheumatology I have complete faith and trust in I've known him since he was a registrar when I was first diagnosed and he's now the Prof. so. He's someone who I feel I can relate to, who actually I feel does listen to me. But he's hampered by what, by what *the constraints of the NHS system are.* (RA04JC, female, 53, rheumatoid arthritis)

In a discussion of a new appointment system based on phoning in on the morning for which an appointment is required:

> That's *the new system* which I think is not one for the patients, but for *the convenience of the administrative staff and the managers*. I'm not being very nice am I? (CP41, female, 73, chronic pain)

Here there is a negative evaluation of 'the system' that is based on the idea that institutions exist for the benefit of those working in them rather than for the general public. Thus men appear more comfortable with the health service when conceptualised as a 'system' than are women, who may perceive 'systems' to be impersonal and alienating. We speculate that there are two possible explanations for this, one is that men, because they are stereotypically comfortable with methods and abstract processes – and therefore 'systems' – are happy to be looked after by health 'systems' which they feel they have a great deal of power to influence so are not too critical of them, whereas women stereotypically are more oriented to people than to abstractions or mechanisms, so are more critical of health 'systems' because these make them feel powerless and alienated. An alternative explanation is that men are hesitant and more likely to accept what is offered – whereas women feel able to criticise the system because health is an area where they have social power and where 'the system' has to some extent adapted to their needs because of their protests about it. This would support a view of illness as a woman's domain – one in which they see themselves as having the authority to express strong negative evaluations and the power to influence procedures, whereas men see themselves more as powerless but grateful beneficiaries of 'the system'. We feel that further investigation of this keyword in other medical contexts might reveal which of these two possible explanations is preferable.

3.4.4 'Pattern/s' and 'technique/s'

A further keyword for traditional masculine discourse is 'patterns' – men speak approximately twice as frequently about their 'sleep patterns', 'thought patterns' and 'shift patterns' all referring to the need for some type of regularity or order in their behaviour. As we saw at the start of this section traditional masculine styles involve particular concern with 'technique/s', used more than twice as frequently by men as women in the interviews. This fits well with other lexical items occurring within this key concept such as 'ways', 'procedures', and 'methods'; and relate to finding a predictable solution to a particular health related problem. Things men describe as techniques are 'cognitive', 'relaxation', 'pain management', 'breathing' and 'distraction' and seem related to an improved state of mind or body. This is in contrast to women who refer to a narrower range of 'techniques' – over one-third refer to the 'Alexander technique'. As we saw earlier, men may adopt a critical stance towards 'techniques' differentiating between skilled and unskilled performers. There is perhaps a degree of fixedness in a way of thinking that encourages belief in a set of rules or procedures that can be applied with predictable outcomes. The concern that men demonstrate with abstractions such as 'systems', 'problems', 'solutions' and 'techniques' indicates a view of the illness situation as something to be controlled – rather than an experience which at times may require them to accept being out of control.

Having completed our analysis of specific linguistic strategies we continue by considering discourse styles that are identified more by semantic content rather than grammatical processes, by examining the topics of sport and swearing.

3.5 Discursive style: Avoidance through sports talk

The following speaker reveals the traditional masculine styles that are symbolised by sport in the culture, but also an ability to reflect critically on these:

> Oh yes. I mean I think that I was [um], a bit of a lard, you know a bit tubby and everything. And I thought well one area is sport so I really, really hit on sport in a whole range of areas [um], and was very aggressive. I played hockey to you know quite high standards but I don't know if I did it for the right reasons. It was done, it wasn't until I was much older that I began to enjoy sport for sport's sake rather than as a proving ground.

> And that would be virtually anything. It would be, in the days when you had discotheques, they're just clubs now but then it was discotheques which was quite new in my day. So it would depend on your girlfriend, sort of the trophy girlfriend approach, because I didn't drive I didn't have a car so that was another whole area that had to be covered up.
>
> No it did make me quite [um], I think I was an objectionable person. Very, very, very, I had, I wanted to be top, I wanted to be the captain of things, I wanted to win things which I don't think I was desperately that way. I mean we're all encouraged, if you go to grammar school you were encouraged to be you know [um], but I think probably I took it to an extreme. (EP34SP4, male, 32, ending a pregnancy)

The speaker comments on the way that his social background encouraged him to be competitive and how this carried over into his relationships. Being aggressive and winning became synonymous with a social life of clubs and 'trophy' girlfriends because in both cases winning and being successful justifies the means employed – being aggressive and dominant. Predictably, women fit into this discourse of traditional masculinity as spectators and as people to impress and to be used to impress others – as trophies. However, we should also note that the speaker is narrating in the past tense and implying that he no longer has the identity that was satisfied by such a traditional masculine style, perhaps because he feels a more feminine identity is necessary for a discussion of the early termination of a pregnancy with a medical researcher; however, this raises the possibility that talking about sport in the first place is a way of avoiding other topics – such as his feelings about illness.

Talking about sport in general, and football in particular, is part of a traditionally masculine discourse style. The participation of boys and men in sporting activities is heavily institutionalised through football clubs, boys clubs and all-boys sports colleges; sport became organised in the nineteenth century as a means by which government could address issues of national fitness levels that were seen to be necessary to deliver bodies that were adequate to the task of defending the nation; this was at a time when social-Darwinist notions of survival within a competitive environment dominated. Connell (1995: 54) notes:

> The institutional organization of sports embeds definite social relations: competition and hierarchy among men, exclusion or

> domination of women. These social relations of gender are both realized and symbolized in the bodily performances.

Throughout history men have been sent to fight in wars and sports have traditionally been a means by which their competitive 'killer' instincts could be retained during times of peace – this showed, for example, in one of the earliest sports in England, archery. A number of studies have demonstrated the social role of sport in preparing men for combat; for example, during the Gulf war, several analysts identified the intermingling of the lexicons of war and sport (e.g. Lakoff, 1991). These views are summarised by Jansen and Sabo (1994: 1) who argue that, during the period of the Gulf war, sports-war metaphors were 'crucial rhetorical resources for mobilizing the patriarchal values that construct, mediate, maintain, and, when necessary, reform or repair hegemonic forms of masculinity'. It is, perhaps, not surprising that during periods of military conflict, the language of press reports draws on familiar domains such as sport. As Connell (ibid.: 54) goes on to elaborate:

> Sport provides a continuous display of men's bodies in motion. Elaborate and carefully monitored rules bring these bodies into stylized contests with each other. In these contests a combination of superior force (provided by size, fitness, teamwork) and superior skill (provided by planning, practice and intuition) will enable one side to win.

Here we can see how attributes such as size, fitness, teamwork, planning, strategy and practice are all necessary for success in military combat – as they are to sport. However, as Johnson and Finlay (1997: 140) argue

> Whilst this football talk may initially appear to be about the exchange and supplementation of information (scores, league table, players and teams), it is actually much more. This is because this type of discourse also performs an important function where social relationships between men are concerned.

This will remind us of Kiesling's (2005) notion of 'homosociality' that we discussed at the start of this chapter. In this section we will suggest that, given the disrupting effect of illness experience, some men will find

traditional masculine topics, such as talking about sport, an effective discursive style for dealing with the experience. Sport is a primary means by which young men are socialised into being competitive and proving themselves to be truly masculine. It is therefore not surprising that sports talk is a source of comfort for some men experiencing illness, although in some cases it may also lead them to question such traditional values.

Men in a full matched sample comparison use 'winning' 12 times of which 7 refer to a sporting contest while women only use 'winning' 3 times and none of these are in the context of sport (2 are winning the lottery and 1 is winning a sweet). Evidently, notions of 'winning' and 'success' are closely related to the type of values into which many young men are socialised; however, the actual experience of 'winning' and the behaviour and social attitudes it encourages may not bring genuine satisfaction in relationships; consider the following:

> One of the things I was just thinking was that I think my life has been successful and I have just turned 50, so it's a good time to think about it. The last 50 years have been highly successful, but my perception for most of the way, or for a lot of the time, is that I have been unsuccessful. So, you know, there has been two things going on, there has been me going on from thing to thing, you know, making a success of virtually everything that I have done, you know, winning friends, influencing people and then, then sort of feeling that I was failing for a lot of that time. (DP23, male, 50, depression)

Here the speaker evaluates his own past performance in an almost contrary way to the social values based in traditional sex roles to which he has been exposed and that have encouraged an orientation to 'winning'. His sense of failure implies that the values based on a highly competitive approach to life are not conducive to his overall development because other areas of his life –such as relationships, affection and so on – cannot be conceptualised in terms of 'winning': trust is often gained through being emotionally expressive rather than 'won' or 'earned'. We see here, then, the issue of identity arising through the discourse of illness experience.

Table 3.6 shows the results for the most frequent items that are classified by Wmatrix under the conceptual key 'Sport'.

Table 3.6 Key concept: 'Sports' in the full matched sample (men compared with women)

	Men 983,085 words		Women 1,094,912 words		
Types	**Tokens (> 10)**	**Tokens per 10,000 words**	**Tokens (> 10)**	**Tokens per 10,000 words**	**p <**
Exercise/s	240	24.41	193	27.7	.001
Sport	35	3.87	6	0.55	.0001
Goal/s	35	3.56	46	4.20	n.s.
Exercising	30	3.05	8	0.73	.0001
Gym	29	2.95	48	4.39	n.s.
Bout	28	2.85	9	0.82	.001
Game	25	2.54	5	0.45	.0001
Golf	21	2.14	8	0.73	.01
Rugby	19	1.93	2	0.18	.0001
Cricket	16	1.62	2	0.18	.001
Swimming	40	1.53	65	5.94	n.s.
Tennis	15	1.53	20	1.83	n.s.
Riding	15	1.53	13	1.19	n.s.
Sports	12	1.22	16	1.46	n.s.
Skiing	12	1.22	6	0.55	n.s.
Games	10	1.02	9	0.82	n.s.
Total	557	56.66	456	41.65	.0001

The table shows that men use a word in this semantic field approximately 35 per cent more frequently than women. However, there is a considerable variation between the actual type of sport indicating the highly gendered nature of sports: for men the most frequently discussed sports are golf, rugby, cricket and skiing, while for women the most frequently mentioned sports are gym, swimming and tennis. This implies the influence of traditional sex roles and how men are culturally conditioned to engage in more physically aggressive sports. We see this in the type of metaphors that men use; for example, they use 'bout' over three times more frequently than women in expressions such as 'bout of pain', and 'bout of depression' suggesting that they conceptualise their struggle with illness as a physical combat. A particular expression that occurs nine times in the men's interviews but only once in the women's interviews is the phrase 'bout of chemotherapy' as in the following:

> I had another scan – CT scan – to check what was happening and it was discovered that the, the, all the beneficial effects of the, of

> the initial *bout of chemotherapy* seemed to be reversed and that the tumours had started to come back again in the, in the liver. So it was decided to put me on to, on to a second *bout of chemotherapy*, which was, which was with different drugs. (CRC14, male, 53, colorectal cancer)

It seems that the use of a word whose primary sense originates in boxing is a particularly engendered instance of language use; so that men with cancer conceptualise their illness as competitive in which they are struggling with an opponent.

Analysis of the social class matched sample shows an interesting variation by social class as regards the specific sports that are discussed; in overall terms high and low SEC men talk about sports with a similar frequency; however, high SEC men talk more about 'gym', 'golf', 'tennis' and 'rugby' while low SEC men talk more about 'exercises' and 'goals'. It is interesting to note that some of the sports that high SEC men talk about more are also those that women in general talk about more than men – for example, 'gym' and 'tennis'. In Chapter 5 we will show that high SEC men in several respects adopt a more traditionally 'feminine' discourse than low SEC men (see also Seale and Charteris-Black, 2008a). We should be wary of dismissing talk about sport as in some way deficient because it is unemotional; in fact, when men talk about sport, it is often both with involvement and as a way of establishing a traditional masculine identity that is subsequently important to them in their experience of illness. For example:

> Because like you arrive at senior school and nobody knows who you are, and like at junior school I was like he's crap at sport, he's good at work, he's crap at sport. I arrived at senior school and because it's like a clean slate, I suddenly realised, 'Shit, I actually am quite good at sport.' And before I know it I'm in the teams you know. (DP04, male, 31, depression)

Here we see how comments about the speaker's deficiencies in sports were important in influencing his self-esteem – initially negatively because he was perceived as 'crap' but then positively because of the satisfaction that he gains from the social approval of getting into the team. Being selected to be part of a sports team enables the performance of traditional masculine identities and this style can be empowering for some men. So sports talk is not necessarily emotionally distancing. It may, though, be a way of avoiding talking about more difficult topics such as illness.

The competitive dimension is not the only aspect of sport discussed by men; since sport enhances physical fitness, which in itself makes illness less likely, some men discuss the inherent benefits of sport as part of a self-help discourse in which men are keen to demonstrate their active participation in curative regimes of the body. This is particularly the case in the use of the expression 'stretching and exercising' which men use ten times in the interviews – which seems to be following specific physiotherapeutic discourse:

> As I said, I'll go over it again, for me to stay upright, my medication is *stretching and exercising* daily, pacing, goal setting, looking forward to the future, challenging me thoughts, you know. Funnily enough, the other morning actually, I caught myself, I get up at half five every morning to me stretches, I don't want a medal but this is part and parcel of me life, I accept it. I don't really mind the *stretching and exercising*, it's, it's just what you do like, you know. (CP46, male, 49, chronic pain)

In this section we have seen how certain ways of talking about sport are associated with a traditionally masculine discursive style; these are predominantly related to its competitive dimension.

3.6 Discursive style: Swearing

In our interview data we found that the use of swear words was part of a discursive style for traditional masculinity as it permitted feelings of frustration felt by some men with the limited potential of language to express the strength of their emotions. 'Bloody' occurred 53 times, and 'shit' occurred 27 times in the interviews with men (full matched sample). Other swear words were 'bugger' (8); 'blimey' (3); 'bollocks' (3) and 'bastard' (2). There were also particular expressions such as 'bloody hell' (10) and 'fucking awful' (5). In the interviews with women 'bloody' occurred only 10 times, 'shit' 3 times and 'bollocks' once.

In the social class matched sample 'bloody' was most commonly used by high SEC men who used it more than twice as frequently as low SEC men. Approximately 25 per cent of the instances of 'bloody' occurred in reported speech following verbs such as 'thought' or 'think' – suggesting that some men construct their gender identity through an imagined internal dialogue as in the following:

> I bought one of these mountain bikes and [er] I got on there, I thought, at first, you're thinking '*Bloody hell'* you know, it tires your

> legs out but then you get a sore bum. ... and I thought *'Bloody hell,* I need to do these like I like another pair of ear holes.' (CP46, male, 49, chronic pain)

Such uses suggest that when swearing, some men perform traditional masculinity through an imagined dialogue in which one of the voices (but not necessarily both) is hegemonic. De Klerk (1997) has argued that the use of expletives is influenced by normative practices of masculinity into which younger males are socialised by their peers and in the age matched sample we found 'bloody' was used more by younger than by older men (though not significantly so) and in the social class matched sample more by higher than low SEC men. Swearing performs a range of expressive functions for men experiencing illness; taking 'bloody' we find these included humour and irony:

> But the one side effect that is mentioned in all these things that I have to take is it enlarges men's breasts! *Bloody massive up here*! It couldn't do something great or make me more virile or something like that, no it has to give me breasts! (HF14, male, 56, heart failure)

They also include the expression of anger or frustration with mental anguish:

> And I remember I think I went there once or something and it was full of *these bloody kids* running around kicking footballs and I thought *sod this* I'm not, [laughs], I'm not staying up here. (YPC09, male, 24, teenage cancer)

– with physical pain:

> Went in to see him and I was *feeling pretty bloody* at this time I was you know it was really, I had lost all my hair, my nails were cracking again because of the chemotherapy, my skin was cracking ... (LC02, male, 53, lung cancer)

– and with emotional pain:

> And the, the diary that my wife wrote I remember reading something in there where she, where she'd shared a feeling, an emotion, she'd shared some information with someone she was chatting to via the internet, and my initial reaction was, *'Why the bloody hell* can you share that with that person you don't know, but you can't share it with me?' (EAP35, male, 38, ending a pregnancy)

'Fucking' was used in seven different interviews with men and occurred in collocation with 'feel' and in expressions such as 'fucking awful'. Interestingly, 'fucking' only occurred in the high SEC interviews and was used much more by younger than by older men. However, it only occurred as an expression of frustration in relation to the recollection of an extreme state of mental suffering – typically depression – as in the following:

> And she turned to this student teacher we had in and she said 'Oh he really fancies himself that one,' you know. *And that sort of thing fucking hurts you when you're young* and you're not ... So yeah, I go back to my metaphor that you lose a few layers of skin. (DP04, male, 31, depression)

It is interesting, then, that swearing – generally treated in the literature as belonging to a uniform category of taboo language enforcing stereotypical or 'hegemonic' masculinity – performed different functions for men. 'Fucking' expressed very intense emotional states brought on by difficulties with relationships (especially for younger men) and appeared to express feelings of frustration relating to a perceived inadequacy at dealing with social expectations of toughness (especially for high SEC men). The only use of 'fucking' that was attributed to a woman was as follows:

> She said to me 'what are you looking at'. So I said 'Oh just looking at people'. So she said 'You're looking at blokes', so I said 'no not really', so she said 'I've been watching you, you're looking at the blokes' and she said *'You're a fucking poof',* so I said 'well no, I don't think so' I said 'it's sort of aesthetic'. (DP23, male, 50, depression)

Here we find a woman's voice within a man's reporting of a dialogue, implying that hegemonic masculinity may be enforced by some men's beliefs about what women will think of them if they *don't* perform according to hegemonic stereotypes. Men's reconstructions of women's voices sometimes contain a discourse that lowers or attacks their own self-esteem:

> ... for a long time I couldn't face her during this illness because I thought well, I don't know what I thought, sorry I don't know what she thought, but I thought that she would think 'God', you know,

> '*look at this bloody wimp* playing around doing nothing'. (CP27, male, 54, chronic pain)

Here a man describes his beliefs about his partner's views concerning him as a man experiencing illness. This suggests that engendered beliefs about illness experience are at least partly socially constructed. Ochs (1992: 338) observes:

> ... utterances have several 'voices' – the speaker's or writer's voice, the voice of a someone referred to within the utterance, the voice of another for whom the message is conveyed etc. The voices of speaker/writer and others may be blended in the course of the message and become part of the social meanings indexed within the message.

In cases such as the ones above it is not clear whether the voice that swears is that of the male speaker or the voice of the female who is referred to; however, it is indeed the constructed blending of these voices that seems to index the social meaning of masculinity to the speaker.

The findings for swearing should lead us to be cautious in assuming that it always enforces a single 'hegemonic' masculinity. Swearing shows the effect of social stereotypes on men, and the way that traditional masculinity, though performed by men, is discursively constructed. Swearing is also often employed by younger, high SEC men to express concerns about their toughness. In this collection of interviews swearing has the dual role for men of directly indexing feelings of emotional frustration with their lack of a language for feelings *and* indexing socially constructed traditional masculine identification. Swearing is emotionally expressive and performs a range of interpersonal and communicative functions for men experiencing illness including – but not restricted to – the indexing of a stereotyped performance of masculine identification.

3.7 Summary

In this chapter we have identified a range of linguistic strategies and discursive styles through which men perform traditional masculinity as a response to illness. We have identified linguistic strategies for distancing such as reification, deictic distancing and the use of abstract and nominal forms. We have also identified traditionally masculine

discursive styles characterised by swearing and by sports talk. Together we have proposed these constitute a discourse of distancing and avoidance. We have suggested that the linguistic strategies of distancing and avoidance may satisfy the needs of some men for some of the time, but we have also hinted that they do not suit all men all of the time. This is because in order to demonstrate control over their illness, by keeping it at a distance, they have to sustain a stoical, and at times lonely, front. However, in the style of traditional masculinity, these more linguistically constrained strategies can be alleviated by the use of other discursive styles – such as sports talk and swearing – that permit greater expression of feeling even if they sometimes avoid talking about what is really on their minds. Methods for emotional disclosure that permit performance of a wider range of masculinities are explored in Chapter 5.

4
A Feminine Discourse of Illness: Transformation and Modality

4.1 Introduction

In this chapter we will investigate how key concept and keyword analysis of the interviews with women may provide insights into feminine linguistic strategies and discursive styles. We will suggest that feminine strategies are characterised by a careful control over the modal resources of language that contributes to a discourse of transformation. 'Modality' is a term used to describe a speaker's attitude towards the possibility, or necessity, of what they are saying; for example, if a doctor was talking to a parent about a sick child, and said 'She must be sick', 'must' conveys the idea that on a scale of possibility the child definitely is sick (given her symptoms) as compared with 'she may be sick' where this is less certain. If the doctor said 'She really ought to be in bed' this is a different kind of modal expression, indicating that it is highly necessary for the person caring for the child to take her to bed, as compared with 'she might need to have a lie down' which indicates a lower degree of necessity. Modality is therefore an important resource in language through which speakers communicate a perspective on the informational content of what they are saying as it indexes how far what they are saying is represented as being true or necessary.

In this chapter we explore feminine linguistic strategies and discursive styles taking into account variation by SEC and age. In linguistic terms we find that women use more mental verbs related to modality such as 'know', 'think' and 'need' than men and this leads us to identify two feminine styles – one which is characterised by low levels of commitment or certainty towards the topic discussed and occurs in the use of cognitive verbs such as 'I think well', 'you know' and 'I mean I suppose', while the other is marked by a high level of commitment and certainty

based on appeals to intuition as in 'I knew something was wrong', or shows in the use of affective verbs as in 'I need to'. A transformational discursive style involves switching from low to high modality according to the speaker's general purpose and we propose that part of a feminine style is to be able to make such discursive switches. This is partially in line with previous studies; for example, Harrington (2008: 92) notes that 'Socially sensitive topics, associated with females, are more likely to be dealt with through devices which enable reduced commitment', and this would suggest a preference for low modality rather than high modality.

We will begin by reflecting on some general considerations regarding research into gender and language from a methodological point of view taking into account the special nature of our corpus of language on which this research is based. Much of the research into language and gender has been based on studies of men and women in situations of spontaneous, face to face, spoken interaction – either in mixed or in same-sex groups. Such research has often been summarised in terms of a distinction between the dominance and difference approaches. A major assumption of the dominance approach was that the linguistic dominance of men over women arose from socialisation in mixed-gender settings. So, for example, women are more frequently interrupted by men in mixed-sex groups (Zimmerman and West, 1975) and have trouble in getting their chosen topics accepted in talk within marital relationships (De Francisco, 1998).

The difference approach (e.g. Tannen, 1992) challenged the assumption that patterns of language behaviour were learnt in mixed-gender settings by arguing that a primary cause of gender differences in language use was through the socialisation of men and women in groups of their own sex. This approach argued that men and women engaged in essentially different subcultures and so developed different communicative styles as a result of such socialisation – rather as primitive tribes, though living in the same geographical area, might develop their own languages. Studies of same-sex groups show women as engaging in collaborative talk by providing ongoing positive feedback to the current speaker and including others who may not be speaking; for example, by asking questions to draw others into the conversation rather than to gather information. Such strategies contrast with the competitive ones of men – characterised by interruption as male speakers compete to hold the conversational floor and engage in display like behaviour through demonstration of technical knowledge and expertise.

The findings of such research (see, e.g. Coates, 2004) are typically based on recordings of men and women in spontaneous spoken interaction – usually conversation – in mixed or single-sex groups to produce naturally occurring dialogues: rather different data from that which we are examining in this book. Semi-structured interviews are necessarily interactive but not fully spontaneous because interviewers use a set of prompts to elicit information; as a result many of the interviews read as extended monologues since the role of the interviewer is primarily to elicit as much talk as possible concerning the experience of illness. The interviews with men are by nature mixed-gender interactions since the interviewers were all women (except for the depression interviews); however, the interviews with women are single-sex interactions for the same reason. However, because of the format of a health research interview, we would not expect the gender of the interviewer to lead to many of the discourse features that characterise informal conversations such as interruptions, overlaps, turn taking strategies, or other means of competing for the floor. Interviewees already have the floor and the role of the interviewer is to produce as many opportunities as possible for offering the floor to talk about experiences that in other interactive settings the interviewees might have wished to avoid. Nevertheless, we cannot avoid the possibility that some of the characteristics we identify arise from the gender dynamics of the interview. Given the lack of male interviewers, it may be that the modality choices of women that we identify in this chapter are influenced by the presence of an interviewer who is a woman.

We see gender as a resource comprised of a range of linguistic strategies and discursive styles through which identity can be performed. However, given the necessary limitations of any individual piece of research, we can only indicate where findings from keyword or key concept analysis confirm or contrast with those of other researchers who have investigated gender using other methods in other settings. A major variable of this study is that of the discourse topic – given the threat that illness poses to the individual there is every reason to expect that it may produce a type of language that is distinct from that produced in talking about more 'everyday' matters, such as football or the weather. It is likely that women talk more about illness because of the experience of child-bearing and child rearing – typically looking after children when they are sick and the greater proportion of women who work as carers, of one form or other. We might therefore anticipate fewer differences between women's everyday language and their use of language to describe illness experience than we would between men's

everyday language and their illness accounts. The primary method for this study is key concept analysis as a prelude to qualitative analysis; we do not claim therefore to have analysed these using interactional or conversation analytical methods and it would be interesting to know how far such methods might complement or conflict with the findings presented here.

4.2 Feminine discourse of illness

4.2.1 Overview

In this section we outline what we mean by the transformational discursive style and argue that many women treat illness as an opportunity for self-transformation and change through self-reflection and interaction. In this respect our findings concur with those of Seale (2002) who found a similarly transformative style in newspaper reporting of the experiences of women with cancer. Their active response to illness is indicated linguistically by verbs – so that they perceive themselves as agents who have control over a range of options rather than as inert entities to which bad experiences happen. This connects, for example, with our earlier analysis of women's constructively critical stance towards the health-care 'system'. Many women are therefore proactive physically and psychologically in their response to illness. We suggest that this mental predisposition conceives illness as *an opportunity for action* – rather than dwelling on its causes – and discursively represents illness as a source of learning and self-reflection. We will interpret this strategy as inherently purposeful and relate it to women's socialisation as primary carers.

We will begin by providing an overview of the findings for a comparative analysis of key concepts using Wmatrix in the full matched sample which are shown in Appendix 2. There were a total of 12 key concepts for the women's interviews (significant at the $p < 0.0001$ level) of which 9 were also key concepts when this corpus was compared with the conversation component of the British National Corpus[1]. This compares with 37 key concepts when comparing the men's interview

[1] The 'demographic' part of the spoken section of the British National Corpus comprises 124 speakers (equal numbers of men and women, approximately equal numbers from each age group, and equal numbers from each of four social groups). Informants used a personal stereo to record all their conversations unobtrusively over two or three days. The BNC can be accessed at http://corpus.byu.edu/bnc/

corpus with the conversation corpus of the BNC ($p < 0.0001$). This quantitative difference indicates that – when talking about illness – men's language differs more from everyday conversational norms than does women's language confirming the view that illness is more part of women's experience.

Some of the key concepts for women concern social support for experiencing illness – these include the key concepts 'Pronouns', 'Kin' and 'Speech Communicative'. We claimed in Chapter 3 that an explanation of the greater use of pronouns by women was the fact that some men avoid use of first person pronouns by deictic distancing while women engage in deictic centring. 'Kin' and 'Speech Communicative' will be explored in Chapter 6 where we examine sources of support. Here we will explore three key concepts: 'Thought and Belief'; 'Knowledgeable' and 'Needing'; we interpret some verbs in expressions such as 'you know' and 'I thought well' – as conveying a low level of modality while others such as 'I need to do' and 'I knew that' convey a high level of modality. Modality may explain the high number of verbs identified for these key concepts; for example, 'Thought and Belief' includes 'think', 'feel', 'suppose'; 'believe'; 'find'; 'imagine'; and 'consider'. 'Knowledgeable' includes 'know'; 'remember'; 'look back'; 'heard of'; 'recognise'; and 'recall'. 'Needing' includes 'have to'; 'need'; 'should'; 'must'; and 'have got to'. We hope that the following analysis of verb choice and modality, though at times technical, will produce some novel findings on feminine linguistic strategies and discursive styles.

4.2.2 Verb analysis

In the interviews with women there were a higher proportion of verbs as compared with those with men. This finding supports Rayson, Leech and Hodges (1997) who, in a study of the spoken section of the BNC, also found females used more verbs than male speakers. Similarly, Schmid and Fauth (2003) found that male speakers used more nouns in conversations found in the International Corpus of English.

Twenty-one of the keywords used by women were verbs (25 per cent of all their keywords) as compared with only 6 verb keywords for men (6 per cent of all their keywords). In contrast, Table 4.1 shows that men used a higher proportion of nouns when compared with women. We have seen in Chapter 3 how a traditionally masculine discourse is characterised by reifications and abstractions. When further comparisons were made by interviews organised by socio-economic category and by age, the same findings were maintained: in all comparison groups women used more verbs while men used more nouns (see Tables 4.3

Table 4.1 Comparison of part of speech of keywords* in the full matched sample (men compared with women)

Men			Women	
Percentage	Number of keywords	Part of speech	Number of keywords	Percentage
57	56	Noun	31	35
6	6	Verb	21	25
17	16	Adjective	13	15
4	4	Pronoun	11	13
6	6	Preposition	0	–
6	6	Adverb	4	6
2	2	Conjunction	5	6
2	2	Article	0	0
100	98	**Total**	85	100

Note: *at $p < 0.0001$ level.

and 4.4). This indicates that the tendency to greater use of verbs by women is consistent across different ages and social classes, although as we shall see when the type of verbs used are examined, some differences by age and SEC are evident. We relate this use to a feminine discursive style that we describe as transformational.

As a linguistic approach to investigate these verbs we categorised them into types using a model proposed by Halliday (1985) which distinguishes between six process types of which we will select three: mental processes – verbs that relate to perception, affect or cognition; material processes involving physical actions or events and verbal processes that relate to actions intended to communicate. Further sub-classifications may be made, for example, mental state verbs can be divided into those referring to a cognitive activity such as thinking and those referring to an affective activity such as feeling.

Table 4.2 shows the keywords for all verbs in the full matched sample that occurred at least ten times.

The total number of keywords for each process type is shown in brackets; men used more keyword verbs in the category of material process, while women used more keyword verbs in the categories of mental and verbal processes. This seems to confirm gender preoccupations of traditional masculinity with physical actions and events – playing sports, running, moving – while femininity is more preoccupied with issues of mental reflection. A feminine discursive style is characterised by a higher degree of concern with communicating

Table 4.2 Verbal keywords* by process type in the full matched sample (men compared with women)

Process type	Men's keywords	Women's keywords
Mental: Cognition	Regarded, guess, advise, assuming (4)	Know, think, thought, mean, knew, imagining, believed (7)
Mental: Affect	Looking after (1)	Wanted, feel, felt, need, needed, cry (6)
Material	Playing, forming, run, overcome, moving, shaving, getting, escape, gives, knock (10)	Go, managed, come, done, do, hoovering, gave (7)
Verbal	Discussing, speaking (2)	Wrote, write, writing, talk, phone, phoned (6)
Total	17	26

Note: *at $p < .001$ level.

Table 4.3 Gender and socio-economic category (SEC) comparison of keywords* by verbal process type

	High SEC people	
Process type	**Men**	**Women**
Mental: Cognitive	Recall, admit (2)	Think, know, thought, seemed, mean (5)
Affect		needed (1)
Material	Eating (1)	Vomiting, wait, tried, come, manage (5)
Verbal	Discuss (1)	Said, rang, talked (3)
Total	4	14
	Low SEC people	
Mental: Cognitive	Consider (1)	Know, knew, thought, admit (4)
Affect	Enjoy (1)	Need, want, wanted (3)
Material	Diving, treat, flow, filled (4)	Sit, sat, sent, come, came (5)
Verbal	–	Said, told, phone, explain, explained, read, asked, spoke, went, gone (10)
Total	6	22

Note: *at $p < 0.001$ level.

attitude and perspective while a masculine one is concerned with the propositions themselves. This explains why in a feminine style we find more keywords used by women that relate to mental processes – both affective such as 'wanted', 'need' and 'feel' and cognitive such as 'know', 'think', 'imagining' and 'believed'.

These findings, we have to remember, are for groups of interviews with all men and all women – albeit with class, age and type of illness experience controlled for; however, when we draw on specific comparisons for men and women separately for class and age categories some interesting divergences emerge (see Tables 4.3 and 4.4). For example, Table 4.3 shows that high SEC women use more material action verbs than high SEC men.

Table 4.4 shows that younger men use more words relating to mental states for communicating affect than younger women. The only gender difference that holds consistently across class and age is that in all comparison groups women use more words relating to verbal processes involving communication. This is especially the case when low SEC women are compared with low SEC men (Table 4.3) and when age comparisons are made. The male groups in these comparisons did not

Table 4.4 Gender and age comparison of keywords* by verbal process type

	Older people	
Process type	**Men**	**Women**
Mental: Cognitive Affect	Learned (1)	Know, thought, think (3) Like (1)
Material	Walking (1)	Got, goes, ironing, take (4)
Verbal	–	Said, hear, ask (3)
Total	2	11
	Younger people	
Mental: Cognitive Affect	Keeping, seek (2) Looking after, wanting, suffering (3)	Think, learnt, learned (3) Needed (1)
Material	Try, trying, carrying, moving (4)	Sit, buy, eat, went, became (5)
Verbal	–	Said, ring (2)
Total	9	11

Note: *at $p < 0.001$ level.

have any verbs referring to communication as keywords, except in the case of high SEC men whose use of 'discuss' was greater than that of high SEC women. In Chapter 5 we describe the linguistic flexibility of high SEC men in some detail, and argue (as in Seale and Charteris-Black (2008a)) that high SEC men appear able, at times, to adopt aspects of traditionally 'feminine' discursive styles when the occasion seems to demand this.

Some verbs are especially worth investigating to establish the attitude towards the level of certainty about the necessity or possibility of events happening; these are women's keywords that occur across comparison groups such as 'think/thought' – a women's keyword for all comparison groups – and 'know'– a women's keyword for all comparison groups except younger women; these are verbs that we will associate with a *low* level of commitment towards a point of view that therefore comes over as hesitant, or uncertain. Another group worth investigating are mental process verbs for intuition such as 'I knew something was wrong' and obligation such as 'need/needed' (a keyword for women in all groups except older women) that is, we will suggest, a linguistic strategy for communicating a *high* level of certainty towards the necessity or possibility of events. We propose that a characteristic of a feminine discourse style is access both to low and to high modality and that this enhances their communicative repertoire in a way that we describe as 'transformational'. This is because it implies the ability to draw on the resources of language (and in particular modality) to express a full range of experiences associated with illness. We structure our findings broadly with reference to two discursive styles: low modality and high modality.

4.3 Feminine discursive style: Low modality

4.3.1 Analysis of mental process verb (cognitive): 'Think/Thought'

Consider how the attitude of this woman towards her pain is marked linguistically:

> I just, sometimes I just grit my teeth and get on with it to be honest with you. [um] *I think well* I'm in pain but it could be a lot worse. 'It could be life-threatening pain that's actually killing me. This condition won't kill me, I know that.' [um] It's not life threatening. I'm not going to die from it. So I tend to try and count my blessings. (CP12, female, 47, chronic pain)

The expression 'I think well' indicates self-reflection as a prelude to elaborating on a point. The function of 'well' is softening and in most cases it could be omitted without influencing the ideational content of the utterance. However, if the cognitive process implied by 'think' were not qualified by 'well' it would enhance the certainty with which the thought is expressed; it is followed by conditional forms such as 'could' and the mitigating verb 'tend to'. 'Well' therefore implies a more measured and tentative point of view as compared with 'I think that ...' when not accompanied by 'well' and so reduces the level of modality. We might expect a verb such as 'think' to be very frequent in a genre that invited people to reflect on their illness experience – there are 9871 instances of this verb in its various forms (thought etc.) in the women's interviews (93 per 10,000 words) and 7150 in the men's interviews (75 per 10,000 words); the difference is highly significant ($p < 0.0001$). Given the number of instances it is necessary to select a smaller number of patterns for purposes of qualitative analysis. A common pattern for 'think' that is much more frequent in the women's interviews is 'I think well'. 'Well' alone also occurs more commonly in the women's interviews (43 times per 10,000 words) as compared with 40 times per 10,000 words in interviews with men (significant at $p < 0.001$).

As in the example above, women's use of the phrase 'I think well' usually marks a positive, or transforming type of thought about their illness condition as in the following:

> I can think a year ahead, I can plan a year ahead because I'm feeling well and *I think well* if something comes up now, I don't think it can be that quick so, I feel I've got a time that I can think about, but not beyond that. (LD15, female, 68, living with dying, breast cancer)
>
> If I want to do it, I do it. You know, *I think well* I might as well get it done and do, I might as well go to the holiday. I might as well do this because I don't know if what's going to happen now. (HA03, female, 53, heart attack)

'I think well' in the women's interviews indicates a desire to get better by modifying one's outlook on illness; in the first extract it is followed by a conditional expression ('if ...') and in the second by several uses of the modal auxiliary verb 'might'; both these patterns reduce the level of certainty in relation to identifying a purpose in life.

A similar pattern occurs in past tense forms; for example women use 'I thought well' to report an introspective narrative in which they

reflect on a range of possible responses at a particular stage in an illness experience – typically on a treatment option that has been offered; for example:

> And the risks didn't seem extremely high it just, he said that quite a lot of people have had surgery and you know they haven't come you know out with any sort of bad side effects or nothing. And so that's what made me in the end decide to go ahead. And *I thought well* if it's going to improve my life a bit then it's worth doing. (EP18SP, female, 35, epilepsy)

The expression precedes a positive appraisal of a treatment option accompanied by a conditional clause ('if' ... 'then') to convey reflection and evaluation prior to arriving at a decision – this reflects a purposeful, though qualified, attitude towards a treatment option. This positive appraisal of a situation contrasts quite dramatically with the uses of 'I think well' and 'I thought well' by men who use these patterns with a rather higher level of modality to communicate more certainty and a fatalistic appraisal of an illness situation:

> Well not only challenge them *I think well* the biggest problem I think with bowel cancer is people, well they don't want to talk about it do they? This is the main trouble, they feel embarrassed and you know they don't want anybody poking about with their rear etc etc. (CRC07, male, 63, colorectal cancer)
>
> So I wasn't particularly worried about it, [um] it was just something that had to be done at the time. And *I thought well* if this is going to go on year after year then I suppose I'll just have to get used to it. (CP29, male, 43, chronic pain)
>
> [Er] I didn't actually ask many questions. I try and read between the lines, I think it was pretty serious in the year of 1998 because they said 'Don't bother to work anymore,' and *I thought well that tells me everything really.* (BC24, male, 61, breast cancer)

Linguistically the expression is followed by a superlative form ('the biggest') a marker of a high level of obligation ('have to') and a simple present form ('that tells'), all of which indicate an attitude marked by a higher level of certainty rather than by self-reflection; the thought that follows the phrase does not indicate the transformational outlook that characterises its use by women.

4.3.2 Analysis of mental process verb (cognitive): 'Mean'

In his study of the language used by people in different social class, age and gender groupings, Macaulay (2005) identifies a range of different functions for 'I mean' as a discourse feature – that is when the phrase is not in construction with another constituent; for example, in the question 'you know what I mean?' the phrase 'you know' is part of the whole construction so it is *not* treated as a discourse marker. He identifies five functions of its use as a discourse marker: elaboration, explanation, adversative, new information and repair. We identified these functions in our data and also established whether there were gender differences in them. We found instances of all these uses in the interviews but we prefer to describe his category 'adversative' as 'contrastive' because we find this function intends to offer a balanced point of view rather than an adversarial attitude; it was the only type of use for which we found evidence of gender differences.

We interpret the greater use of the contrastive function of 'I mean' by women as a transformational strategy because it allows distinctions to be made, between, for example, evaluations of the efforts of health staff and how well particular treatments worked. Consider the following:

> Oh yes, yes [um] ... (2.0) he'd done it obviously so often before but giving somebody bad news of that kind he was, it was very good, he was he was very sensitive the way he said it you know. But *I mean* no matter how it's said to you it's shattering. (LC31, female, 61, lung cancer)

Here the female speaker contrasts her positive evaluation of the style of delivery of information concerning a medical diagnosis with the negative emotional impact that it had on the couple. We do not see this as adversarial but as a contrastive strategy that distinguishes between the style of language use and the effect of its information. We suggest that creating such distinctions is a discursive style associated more with femininity.

The most frequent collocation for both men and women for the women's keyword 'mean' is 'I mean' which occurred 22.7 times per 10,000 words in the women's interviews and 19.5 times per 10,000 words in the men's interviews. This difference was highly significant ($p < 0.0001$) and therefore we decided to examine it in more detail. The method adopted was to sample 100 uses for each gender distributed across the first 1000 uses in each of the interview sub-corpora

Table 4.5 Uses of 'I mean' in the full matched sample (men compared with women)

	Men	Women	Total	Percentage of all uses
Elaboration	44	34	78	39
Explanation	31	24	55	28
New information	15	16	31	15
Contrastive	5	19	24	12
Repair	5	7	12	6
Total	100	100	200	100

(examining concordance lines 1–10; 101–110; 201–210 etc.) to ensure that we controlled for individual variation since these uses would be distributed across speakers for each gender. Our findings are summarised in Table 4.5.

Our findings contrast with those of Macaulay's which were based on everyday conversations in that he found 'new information' was the most frequent whereas in these interviews 'elaborations' and 'explanations' are both more common; this can be accounted for by the purpose of the interviews which was to elaborate on the experience of illness and explain the speaker's perspectives on a range of topics relating to this experience. There was little difference between genders in the two most frequent discourse functions of 'I mean', but we did notice a difference in a use in which the speaker contrasts a point with something that they have previously mentioned. As we have indicated the greater contrastive use of 'I mean' is a way of making more precise exactly what is being evaluated: people or medical outcomes. We will briefly illustrate the discourse functions of elaboration and explanation that were used in similar ways by men and by women and then focus on the contrastive function of 'I mean'.

4.3.2.1 Elaboration

'I mean' introduces an elaboration of a point that has previously been made; in the following a positive evaluation of hospital staff is elaborated by a man:

> This was all done as an out-patient and the hospital staff were absolutely, *I mean* they were phenomenal, wonderful people to deal with. (LC02, male, 53, lung cancer)

A woman also elaborates a point using 'I mean' to describe her embarrassment:

> ... but with the bowel movement it's so embarrassing that people feel we all, sort of, don't want to talk about it easily. *I mean* even I'm careful who I discuss this with because I think some people may find it quite you know [er] unacceptable or embarrassing. (CRC12, female, 56, colorectal cancer)

A characteristic of elaborations in our data is that – as in the extract above – the person experiencing illness evaluates an experience that is related to the treatment of an illness condition. Quite often the evaluation is direct and intensified through the use of an adjective or adverb describing their experience as in the following:

> [um] Perhaps I haven't described what a bad day is, *I mean* a bad day is being paralysed on the floor screaming in agony, that's a *bad* day. (CP27, male, 54, chronic pain)

'Mean' here adds emphasis to give a stronger emotional commitment to the evaluation implied by 'bad'. In other cases the evaluation is more indirect and needs to be inferred:

> Men are, men self medicate as well *I mean* you know a lot of blokes you just think, 'Oh bollocks, I'll go and get pissed or something,' you know. (DP04, male, 31 depression)

Here we infer that the speaker is evaluating men's tendency to self-diagnose and pay insufficient attention to his health condition by an avoidance strategy such as getting drunk. Evaluation was the most common function for the expression 'I mean' for both men and women and is a discourse function that is used in a very similar way by men and by women.

4.3.2.2 Explanation

'Explanations' were the second most common function of 'I mean' for both men and women; 'I mean' is used to introduce an explanation of an aspect of their illness or its treatment as in the following:

> [um] Particularly because you can't then explain to that individual that if you were able to run around like they do then you wouldn't

> be this size. And, *I mean* my size is a, a symptom if you like, of my condition. (CP31, female, 41, chronic pain)

Here the speaker employs 'I mean' to introduce her interpretation of her size as a symptom. The main difference between elaborations and explanations is that elaborations evaluate an aspect of experience whereas explanations provide a response based on reasoning to some aspect of illness experience. Sometimes these two main purposes of 'I mean' occur in close conjunction with each other:

> You really just get used to it. It's not, it doesn't become, *I mean* if it is controlled it's not really life threatening or anything. It's not the end of the world. *I mean* there's worse things out there. (EP32SP4, male, 26, epilepsy)

In the first of these the speaker *explains* that the illness, when treated, is not life threatening but in the second he *evaluates* this condition in comparison with others. As with the evaluative function there is little difference between men and women in how they used 'I mean' for explanation.

4.3.2.3 Contrastive function

The contrastive use of 'I mean' occurred nearly four times more frequently in the interviews with women (significant at the level of $p < 0.01$); we shall therefore consider a few examples of its use by women. In the following extract a woman is describing the effects of an injection she has been given in the throat by contrasting overall acceptance of the experience, but nevertheless indicating that it was discomforting:

> *I mean* alright it didn't last long sort of twenty four hours later I was alright but *I mean* the bruise was still there [laughs] as if I'd been punched in the throat. (LC31, female, 61, lung cancer)

She is not complaining about her treatment but contrasting two aspects of the experience: its duration (short) and the amount of physical suffering (high). In the following extract a woman is talking about the difficulty she has in finding an appropriate diet for her health condition:

> The same thing tomorrow can cause problems and that I feel I still haven't found the answer or found anyone to help. *I mean everyone*

> has been very kind in trying to help me but again each body is different (CRC12, female, 56, colorectal cancer)

There is a contrast here between positive evaluation of the efforts of health staff to assist her in identifying an appropriate diet and the ineffectiveness of their advice (because of individual variation). This contrastive use of 'I mean' by women seems a successful discursive strategy for people experiencing illness because it permits a distinction between, for example, a positive evaluation of the efforts of health staff with a negative evaluation of the efficacy of the treatment. From a transformational point of view this is preferable to moving to a single evaluation of the treatment that does not examine it from different points of view. This is because it indicates that the patient still has confidence in the health staff's good intentions, and so there may be a continuing sense of purpose to find a treatment that does work; by contrast, a negative evaluation that does not distinguish between the intentions of staff and their results may be a less effective strategy because it discourages purposeful effort. The contrastive use of 'I mean' can therefore be interpreted as contributing to a transformational discursive style.

The contrastive function of 'I mean' to imply giving a balanced point of view is a feminine discursive style that is also characterised by low modality – that is, by a desire to mitigate the certainty with which a point of view is expressed. Low modality may be a highly appropriate style for accounts of illness experience because of the low degree of certainty that exists in relation to illness, its prognosis, how individuals will respond to different types of treatment and so on. The style is characterised by a desire not to challenge opinions but to express a qualified point of view. In many interactional contexts such mitigation would be seen as 'powerless' language associated in the literature with women; however, as Cameron (2005) has argued, in many contemporary interactional settings language that was traditionally powerless becomes powerful. It would seem that illness is one such setting because a low level of modality and high self-reflexivity would seem to be appropriate for people who are experiencing illness. Sounding uncertain in relation to illness is a subversive strategy for asserting one's control over it: to sound authoritative is, under this interpretation, likely to be less effective in the discourse of illness experience precisely because there are so many unknowns.

Taking this further, it is of interest to note that the expression 'I mean I suppose', which is a discourse pattern that conveys self-reflexive modality, occurs 18 times in the interviews with women but only

3 times in those with men. Although the pattern 'I mean I suppose' can be used for all purposes, the most common function is to provide an explanation as in the following:

> Yes. [um] We, it was quite quick actually, the whole scan procedure, because *I mean I suppose* that's just the measuring scan, so they don't really, and at that stage especially with the sort of less powerful scans. (EAP02, female, 39, ending a pregnancy)

However, the expression can also be used contrastively:

> She doesn't seem to think that diets are all that necessary but I don't know. *I mean I suppose*, my son thinks if I lose a stone or so it would be less of a heart strain, yes. (HF31, male, 76, heart attack)

Here there is a contrast between whether dieting is necessary or not. Sometimes the two verbs are repeated separately and in collocation:

> Well that's the liver secondaries but *I mean I suppose* it comes from the bowel. Well *I suppose* just 'How do you get it? Why do you get it? And how can it be stopped in the future?' And *I mean* I have been concerned about my two children because at first they said they should have check-ups but now they're changing their mind and saying it's not really necessary. (CRC25, female, 66, colorectal cancer)

Here the primary purpose seems to be explanation and in particular to emphasise reflection – as indicated by the three adjacent questions; however, there is also a degree of emotional emphasis. We suggest that the difference in frequency of this pattern between men and women is indicative of the higher reflexivity and lower modality that characterises a feminine discursive style for expressing illness experience. This is fully demonstrated in the following:

> But *I mean, I suppose* in an ideal world in the NHS you know, even if it's free you *should*, if you don't get on with that person and it's not right for you, you *should* be able to transfer to somebody else. Because *I think it's such a personal thing* that you *really just need to have*, that person *might* be really good for someone else, but they *might just* not be right for you. (DP02, female, 27, depression)

The italicised verbs, modal forms and adverbs all contribute to mitigate the level of certainty with which the proposition that a person should be able to transfer from one medical professional to another is expressed; they emphasise that the idea has been arrived at after some deliberation and accepts a high level of uncertainty.

4.3.3 Analysis of mental process verb (cognitive): 'Imagine'

'Imagine' occurs 1.16 times per 10,000 words in the women's interviews but only 0.95 times per 10,000 words in the men's interviews. This difference was significant only at the $p < 0.05$ level. The form 'imagining' was a keyword for women as it occurred 18 times in the interviews with women (in 5 different interviews) but did not occur at all in the interviews with men; for this reason we focus the analysis on this form of the verb. We would first like to illustrate how the following account of a method for relaxation illustrates how women talk about 'imagining':

> Yeah [er] there's a process of relaxation first, you relax you whole mind and body and go to a place that's like a neutral, what I would call a neutral, a stimulus, a place where one enjoys being and I would go to the beach because I love the sea, particularly the South African sea which is quite active and it has this repetitive [er] sound you know the waves flow in and then they ebb back and they flow in, they ebb back, it's very, very healing listening to that sound. So I would find myself on the beach and *then would start imagining that I had this white clad army, so strong, that is my immune system killing off the stragglers of the grey army. The grey army is made up of people that we don't let cause problems in society like various criminals, people who cause, and have no positive influence in society. So I'd seen the white army get rid of the grey army, totally rid of it* and then project myself into the future of seeing myself in a year, 2 years, 5 years being well and living my life and then go back to the beach and then I'd open my eyes after counting a certain amount of time, I'd open my eyes and the exercise was done. And it would just take a few minutes, every time I did it but it was essential because *I was fighting this illness. I didn't want this enemy to overtake me.* (CRC08, female, 65, colorectal cancer)

Notice how focus on process and action is conveyed through the plentiful use of verbs: 'relax'; 'love'; 'flow'; 'ebb'; 'find'; 'get rid of'; 'fight' and so on. Then notice how the whole section is deictically pointing towards the lived experience of the self. Then notice how metaphor (shown in italics) is employed to restore a sense of control over cancer by

conceptualising it as an enemy to be countered (though Sontag (1991) explicitly rejects the military metaphor for cancer). We will propose that this sort of language as a response to illness experience is characteristic of a transformational style. This is because it rejects a passive response to illness as something that is natural by conceptualising it as motivated by design (in the image of a grey army comprised of anti-social people); this concept activates a sense of purpose in resisting the 'purposes' of the illness which are to 'overtake' the self.

One situation where this psychologically proactive response is important is in cognitive therapy as described by this woman with cancer:

> I also started seeing a counsellor [er] who sort of tried to give me strategies to cope with what I was going through. But she, she used to talk about *imagining* the cancer, and *imagining* the chemotherapy attacking it, so I had this whole analogy of [erm] worms eating through [erm] a sort of biomass, and checking out the other side, and the sun being [er] making everything better. (YPC08, female, 21, teenage cancer)

Here the woman describes a technique of visualisation used by her counsellor that is based on imagining and in which chemotherapy is visualised as the action of worms. The speaker goes on to explain how coming off Prozac (against her doctor's advice) contributed to an improved health condition as she starts writing poetry and walking. This illustrates a purposeful and transformational approach towards illness that we suggest motivates a range of words related to the concept of thought and belief. In the following extract there is a strong positive evaluation of the imagination as a way of heightening self-awareness through meditation*:*

> ...at the back of the book there are several which are quite simply explained, different ways of meditating. For example, *imagining the breath coming from the earth,* the energy coming from the earth. *Imagining it coming from a higher [er] energy centre,* and meeting and becoming stronger in the heart centre. Um, I'd become aware of the different energy centres, they're sometimes called Chakras, [at the same time] [er] and link with the glands and so on. And I can *visualise or feel*, however you want, the different colours, because colour is important to me. [um], So I use all that, [um], and I've learnt to just let, [er] extraneous thoughts come and go, not try to fight them, or just let ... (DP28, female, 58, depression)

Here the acts of imagining, visualising and feeling all contribute to displacing the self that is experiencing the illness from the sick body and relocating the sense of self in a spiritual centre.

4.3.4 Analysis of mental process verb (cognitive): 'Know'

In the interviews women used a form of the verb 'know' 120 times per 10,000 words while men used a form 99 times per 10,000 words – a difference that is highly significant ($p < 0.0001$) which suggested that this keyword and key concept were pertinent to our study. A very common pattern for the verb 'know', as has been identified in much previous literature, is as a discourse marker – 'you know' (e.g. Erman, 2001). 'You know' is treated as a 'discourse marker' when it is not crucially part of the syntax of the clause and it may have functions that vary both according to individuals and according to social variables. The term pragmatic marker is also used to refer to 'you know' because it conveys the speaker's attitude towards aspects of the context such as both the person to whom they are speaking as well to what they are saying. Bernstein refers to 'you know' as 'sympathetic circularity sequences' (1971: 97) because it invites the hearer to sympathise with the speaker and as characteristic of a 'restricted code' used by working-class boys. Erman (2001) explains that the general purpose of pragmatic markers is to monitor discourse rather than to put forward propositions and emphasises the metalinguistic function of 'you know' in hedging and approximating and its social function – to ensure that the speaker is understood. He identifies in particular a greater use of the modal metalinguistic function by adolescent speakers. Generally researchers have associated 'you know' with the powerless style of women because it invites agreement (e.g. Fishman, 1978, 1980). However, some researchers, such as Holmes (1986) and Stubbe and Holmes (1995), have challenged the view that it is a form used more by women than by men as claimed by this earlier research.

Our findings for both 'you know' and 'I don't know' as shown in Table 4.6 both indicate they are used more by women experiencing illness.

We will argue that both these forms communicate low modality and that this is characteristic of a more feminine style – since in general terms both 'I don't know' and 'you know', when used with a bracketing function, indicate something that the speaker is not sure about – either because they are asking for confirmation or because they are stating their lack of knowledge.

Macaulay (2005) found that females used the form around twice as frequently as males and that although working- and middle-class

Table 4.6 Comparison of 'you know' and 'I don't know' in the full matched sample (men compared with women)

	Men		Women		
Phrase	**Tokens**	**Tokens per 10,000 words**	**Tokens**	**Tokens per 10,000 words**	**p <**
You know	5,864	59.6	7,796	71.3	.0001
I don't know	587	5.97	860	7.89	.0001

speakers use 'you know' with similar frequency, middle-class speakers are more likely to use it to focus on a topic whereas working-class speakers use it more as a bracketing feature. We found this distinction useful in analysing our data; typically when 'you know' is used with a focusing function it occurs in the initial position of a sentence as in the following example:

> *You know*, any, anyone can start a web site. And it's important to keep to the official web sites really. (YPC30, male, 19, teenage cancer)

Here 'you know' is used by a young man with a high level of modality to focus on the topic of web sites and to highlight some new information that is being provided rather than as an invitation to the hearer to agree. This is rather different from the bracketing function that we see in the following:

> [Em] I don't think so, [em] I mean it was made pretty public when my Mum was there teaching and my Auntie was there [em], at that time that, you know, it was very, very difficult 'cos my Mum really couldn't get involved in it obviously being a teacher there, [em] so [em], *you know*, when I came home crying my eyes out and sort of saying, 'I don't want to go back there, don't-don't make me go back there'. (YPC21, female, 22, teenage cancer)

Here 'you know' is a mitigating strategy which lowers modality and corresponds with other hesitancy fillers such as 'em', or 'er' that invite sympathy. Table 4.7 compares this bracketing function of 'you know' in our data according to the SEC and age variables.

These findings support the claims of Bernstein (1971) and Macaulay (2005) regarding the influence of social class; when we compare the

Table 4.7 'You know' with bracketing function: Comparison by gender, age and SEC

	Men		Women		
	Tokens	Tokens per 10,000 words	Tokens	Tokens per 10,000 words	p <
High SEC	6	0.24	3	0.12	n.s.
Low SEC	21	1.05	29	1.07	n.s.
Older people	9	0.46	10	0.49	n.s.
Younger people	27	1.28	9	0.38	.01

combined low SEC groups and compare them with the combined high class groups we find a highly significant difference ($p < 0.0001$). Low SEC people use 'you know' as a bracketing feature around five times more frequently than high SEC people; it is typically preceded by some form of non-verbal hesitation marker:

> and I think I'd worked around the clock but I finished a week of night shift on the 23rd or thereby, [um] and [er], *you know*, having a young daughter, she's up at the crack of dawn, so [er] my back shifts are 2pm to 11 or midnight [er], I could be coming home. (CP39, male, 38, chronic pain)

People who feel 'powerless' in response to illness (typically low SEC people and younger men) use the bracketing function of 'you know' more than other groups, although as we have seen from Table 4.6, the feature in general is used more by women. The interaction effect of age and gender is important: although the overall use of 'you know' is more frequent among women, when the bracketing function of 'you know' is compared by age, SEC and gender the only significant difference is that younger men use it *more than* young women ($p < 0.01$). The more frequent use by younger people is in line with the findings of Erman (2001) who identified an increasing using of 'you know' for modal and metalinguistic purposes. What is interesting in our data is its higher use by young men; 'You know' is quite often repeated, for example, in the following extract all three uses seem to be invitations to empathise with the pain experienced by the speaker.

> I wasn't crying, sobbing, but the tears were streaming down my face, *you know*, it was the pain that I was under and [er] it became something

> of a joke [er] in the, me dining table, *you know*, and amongst the, amongst peers that [um], *you know*, 'This woman's a torturer', [laugh] but they made light humour out of it and [er], which was very good. (CP39, male, 38, chronic pain)

Most of the instances of 'you know' in younger men's language realise its bracketing function and are often preceded by a hesitancy filler (as in the example above) – they invite sympathy as well as indicating uncertainty. In the context of illness, it is possible that the bracketing function of 'you know' combined with a hesitancy marker such as 'um' indicates the speaker's difficulty in talking about painful experiences. This apparently 'weak' use of 'you know' gains the inverted 'power' of a feminine style because it invites sympathy from the listener and therefore the potential to assist – if only through listening.

4.4 Feminine discursive style: High modality

In this chapter we have proposed that a characteristic of a feminine discourse style is the ability to switch modalities so that points of view can either be communicated with various degrees of hesitation and commitment (as with 'I mean I suppose'), or they can be communicated with higher degrees of certainty (as with the contrastive function of 'I mean'). This switching of modalities is a discursive style that is transformational in so far as there is movement in the discourse from an apparently inverted powerless style to a powerful style based on deictic centring and higher modality that positions the speaker's perspective as one demanding the attention and actions of others. In this section we will explore uses of higher modality in more detail by examining the past form 'knew' and affective verbs such as 'need' and 'want' that communicate a high level of certainty regarding the needs and desires of the self.

4.4.1 Analysis of mental process verb (cognitive): 'Knew'

'Knew' occurs as a keyword for women interviewees in the full matched sample and for low SEC women in the SEC matched sample; it is also interesting to explore its collocations; the phrase 'I knew there was something' occurs 18 times in the interviews with women (in 10 different interviews) but does not occur at all in the 99 interviews within the full matched sample. As might be anticipated from the context of illness experience, the unnamed and perhaps vague 'something' relates to a health problem of some type as we can see

from most of the concordance lines for this phrase from the women's matched sample:

1. So then I *knew there was something* not right about it.
2. I, I wasn't in complete denial, I *knew there was something* wrong, but it was almost like, 'Well, if
3. My daughter flew home from Brunei because she *knew there was something* wrong.
4. Before I went to see the doctor I *knew there was something* the matter but I didn't really tell
5. I knew *there was something* wrong.
6. and he's probably the brightest of the four, and he *knew there was something* going on.
7. my clients were terribly nice to me, they *knew there was something* wrong but the day I got to
8. 'As soon as I *knew there was something* there my feeling was I want this out and I want to be out
9. slept in my own bed since – I think, deep down, I *knew there was something* really wrong, even
10. David was born which is sixteen years, which is when I first *knew there was something*.
11. I don't know, I just *knew there was something* wrong.
12. He *knew there was something* wrong and he left me, and I was a bit angry with him.
13. Even when I got the bruising and the pain, I *knew there was something* wrong but I never,
14. of going to the doctors every single week he *knew there was something* desperately wrong
15. I was distraught because I *knew there was something* wrong and I couldn't find out what.
16. because in the flashes that she had, she *knew there was something* wrong but there was this
17. 'Oh my God he's back on that track again'. And I thought I *knew there was something* [laugh].
18. And she *knew there was something* drastically wrong because she was talking to the doctor.

In 12 of the 18 lines the adjective 'wrong' follows the phrase; what is interesting though is the claim to knowledge in relation to a health issue that is made only by women and therefore may be taken to indicate

something about feminine discourse styles. Although there is a lack of precision in specifying exactly what it is that is wrong, the speaker is, nonetheless, sure that something is! This is very different from the bracketing function of 'you know' that we analysed above which we saw was characterised by a low level of certainty towards a proposition. Here we have a claim to knowledge that shows a much higher level of certainty. It is not a claim that would identify specific symptoms and diagnose possible causes of these symptoms in rational, medical terms; but it is a claim based on personal intuitions about how the body has departed from its normal state. Although women also sometimes attribute intuition to men as in 'he knew there was something wrong' – it is not a claim that men make about themselves. It may be that a claim to intuitive knowledge of the body is more in line with stereotypes of traditional femininity, and may challenge traditional conceptualisations of masculinity where the focus of attention is supposed to be outside the self and the body.

What is interesting about the claim to 'know that something was wrong' is that it is a retrospective one and at the time the speaker probably did not know that anything was wrong at all, but later needs to legitimise actions by a claim to such albeit vague knowledge. Claims to special intuitive 'women's' knowledge have more to do with the social construction of gender – in this case of women being intuitive – than any substantiated independent existence of such knowledge. We can speculate, then, that men avoid the phrase 'I knew there was something wrong' not because they do not have intuitions, but because it is not part of their social role to engage in self-representations as 'intuitive', 'instinctive' or 'insightful'.

4.4.2 Analysis of mental process verb (affective): 'Need'

In the full matched sample, women use a form of the verb 'need' approximately 14 times per 10,000 words whereas men use one 11.8 times per 10,000 words; this difference is significant statistically ($p < 0.0001$) and becomes more pronounced in particular collocations; for example 'I need to' is used 1.28 times per 10,000 words by women and only 0.74 times per 10,000 words by men (significant at $p < 0.001$). This is partly explained by the more frequent use of first person pronouns by women and the preference by men for the more distancing form 'you'. Personal need statements are particularly interesting to examine in the context of the experience of illness – a situation in which all people very evidently have needs if only to get better. Our findings suggest that

a characteristic of the feminine discursive style is one of high modality in which the speaker's needs are placed at the centre.

First, we compared all those uses of 'need' that occurred more than 25 times in either men's or women's speech in the full matched sample and then we analysed the verb following 'need'. There were several verbal phrases that occurred and these are summarised in Table 4.8.

The two phrases that are used more by women are 'need to do' ($p < 0.01$) and need to take ($p < 0.05$). The needs statements of women experiencing illness reflect a view of a life of purposeful self-realisation in response to the challenges of illness. In the following extract the speaker expresses her whole sense of being alive in terms of specific needs to fulfil purposes:

> [Er] something somebody said to me the other day and they laughed about it. [Um, pause 2 secs] they said, 'It seems to me you haven't got time to be ill and die you're too busy'. [Laughs]. And I think that's some of it, what I'm worried about; *I won't have finished what I need to do*.
>
> There's *so many things I need to do*. [Er] I want to make my mark. I want to make sure that nobody ever feels the way I have in the past. (LD25, female, 41, living with the dying, end-stage COPD)

Here the speaker seeks to embark on behaviour that contributes to an improving health condition while changing behaviours that may be partly responsible for a poor health condition. A discourse of self-realisation in the 'need' expressions corresponds with one of self-improvement. In the following extract a woman experiencing depression is talking about a book entitled *Feeling Good* (authored by a man) which

Table 4.8 Three-word clusters for 'need' in the full matched sample (men compared with women)

	Men		Women		
Phrase	**Tokens**	**Tokens per 10,000 words**	**Tokens**	**Tokens per 10,000 words**	**p <**
Need to do	19	0.19	46	0.44	.01
Need to get	16	0.16	17	0.16	n.s.
Need to take	6	0.06	19	1.84	.05
Need to tell	3	0.03	9	0.08	n.s.
Need to talk	10	0.10	11	0.10	n.s.

has helped her to deal with some of the patterns of thinking that have given rise to her condition:

> Mhm. [um] I call, [um] what I've got in my head my chatter box. [um] Basically it is my mind, seeing things a particular way. And with depression you see it really negatively. You see everything negatively, you'll always pull out the negative over the positive if you ever see a positive, you'll ... if for one positive you'll give ten negatives. [um] And that little voice in your head, that's telling you, oh God, you know, [um] that person doesn't like me, or [um] oh, [um] I don't look very good today, or I feel fat or, you know, all these horrible negative things that come into your mind are your chatter box telling you all these frightful things. It teaches you that, you don't have to let what your mind is telling you be the case ... *So you need to* just sit there and go, right ok, I behaved this way, I behaved this way because it's a preconditioned response, it's something that was instilled in me many years ago and I don't want it any more. So *what do I need to do* in order to change that? And, you know, the book is fantastic for teaching you methods and ways of doing things like that. And there are loads of self-help books out there. [um] And I never even thought twice about looking at them until, you know, a couple of years ago. But some of them really do speak some really ... (DP15, female, 24, depression)

What is interesting here is the speaker's faith in the cognitive therapy methods advised in the book and her determination to act upon herself to engage in 'a reflexive project of the self' (Giddens, 1991: 214). Other activities that women see themselves as needing to do include walking, taking exercise, have something to eat. In contrast, men only used the expression 'I need to do' 19 times in the 99 interviews and the one of them relating to exercise was heavily ironic:

> Anyway, I went to see the physiotherapists, they give me exercises, I found them really too hard to do, 'cos they said to me 'I want you to do ten of these, five of these, ten of them' and, when I was in so much pain, I just said to myself well I got up to six or seven of whatever exercises they asked me to do and [um] and I thought 'Bloody hell, *I need to do these like I need another pair of ear holes*' and I stopped. (CP46, male, 49, chronic pain)

Men experiencing illness often do not see themselves as needing to modify their behaviour or to take specific mental or physical actions

to the same extent as women – possibly because giving in to their needs may conflict with their traditional gender role. Consider the engagement of the same woman above with her condition and how this leads to behavioural change:

> So, [um] I set mini goals. *I need to get* to lunch time. *I need to get* to home time. *I need to get* to here. *I need to get* to there. [um] And then I come home and I just maybe ... sort of think about all the good things I've had, try my best not to dwell on the bad things, [um] try and still argue my chatterbox, still sort of trying to [um] make head or tail of the situation. Still accepting that *I might still need help*, [um] keeping up to date with my GP. Speaking to my counsellor whenever I need her across the phone. Writing ... (DP15, female, 24, depression)

This discourse is structured around the reiteration of need statements showing a young woman who has a clear self-reflexive purpose of recovery. She continues by describing how she has left home as a result of her parents' divorce:

> And then one day I sat down with [um], the woman, and said [er], '*I need to tell you* some facts about why I'm living here with you' [um], so I asked her to go and get her husband. So he came downstairs at sort of late on in the evening, children were in bed. And I said *I need to tell you* the real reason why I'm living here so young. And told them. And they were just absolutely shocked. Their mouths dropped. They were really upset for me. And they were like, '[participant's name removed], you're an amazing person, you're a lovely girl, you can stay with us as long as you need to. You're part of the family, you know, don't worry about it.' (DP15, female, 24, depression)

Here expression of the need for support leads to the couple who she is living with to respond to these needs because they have been directly expressed. Expressing her needs using a level of high modality and deictic centring provides the opportunity to obtain emotional support. Another woman expresses a need to talk with health professionals rather than with her mother:

> [um] Although it, it really made me realise when I saw that doctor that actually my family and friends don't, can't really understand quite what its like and sometimes *you do need to talk to someone that's seen other people going through it* and seen other people having the

> same feelings to really, to really *talk properly* about it, for them to say 'Yep that's normal, you know of course you feel like that,' because you know your mum can say that but you don't really believe it because you know she's saying it to make you feel better. So you know sometimes I have like a, like *I need to talk to people who are from the hospitals* and things, but [um] you know I've always fought against sort of the counsellor, that's my silliness but that's how I've dealt with it. (YPC13, female, 24, teenage cancer)

Interestingly, there are 11 instances of the pattern 'I need to talk' in the women's interviews but only one occurrence 'I need to talk' in all the 99 interviews with men (men avoid the first person with this phrase); that is by a gay man who 'needs to talk' about the end of his relationship with another man:

> After ... we spent the first six sessions talking about the man basically and the betrayal as I saw it at that time. And that led me then to have a meeting with him, in the middle of the 12 weeks, I rang him up and I said 'we *need to talk*' and when he came round I said 'look I'm in counselling' and his first reaction was 'who are you seeing, what are they talking about', he wanted to control that. And I said 'it doesn't matter who I'm seeing, what *I need to talk to you* about is what's happened with us, the fact that we were seeing each other regularly, it was some sort of relationship and then nothing happened through Autumn 98 and then I discovered from somebody in the sauna that you're ... that you know, that you're seeing somebody else, you know and I felt betrayed'. (DP23, male, 50, depression)

The repetition of the phrase 'need to talk' and other related expressions such as 'I'm in counselling', 'what are they talking about' shows a high degree of sensitivity to the act of talking by this man – although it appears, ironically, it is through talking with another person 'in the sauna' that the speaker learns that the man who he is having a relationship with is 'seeing somebody else'. The extract is interesting in that it shows the centrality of communication and spoken interaction in the life of this gay man – and in this respect how the 'feminine' need for speech is not one that is restricted to women, but may lead some men to adopt identities that challenge traditional masculine ones. The reluctance of most men to express their need to talk – especially when they are in situations that research has shown would be beneficial for their health to do so – is very evident in the corpus and we will follow

up the importance of talk in the next chapter on sources of support and support strategies.

4.4.3 Analysis of mental process verb (affective): 'Want'

Women in the full matched sample used a form of the verb *want* 26 times every 10,000 words while the men used this verb 22 times per 10,000 words, a significant difference ($p < 0.0001$). However, apart from this difference in overall frequency of use of the verb it seemed to be employed in rather similar ways; we can see this through analysis of the 19 most frequent three-word clusters including or next to the word 'want' (see Table 4.9) which are in fact the same for both genders (though not in quite the same order of frequency).

Table 4.9 Three-word clusters for 'want' in the full matched sample (men compared with women)

Men's			Women's		
N	**Cluster**	**Freq.**	**N**	**Cluster**	**Freq.**
1	I want to	228	1	I want to	260
2	Don't want to	192	2	I wanted to	243
3	I don't want	157	3	Don't want to	238
4	You want to	149	4	I don't want	204
5	I wanted to	146	5	You want to	174
6	Want to be	130	6	I didn't want	171
7	Didn't want to	124	7	Want to be	167
8	Want to do	117	8	Didn't want to	155
9	I didn't want	99	9	Want to do	149
10	Want to go	79	10	Want to go	128
11	Want to know	79	11	Want to know	115
12	I want to	65	12	I want to	103
13	You don't want	55	13	Don't want	85
14	If you want	54	14	Do you want	74
15	Don't want	48	15	Wanted to do	69
16	Didn't want	47	16	I don't	65
17	Do you want	47	17	If you want	63
18	Wanted to do	47	18	Didn't want	62
19	Really want to	45	19	Really want to	52

The only clusters that are different are 'you don't want' which is the impersonal use of the second person pronoun that we discussed in Chapter 3 as a male distancing strategy; this occurs in 22nd position in the women's frequency list; second, 'I don't' in the women's cluster occurs in 23rd position in the men's frequency list. One other point worth further investigation was that women used a negative form of the verb much more frequently than men; for example, women use 'don't' or 'didn't' 'want' 5.5 times per 10,000 words, whereas men use a negative form only 4.4 times per 10,000 words (significant at $p < 0.0001$). A particular pattern that occurred four times more frequently in the women's interviews is 'I didn't want anyone/anybody/anything'; these were at times related to a need to express anxiety about appearance:

> [Um] Because of the scar on, *I didn't want anybody* to look at me, even my legs, you know with the scar all up my leg. *I didn't want anybody,* I'd wear trousers all the while. And *I didn't want anybody* to see the scar down my chest. It sort of, it's you know, it was horrible, it was. And I didn't feel, and I just didn't feel sexual at all. *I just didn't want to know anything* like that. [Um] (HA03, female, 53, heart attack)

Women and, in particular, girls and younger women experience strong social pressures to look good, so that when illness affects their ability to look good they feel this pressure.

4.5 Summary

In this chapter we have proposed that a feminine discursive style is characterised by both self-reflection, and proactive agency in response to illness and that together these constitute a transformational discursive style. We have identified through an analysis of mental verbs (cognitive and affective) such as 'think', 'know' and 'need' two primary discursive styles. One is when a speaker's attitude is characterised by low modality – that is when they convey less certainty about, or commitment to, the possibility or necessity of what they are saying. This corresponds with more traditional notions of femininity and is seen as one appropriate response to the uncertainties entailed by illness. The other type of response is one of high modality, characterised by deictic centring and placing the life of the person at the centre of the illness experience through the use of verb patterns such as 'I knew something was wrong', 'I need to talk' and 'I didn't want anyone'.

We suggest feminine styles demonstrate the ability to switch between low and high modality for particular rhetorical purposes and while our methods have identified statistically significant verb patterns that characterise women speaking about illness in interviews, further research might be oriented to how these are employed by particular speakers with particular purposes in other interaction contexts. We saw in Chapter 3 how men following traditional masculine discursive styles distanced themselves from their experience or avoided talking about it by focusing on other topics such as sport; in this chapter we have seen how women engage more fully with the experience – either tentatively by expressing their uncertainties about illness or less tentatively by clearly stating their needs and desires. We have also seen how some groups of men such as young men, low SEC men and gay men have adopted more feminine styles such as the bracketing function of 'you know' or 'I need to talk'. In the following chapter we will explore in more detail how some groups of men draw on the resources of feminine discourse in describing their feelings about experiencing illness.

5
Emotional Disclosure: Socio-economic Classification, Age and Gender

5.1 Introduction: Gender and emotion

In Chapter 3 we argued that a traditional masculine style is characterised by reification, and deictic distancing, although we also saw evidence of emotional expressivity in sports talk and swearing and in Chapter 4 we saw how feminine styles range from low modality and uncertainty to high modality and deictic centring according to context. In this chapter we explore linguistic evidence for emotional expression through the use of adjectives. Though we will report findings for both genders, a particular focus will be on how high SEC men express feelings using words that are more commonly used by low SEC women. Recent theory from the field of language and gender has proposed that the performance of masculinity is heterogeneous and influenced by contextual factors (e.g. Cameron, 2003). According to these perspectives, men and women are best regarded as agents in creating their own identities and drawing on a range of culturally available discursive repertoires, or stylistic resources, according to their communicative purposes within specific contexts of interaction. The use of emotionally expressive adjectives by high SEC men shows how SEC interacts with masculinity to produce a range of masculinities. Such performances entail the construction of a range of locally context-dependent gender identities rather than single context-independent 'hegemonic' ones.

Emotional disclosure – especially in potentially traumatic situations such as experiencing illness – is generally considered to have positive

health outcomes. As Brody (1999: 269) summarises:

> Accumulating evidence indicates that expressing feelings associated with traumatic experiences, including fear, anxiety, sadness, and depression relates to better mental and physical health.

Brody suggests a number of explanations of these enhanced health benefits of emotional expressivity – in particular of negative emotions – arguing that efforts to understand a situation giving rise to the emotion, encourage reflection and acceptance. In addition, expressing feelings communicates to others the speaker's needs and the act of communicating needs enhances the likelihood of their being satisfied. The expression of feelings can improve social relationships; research has shown that people who express feelings are better liked (Dimatteo, Hays and Prince, 1986 in Brody, 1999: 263); it also potentially gives speakers more power over other people, which, Brody suggests, may also contribute to better health. In this respect emotional expression stimulates adaptation to changing environments – such as the experience of illness. Gender differences in emotional disclosure, therefore, have implications for the comparative health advantages of women and men.

Previous research has generally focused on differences rather than similarities in the expression of emotion. A belief that has been widespread in the ideology of gender is that men – as compared with women – are deficient in the communication of their feelings and emotions (e.g. Jansz, 2000), although this has been questioned by Galasiński (2004). In a review of the research literature on the various components of emotional experience Alexander and Wood (2000: 197) identified a consistent sex difference: 'Women report more intense positive emotions than men, they more frequently express such emotions to others, and they respond more extremely on certain psycho-physiological measures, especially endocrine levels and facial muscle movement'. They continue: 'the differing roles that men and women fill within post-industrial Western societies have a sufficiently consistent, powerful effect or yield greater emotional responsiveness of women than men in the majority of research we reviewed' (ibid.: 204).

This confirms Brody's (1999: 268) findings that 'Women tend to express more intense and frequent emotions across many different situations than men do, especially those conveying distress and dysphora'. Gender differences in emotional expression have been explained by

an underlying distinction between masculinity, rationality, science and a world view that implies dominance and control of the material world and femininity, emotionality and influence over a private and domestic order. As Connell (1995: 6) points out – the notion of scientific knowledge as inherently masculine is very potent:

> Western science and technology are culturally masculinized. ... The guiding metaphors of scientific research, the impersonality of its discourse, the structures of power and communication in science, the reproduction of its internal culture all stem from the social position of dominant men in a gendered world.

We saw some evidence of this in our analysis in Chapter 3 of the conceptual key for men verbalised as 'mental objects: means and methods' and the traditional masculine preference for words such as 'systems', 'patterns' and 'techniques'. There is, then, much previous research that contrasts a feminine relationship-oriented interpersonal knowledge that encourages emotional expression with a masculine, expert-based informational knowledge that inhibits such disclosure.

In Chapter 3 we illustrated how some men develop strategies that avoid dealing directly with feelings of emotional uncertainty and loss of control arising from illness through the creation of a discourse of distancing and avoidance. This may be associated with a way of looking at their health condition from an external or 'objective' perspective whereas, as was shown in Chapter 4, some women experience illness as offering the potential for transformation, viewing it as an experience that can be lived and verbalising this through deictic centring. Generalisation and abstraction from experience by drawing on traditional styles associated with scientific and technical discourse are perhaps ways in which men following such styles react to the feelings of helplessness that illness brings about by seeking to demonstrate control over it. When experiences are represented in an abstract and general way we often do not know the social agents involved: that is, who did what to whom – and this gives a characteristically masculine style of certainty and strength, as de Klerk (1997: 145) summarises:

> 'Be a man' is a message heard in many societies, which nonetheless seem to lack the equivalent incitement to 'be a woman'. In most western contexts, the tendency to categorize the male principle as one of strength, and the female as one of docility, has led to men

> having to choose between the hard and the soft, or some subtle combination of the two.

Conversely, 'being a woman' often involves *disclosing* or *revealing* feelings of insecurity, loss of control and uncertainty that are caused by illness. While traditional femininity – with its orientation to emotional proximity, disclosure and revelation – is well suited to the psychological and physical trauma entailed by illness, traditional masculinity requires that men adopt a supporting role rather than being in need of support; this is well summarised in an interview with a woman as follows:

> So I think men in general deal with these things sort of slightly differently, and [um] that's, [um] you know, just is a difficult role because [um] they're more worried for you at that stage. Whereas all your focus is on the baby, their focus is, okay, the baby, but in a way you're number one. And also, because I think men are used to this role of support and making things better, that's a situation where they can't make anything better, so I think it's quite frustrating for a man to [um] try and help a partner and being totally helpless. No. And I think that they, they, men keep, tend to keep a lot inside, because I think they think that if they show their emotions they're going to make you worse. In actual fact it's probably, quite the opposite, because it's quite a relief to see that your partner is grieving just as much as you, so you don't feel quite that alone in your grief. But they feel that, 'Oh, if I say something, you know, she might cry or she might feel worse'. (EAP02, female, 39, ending a pregnancy)

The speaker summarises how it is socially acceptable for women to express strong emotions, while there are constraints on men doing so because this would undermine their masculine role. However, she also questions this ideology by suggesting that a woman would feel the experience to be more shared if her partner were able to express his grief. This fits with an ideology based on gender differences in interpreting what constitutes 'successful' affective responses to an emotionally demanding situation. Of course, arguments based on 'I think that they think' suppositions are in themselves reflections of a particular speaker's point of view rather than being, necessarily, an accurate account of what 'they' think – they are indicative of views on the 'self' and the 'other' based on a world view that requires 'self' and 'other' positions.

A further explanation of these gender-based roles is that they are perpetrated by exposure to media representations that have become

naturalised in the culture. For example, Seale's studies of the portrayal of cancer experience in print media (2002) and in popular cancer web sites (2005a and b) demonstrate many continuities with these gender differences. In newspaper reports of cancer experience women's skills in emotional self-transformation and their capacity to draw on support from others are commonly portrayed. Men are shown to be stoical, isolated and psychologically unchanged by their cancer experience. What such studies show is that there are stereotypical ways for people to enact gender when experiencing illness: some men focus on information – in line with their supposed role as scientific experts – and some women on emotional support – in line with their supposed understanding of feelings. It is likely that the effect of media representations is therefore to enforce conventional sex roles. However, we will show in this chapter that although not *all* men express their emotions directly as often as women do, there is considerable evidence that *some* men prefer to adopt styles of emotional expression normally associated with femininity. We will explain this with reference to the variables of age and SEC interacting with gender – something that we have explored less in earlier chapters that were concerned with 'traditional' masculine and feminine discursive styles – but we will also suggest that there are not always adequate opportunities for men to be emotionally expressive.

We will analyse adjectives relating to the emotions that occurred more than once per 10,000 words. Some of these were keywords because they were used more by one gender than the other, while others were not statistically different in terms of frequency. They are nonetheless of interest in that they show evidence of similarity in how people express evaluation – irrespective of their gender. We examine the interaction of these adjectives with SEC and age to examine the effect of these variables in relation to gender. We then undertake qualitative analysis of adjectives that were used in similar ways by groups established by SEC, age and gender – as well as those that were used differently. We find that where adjectives are used with different frequency this is usually because of the reluctance of men – especially low SEC men – to express emotions in keeping with traditional masculine roles for doing illness; but we also find evidence where adjectives are used with a similar frequency that some men, especially high SEC men, are using a style of expression that might be considered more 'feminine'. This is typically through the use of expressive adjectives which are more frequently used by women for the direct expression of emotion. We argue, therefore, that verbalisations of sex roles are not predetermined either by socialising influences or by nature, but that language offers a set of masculine or feminine

linguistic and discursive resources on which individuals encountering illness may draw according to other aspects of their identity – such as their age and social and economic class.

5.2 Socio-economic classification (SEC)

5.2.1 Overview – Emotional disclosure

One way that women communicate traditional femininity is by evaluations that permit them to express their feelings and one way that men demonstrate traditional masculinity is by suppressing their expression of feeling. The direct expression of emotion that is associated with a feminine style involves providing an evaluation of some sort. Hunston and Thompson (2001: 5) define evaluation as 'the broad cover term for the expression of the speaker or writer's attitude or stance towards, viewpoint on, or feelings about the entities or propositions that he or she is talking about'; they go on to point out: 'Every act of evaluation expresses a communal value system, and every act of evaluation goes towards building up that value-system. This value-system is in turn a component of the ideology which lies behind every text' (ibid.: 6). We have already seen how women exploit the modality system of language to offer a perspective on what they are saying, and evaluation is the same process when applied to a discourse topic. We find in the interviews that women often express feelings and emotions towards some aspect of the experience of illness by emotionally expressive evaluations that heighten modality:

> [Uh] But when I actually did come home that was the *terrifying* part. I was really *frightened*. You, you miss that all round support that you get, you know. And it always felt if anything went wrong, well there's always someone to turn to. (HA35, female, 80, heart attack, retired nurse)[1]

Evaluations can either be positive or negative, and emotions can be classified into those that express positive experiences and those that express negative ones. Evaluation is also scalar which means that it can be *more* or *less* positive or negative. For example, negative emotions

[1] In the sections of this chapter dealing with socio-economic classification (SEC) we have included informants' occupations as these are relevant – elsewhere these are not given for reasons of space.

can be placed on an ascending scale from 'nervous', 'worried', 'afraid', and 'frightened' to 'terrified'. We divided adjectives into two groups – those expressing positive emotions and those expressing negative emotions and because we were also interested in the influence of SEC we selected the group of interviews that were matched according to SEC. Tables 5.1 and 5.2 show the findings for adjectives that convey negative emotions in groups determined by socio-economic classification; Table 5.1 shows words that keyword analysis revealed as being used differently by men and women from different socio-economic categories, while Table 5.2 shows those that were used with a similar frequency.

These findings imply that gender is a primary influence and SEC an important secondary one. All of the adjectives for which there were significant differences between genders are used more frequently by women; they use 'awful', 'upset', 'poorly' more frequently than men at a level exceeding $p < 0.0001$; they use 'frightened' more frequently at $p < .001$ and 'worried', 'scary', 'nervous' and 'unhappy' more frequently at a level of $p < .01$. When the level of significance is lowered to $p < 0.05$

Table 5.1 Keyword negative emotion adjectives compared by gender and SEC+ (tokens per 10,000 words)

	Men		Women		Gender comparison
Adjective	**High SEC**	**Low SEC**	**High SEC**	**Low SEC**	**(p <)**
Awful	0.88	1.26	3.59*	2.47	.0001
Upset	1.73	0.90	2.0	2.95*	.0001
Poorly	0.16	0.20	0.91*	0.52	.0001
Frightened	0.76	0.80	1.66*	1.44	.001
Scary	0.40	0.05	1.16*	0.07	.01
Worried	1.93	1.61	2.45	2.88*	.01
Nervous	0.24	0.20	0.50	0.70*	.01
Unhappy	0.20	0.10	0.66*	0.30	.01
Anxious	0.40	0.20	0.95*	0.41	.05
Terrible	1.00	0.90	1.54*	1.29	.05
Traumatic	0.28	0.25	1.03*	0.11	.05
Group total	7.98	6.47	16.45*	13.14	
Gender total	14.45		29.59		.0001

Notes: +SEC = Socio-economic classification; *show the group that used this adjective the most frequently.

Table 5.2 Non-keyword negative emotion adjectives compared by gender and SEC+ (tokens per 10,000 words)

	Men		Women		Gender comparison
Adjective	**High SEC**	**Low SEC**	**High SEC**	**Low SEC**	**(p <)**
Silly	0.40	1.11	0.70	1.40*	n.s.
Angry	0.76	0.70	1.33*	0.70	n.s.
Afraid	0.60	0.65	0.99*	0.52	n.s.
Alone	1.00*	0.50	0.62	0.63	n.s.
Weak	0.92*	0.25	0.66	0.37	n.s.
Stupid	0.36	0.45	0.95*	0.44	n.s.
Miserable	0.48	0.55	0.95*	0.11	n.s.
Unpleasant	0.44	0.30	0.82*	0.22	n.s.
Group total	4.96	4.51	7.02	4.39	
Gender total	9.47		11.41		.01
Combined total for tables 5.1 and 5.2	12.94	10.98	23.47	17.53	.0001

Notes: +SEC = Socio-economic classification; *show the group that used this adjective the most frequently.

women use 'terrible', 'anxious' and 'traumatic' more frequently. Overall, women use one of the negative adjectives shown in Table 5.1 more than twice as frequently as men do.

When we examine both tables – including Table 5.2 which shows adjectives for which differences were not significant – all of the adjectives are used most by one or other of the female groups except for 'alone' and 'weak' that are used most by high SEC men. High SEC men are more confident than low SEC men in expressing stronger and more intense emotions in an interview situation; they use 'scary' and 'weak' more than low SEC men at a level of $p < 0.01$; 'upset' at the $p < 0.05$ level and they use 'alone' and 'anxious' more frequently than low SEC men but not significantly so. Though the differences between genders for individual adjectives in Table 5.2 are not significant, when they are aggregated women used this group significantly more than men. This is largely because of their greater use by high SEC women. These results suggest that the primary influence on adjective use is gender but that SEC also has an effect both on emotional expression since high SEC

people use more emotion adjectives than low SEC people of the same gender and this is especially the case for women.

The more direct expression of negative emotion by high SEC people (men and women) can be related to their greater confidence in expressing opinions generally, which, as Macaulay has noted, is a characteristic of middle-class language:

> Thus, similar to the findings from the Ayr interviews, the working-class speakers in the Glasgow conversations appear not to want to impose their views on their hearers but rather to let the hearers make up their own minds. One of the ways in which they do this is by rarely employing the adverbs and evaluative adjectives that the middle-class speakers use more frequently. (Macaulay, 2005: 182)

He continues by way of explanation:

> It is not that these middle-class speakers are aggressive or dogmatic; in fact, some are timid in many ways. But when they use words such as amazingly, awfully, badly, drastically, enormously, overly, properly, and terribly, they take it for granted that their middle-class interlocuters will share their view that something is amazing, awful, and so forth. (Ibid.: 184)

We would support this in relation to our data but with the reservation that there are a small group of adjectives used more by low SEC women – for example, 'upset', 'worried', 'nervous' and 'silly'. High SEC groups, male and female, use more negative adjectives than low SEC groups of the same gender and they are more confident in using those that give very direct expression of their emotions to communicate a higher level of certainty.

There is some convergence of the findings for low SEC women with those for high SEC men – for example, frequencies are similar for 'terrible', 'afraid', 'alone', 'anxious' and 'unhappy'. This suggests that high SEC men may be rather less emotionally constrained than low SEC men – since they express their feelings using adjectives associated with a feminine style. The following two sections will provide evidence of this convergence. Tables 5.3 and 5.4 show the findings for adjectives that convey positive emotions; Table 5.3 shows adjectives that keyword analysis showed were used significantly differently by men and women; while Table 5.4 shows adjectives where gender differences were not statistically significant ('non-keyword' adjectives).

Table 5.3 Keyword positive emotion adjectives compared by gender and SEC (tokens per 10,000 words)

	Men		Women		Gender comparison
Adjective	**High SEC**	**Low SEC**	**High SEC**	**Low SEC**	**(p <)**
Great	5.9*	4.57	4.32	2.73	.0001
Fine	3.17	2.16	4.32	6.90*	.0001
Lovely	0.60	0.60	1.24	2.88*	.0001
Happy	2.33	1.81	2.20	3.76*	.01
Wonderful	1.97	1.76	2.20	3.39*	.01
Fantastic	0.92	0.45	1.24	1.36*	.01
Pleasant	0.84*	0.35	0.33	0.33	.05
Total	15.73	11.70	15.65	21.35*	
Gender total	27.43		37.00*		.0001

Note: *show the group that used this adjective most frequently.

Table 5.4 Non-keyword positive emotion adjectives compared by gender and SEC (tokens per 10,000 words)

	Men		Women		Gender comparison
Adjective	**High SEC**	**Low SEC**	**High SEC**	**Low SEC**	**(p <)**
Lucky	1.97	2.06	1.91	2.76*	n.s.
Brilliant	1.00	0.70	0.70	1.51*	n.s.
Fortunate	1.16*	0.50	0.75	0.48	n.s.
Caring	0.60	0.30	0.91*	0.55	n.s.
Excellent	0.84*	0.50	0.62	0.30	n.s.
Determined	0.44	0.45	0.70*	0.07	n.s.
Sympathetic	0.52	0.15	0.25	0.70*	n.s.
Confident	0.36	0.55*	0.29	0.37	n.s.
Perfect	0.24	0.65*	0.19	0.22	n.s.
Tremendous	0.60*	0.15	0.16	0.22	n.s.
Group total	7.73	6.01	6.48	7.18	
Gender total	13.74*		13.66		n.s.
Combined total for tables 5.3 and 5.4	23.46	17.71	22.13	28.60*	.0001

Note: *show the group that used this adjective most frequently.

We should first note that positive adjectives were used more frequently than negative adjectives for all groups and that this difference was especially marked for men. They used over 40 positive adjectives compared with 24 negative adjectives per 10,000 words, while women used over 50 positive adjectives compared with 41 negative adjectives.

The findings for positive evaluations contrast with those for negative evaluations in that low SEC men appear to be an outlying group. High SEC men's use of positive adjectives is with similar frequency to that of high SEC women. For example, high SEC men and high SEC women each use approximately 23 positive adjectives per 10,000 words – suggesting an interaction between SEC and gender. The most pronounced difference is that low SEC women use more positive adjectives than low SEC men. Similarly, high SEC men also use more positive adjectives than low SEC men and therefore might be regarded as deviating from the norms of traditional masculinity. High SEC men use 'fine'; 'fortunate'; 'pleasant'; 'sympathetic'; 'tremendous' significantly more than low SEC men.

The following adjectives are employed with a very similar frequency by high SEC men and women: 'happy'; 'wonderful'; 'lucky'; 'fantastic'; 'excellent'; 'confident' and 'perfect' – we may recall that high SEC men used negative adjectives with similar frequency to low SEC women. Overall gender differences arise largely because of the *under-use of adjectives* by low SEC men. High SEC men use 'great'; 'fortunate'; 'excellent'; 'pleasant'; 'tremendous' and 'terrific' more than the other groups, while a large amount of positive evaluations are also given by low SEC women who used five out of the seven positive adjectives for which there are significant differences between genders; these are 'fine'; 'happy'; lovely'; 'wonderful' and 'fantastic'. Perhaps high SEC men are influenced by current ideologies favouring a feminine discursive style.

5.2.2 Low SEC women

Table 5.3 shows that low SEC women offer positive evaluations with adjectives such as 'fine'; 'happy'; 'lovely'; 'wonderful' and 'fantastic' and overall they use positive adjectives that are keywords nearly twice as frequently as low SEC men. The use of hyperbolic 'absolutely' to intensify a positive evaluation is characteristic of low SEC women when they talk about their experiences being 'absolutely brilliant' and 'absolutely fantastic' – as in the following concordance lines:

N	Concordance
1	I'd had my hysterectomy [er] it was *absolutely wonderful*, because most of

then I didn't, everybody said 'You'll feel *absolutely wonderful* and I was expecting
(Laughs) I mean the pre-med is *absolutely wonderful* you just you're quite
person and so was my father-in-law, *absolutely wonderful* people. [um] But he
They'll never send you out, they were *absolutely wonderful* you know I mean
nurses came in and they were *absolutely wonderful* and talked to you.
of support from them, my husband is *absolutely wonderful*, I would never have
for what he's done for me, he's been *absolutely wonderful*. And his sister
in my case I've got to say that it's been *absolutely wonderful* for me but I do think
Because I've had that done, that's *absolutely wonderful*, like Indian head
hospital. And the consultant there was *absolutely wonderful*, well they've all
the registrar and he was absolutely, *absolutely wonderful*. And he was, he
wonderful. And he was, he was *absolutely wonderful*. And he came to,
that man treated me I thought he was *absolutely wonderful*. I don't think it's as
wonderful, wonderful. Yeah they were *absolutely wonderful* the nurses, the
had been booked into the Breast Clinic, *absolutely wonderful*. TC 1:54:00 They

Ten of these lines refer to people and six to an experience of some aspect of their treatment. Consider how one women talks about her husband:

> And I had an awful lot of support from them, my husband is *absolutely wonderful*, I would never have got through without [my husband]. Because I'm quite fiery and out-spoken you know a bit, I get a bit emotional and worked up, I'm passionate about things but [my husband] is very calm and collected and he can just get on with it you know. I've always said that if it had to happen I'm glad I got it and not him because I couldn't have done for him for what he's done

> for me, he's been *absolutely wonderful*. (LC20, female, 64, lung cancer, gold block printer)

Here there is an ideological self-representation of the speaker as an 'emotional' woman while her husband is 'calm and collected' and this meaning is reinforced by the use of an intensifier such as 'absolutely'. Low SEC women also evaluate medical staff using hyperbole:

> No, no, no I just came home and as I say the nurse came to see me, very nice nurse but Oh *wonderful, wonderful*. Yeah they were *absolutely wonderful* the nurses, the doctors they were, I can't praise them enough I just can't, I can't. (LC40, female, 72, surgical appliance officer)

Hyperbolic appraisal of the husband and the health-care staff is part of these speakers' feminised discourse. The use of the same pattern of intensifier + positive adjective occurs with other adjectives:

N	Concordance
1	through something like this, they're *absolutely brilliant* yeah they can't do
2	they all kept me going. Well I think its *absolutely brilliant* because going back
3	was, she was about 85 and she was *absolutely brilliant*, every Friday she'd
4	to kick in but they're absolutely brilliant, *absolutely brilliant* and that eased it and
5	about three days to kick in but they're *absolutely brilliant*, absolutely brilliant
6	children' and it's a brilliant book, it is *absolutely brilliant*, yes. But yeah I
7	just absolutely brilliant the nurses were, *absolutely brilliant*. The chemo nurses
8	it was a day out, I mean they were just *absolutely brilliant* the nurses were,
9	open arms by the staff in there. They're *absolutely brilliant* and I often get a
10	it's called. And I have to say that it's *absolutely brilliant*, absolutely. The first

We have seen how women in general establish authority by giving powerful negative evaluations of the health-care system; low SEC

women seem to gain a degree of authority from providing a highly optimistic perspective drawing on their own personal experience of how other people have treated them. Their readiness to do this is matched, perhaps, by a reluctance to criticise health-care professionals, suggesting a lower degree of authority in relation to social systems.

A positive adjective that is most commonly used by low SEC women is 'lucky'; its use by a low SEC woman occurs in the following:

> I mean I have been so *very, very lucky* because as I say I've always blamed myself thinking well if I hadn't smoked as much as I would, I did do, then I wouldn't have got it may be in the first place. But I've also had some good experiences since because I do quite a bit of publicity work for Cancer Research, I don't know if I can say that. (LC20, female, 64, lung cancer, gold block printer)

It may be combined with other positive adjectives such as 'lovely' and 'nice' as in the following:

> I've had some *nice* experiences like I've been to Buckingham Palace to a garden party, the Queen's Garden Party and I've met Prince Charles at the hospital that I attend a lung cancer support group and I've met Princess Alexander. So I've had some quite you know *lovely* experiences and photographs taken and done quite a bit of publicity and what have you. So I've been *very, very*, I consider myself *very, very lucky* so yes it's been, I mean no one can say that they're glad they've had it obviously but as I say it's certainly altered my life since you know. (LC20, female, 64, lung cancer, gold block printer)

Here there is use of the repeated intensifier 'very' as well as a range of positive evaluations in the adjectives in a style characterised by hyperbole.

However, Tables 5.1 and 5.2 show that there is a small group of negative adjectives used more by low SEC women than other groups – in particular 'upset', 'worried', 'nervous' and 'silly'. These describe personal emotional responses to illness experience rather than evaluations of the health-care system. 'Upset' typically describes a response to an illness diagnosis:

> I saw the scan, I couldn't, he pointed out the different things and I could see the tumour was quite big, I don't think I could read a scan as such but pointing it out it did show it. Again I came away and

> I was *very upset*. Spoke to friends. Talking about it has been fantastic, talking to other people. (LD41, female, 58, fitness instructor, living with dying, ovarian cancer)

Though in other cases it describes the reactions of intimates:

> [um] And the worst part was, was telling people. I had to tell my sister. And obviously she was *very upset*. I was [um] ... (HA01, female, 63, sessional carer)

A similar concern for the reactions of others shows in the concordance lines for the expression 'very worried':

N	Concordance
1	he was getting pains and she, he was *very worried*. She felt there wasn't a
2	And I think until in the end my mum got *very worried* because these instances
3	for it myself and my mum was very, *very worried* about this, but she wouldn't
4	her back but she didn't, so she was *very worried* about me because I didn't
5	air is fine anyway, I did lose a bit, I was *very worried* about just wasting away. No
6	there was, it was so tender I was, I was *very worried* and she did, she went very

We see in the first four of these that the emotional response of someone else is described perhaps as part of a social role in which low SEC women are taken to be primary carers and obliged to be concerned with the feelings of others. As far as other negative responses are concerned some seem to be related to anxiety about the impression that they will make on others:

> You're in pain, you're hurting because of it, but it's something which you can live with it, if that's, I know that might sound *a bit silly*. It's always there, [um] and you love your child, but you're hurting as well because of how and what happened. (EAP08, female, 29, classroom assistant)
>
> ... my friend saw a lady, she actually wasn't really an osteopath she was more of a healer. I know that sounds *a bit silly*, but she said

> basically, when she lays down she sort of runs her hands over the top of you. (CP20, female, 38, administrator)

In both extracts the speaker is concerned about the 'voices' of others and how these might contribute to a negative impression of their intelligence: by displaying self-awareness of how they might 'sound' they are protecting their face from such disparaging thoughts.

There is some convergence of the findings for low SEC women with those for high SEC men. This can be seen in crude terms by the fact that low SEC women are the most likely group to use positive adjectives, and high SEC men are next most likely (see bottom row of Table 5.4). This is a theme developed in the next section.

5.2.3 High SEC men

The findings for emotion adjectives support the view that high SEC men exercise greater individual choice than low SEC men in drawing on the stylistic resources of gender in the development of a discursive repertoire for the performance of self in illness, and that they do this by drawing on a lexicon for emotional expression that can be empirically demonstrated to be in other respects typically feminine. High SEC men are oriented to the expression of more positive than negative emotion – they use a positive emotion adjective around twice as frequently as a negative emotion one – in contrast to high SEC women who we have seen use more negative than positive adjectives. In this respect high SEC men are more similar to low SEC women who use positive adjectives around one and a half times more frequently than negative emotion adjectives. Both groups also use similar frequencies for negative adjectives such as 'terrible', 'afraid', 'alone', 'anxious' and 'unhappy'. It seems that high SEC men engage in a degree of emotional labour to emphasise the effort needed by an individual to overcome their illness.

High SEC men generally precede 'alone' with a negative form in the course of discussing various strategies to avoid feeling alone:

> But, you know, just the feeling that you ... *you aren't alone* [um]. It was a great source of comfort. Equally, the best thing that my ... my wife said to me during, during the illness was, was, 'Don't worry I'll look after you.' And sort of to feel that, that well, you know, you know, somebody looking after me, and will look after the day to day things that I'm no longer capable of doing was also a source of comfort and a source of help. (DP05, male, 33, depression, computer programmer)

The negation of a negative evaluation turns it into a positive one and in this respect the speaker's discourse is proactive in advocating agency and involvement – particularly by people experiencing illnesses closely related to the emotions such as depression. The notion of sharing an experience might be considered a feminine 'transformational' strategy for handling intense emotions and as part of the greater emotional responsiveness of women noted by Alexander and Wood (2000). High SEC men realise that illness is something that has the potential to separate them from contact with others but also realise that such feelings of separation can be overcome. We should be cautious, then, in automatically attributing evaluative content to a particular isolated word: here the negative evaluation of 'alone' is only the basis for *avoiding* being alone and for engaging with supportive others.

High SEC men express emotions using adjectives such as 'great', 'terrific', 'excellent' and 'tremendous' to communicate strong positive emotion using a characteristic that, as we have seen, is associated with women's language – hyperbole. Some adjectives, such as 'tremendous', appear to index an interaction of high SEC with masculine gender. High SEC men indicate strong approval with the adjective 'tremendous' as in the following tribute to medical staff:

> [Um], and talking about team work, I mean the other team that was really being effective of course was the hospital team: the consultant, the two oncology nurses who treat me and the patients, plus all the support staff and I haven't, I haven't had a bad experience. People have been polite, *helpful, friendly, courteous, understanding* without being sloppy about it [um], the whole medical experience has just been so *positive*, so *tremendous* I just, I'm so grateful to all those people involved who form part of the medical team, who form the medical team that has helped me to make this progress. (CRC26, 57, colorectal cancer, management consultant)

Here both the naming of social groups worthy of positive evaluation and the listing of adjectives that imply strong approval of the social nature of medical assistance are emotionally expressive. In the following extract the same speaker draws a parallel with sport, discussing this traditionally masculine topic using what is a predominantly feminine discursive style for giving positive evaluations:

> [Um], which was just, just *tremendous*, it was something that I hadn't really experienced before, it was like *I love sport* and I you know

> playing in a team sport, if you have a *successful* team you have that feeling then when a team is all pulling together and all working for each other. And I felt that this was a team, everyone I knew you know was being *supportive*. (CRC26, 57, colorectal cancer, management consultant)

The speaker shows discursive skill in transforming a notion of sport as a metaphor to evaluate cooperation among medical staff positively, something that we may have predicted from the analysis of sports talk as a masculine strategy. The experience of illness also creates opportunities for new types of emotional relationship that may break down traditional doctor-patient relationships:

> Yeah, he was *tremendous*. *Very supportive* [um] and he's turned into a friend, I mean last time he saw me he was *quite amazed*. [er] Unfortunately because I have moved house I might have to find another GP but [er] I will always go back to [er] my original one when I return home. (CP09, 73, chronic pain, managing director)

The use of boosters and intensifiers is traditionally associated with women's language, but we can see here how high SEC men employ markers of discursive femininity in their reporting of illness. What we mean by this is that high SEC men adopt some of the characteristics of a transformational discursive style that are conventionally associated with women – and quite often with low SEC women. They exhibit more variability in their personal performances of masculinity and display a more reflexive and critical perspective on conventional masculinity than low SEC men, suggesting that their greater cultural capital involves access to a wider discursive repertoire.

In the previous section we saw that 'wonderful' is an adjective used most frequently by low SEC women – however, there are a number of instances where high SEC men use this:

> All the nurses were *wonderful*. [um] We, every, they got on with absolutely everyone. [um] And they'd always. They didn't seem like nurses most of the time. They were more like your friend and you got to know them so well because you were going there so often. [um] And you looked forward to seeing them. (YPC30, male, 19, teenage cancer, medical student)

The positive enthusiasm towards medical health professionals, expressed here using hyperbole, is also characteristic of women's speech style.

Another adjective that was most frequently used by low SEC women was 'lucky', but in the following extract a high SEC *man* evaluates himself as 'lucky' in giving an account that explicitly rejects stereotypical views of gender roles:

> They say in the macho thing big men don't cry and things but it was six foot six friends coming to see me after the hospital and one of them gave me a huge hug and started crying you know. No I've been *very lucky* really so no I've been offered to join the local support group, and I just know, because the nurse would say alright you're the social worker, do you feel like going to see so and so tomorrow night or whatever and I would say okay I will. But I know how the time I have is so precious, I want to spend it with my family really. (IC33, male, 43, intensive care, social worker)

Here the notion of being 'lucky' seems to be linked to the emotional expression of supportive friends, support groups and family – it is combined with other adjectives such as 'precious' that might normally be linked to a feminine style. We might recall that we are not focusing here on emotion adjectives that are used differently by men and women (as in Tables 5.1 and 5.3) but on those that are used with similar frequency (Tables 5.2 and 5.4) and are now illustrating how they are also used in similar ways. There is no significant difference between the frequency with which men and women use 'lucky', so this is a case where similarity between high SEC men and low SEC women needs to be considered in interpreting the quantitative findings. Consider, for example, the concordance lines for 'very lucky' for high SEC men:

N	Concordance
1	something to occupy your mind. I'm *very lucky*, I spent the last fifty five years
2	with chemotherapy I was actually very, *very lucky* with the chemo. A bad, a
3	started crying you know. No I've been *very lucky* really so no I've been offered
4	football I guess, but I think we're *very lucky* to have it. 00:31:41 I think so.
5	true. [32:06:21] Not really. I've been *very lucky*, I've had, it's sometimes
6	to do your life differently. But I've been *very lucky*. I mean how many people

7 half a life, I think it's less. I think I'm *very lucky* to be sitting here looking out
8 I could phone him, but I have been *very lucky* with emergency services as
9 runs courses. Now in a sense, I was *very lucky* to be able to go on the
10 a really good GP. He was, I've been *very lucky* in my life, I've had three
11 be my guess, yeah. Again I've been *very lucky* or call it good, good planning
12 but nothing happened, and uh, I was *very lucky*. I felt that the first treatment
13 up in a really bad state. I mean I was *very lucky* that although I never really
14 you. [um] [mmm] Well I was very, *very lucky* with all my treatment. [um]

In every instance the collocation is preceded by a first person pronoun. We will recall that one strategy for a traditional masculine discourse style was deictic distancing by the *avoidance* of first person pronouns – so here we find a pattern that is generally characteristic of women's language being employed by high SEC men. Quite often a self-image of being 'lucky' is associated with a generally positive attitude towards their illness condition although this can also be part of a more self-conscious display of heroic attitude in the face of illness.

Another positive adjective which high SEC men employ is 'brilliant'; Table 5.2 shows that this is a word used more frequently by high than low SEC men, but most frequently by low SEC women (though none of the differences are statistically significant). In the following extract the male speaker evaluates the performance of health-care professionals using several emotionally expressive adjectives and adverbs that we have put in italics:

> We were actually able to go through the three chemos, the first one which I'd only received stage but the other two chemos *fantastic* treatment throughout from the oncology department, my oncology nurse is a *wee* poppet, she's *absolutely fantastic*, my oncologist, the guy himself was just *pure brilliant* and all his staff were too, *really fantastic* people. (LC02, male, 53, lung cancer, university lecturer)

We saw in Section 5.2.2 that 'absolutely wonderful' and 'absolutely brilliant' were collocations characteristic of low SEC women, but they are also used by high SEC men in the following lines:

N	Concordance
1	actual, there's no pain at all. They're *absolutely brilliant* though they really are.
2	the lab as it were and honestly they're *absolutely brilliant*. It's like looking at,
3	ward. Well, my wife who was brilliant, *absolutely brilliant*. And one thing, they

The last of these can be expanded as follows to provide a description of his wife for whom he is a carer.

> Well, my wife who was *brilliant, absolutely brilliant*. And one thing, they were very good in Intensive Care, they were very good with her. They kept her very well informed, they listened to what she said too. I think they helped her a lot. And, yeah, and I had, I was sort of, small circle of close friends and they were all great. (IC08, male, 50, intensive care, teacher)

The speaker uses a feminine discursive style of intensifying positive evaluation by listing and repetition, and using a range of words from the lexical field for expressing positive feelings. Such uses of hyperbole have been associated in the literature with women's use of language (e.g. Lakoff, 1975). A phrase used more frequently by high SEC men than either high or low SEC women is 'absolutely fantastic', as in the following concordance lines for high SEC men:

N	Concordance
1	looking through this window. They were *absolutely fantastic*. And it's painless,
2	taking a photograph down that way. It's *absolutely fantastic* and the way they do
3	friends you know and my wife has been *absolutely fantastic* throughout this.
4	again given the operation it had been *absolutely fantastic*. The district nurse
5	straight to me. (11.47) And it was *absolutely fantastic*. I remember her

6 on another level, we'd arranged this *absolutely fantastic* service where it was
7 be arranging your funeral. You've got an *absolutely fantastic* opportunity to
8 valves dangling from your chest. It's an *absolutely fantastic* system, no pain,
9 oncology nurse is a wee poppet, she's *absolutely fantastic*, my oncologist, the
10 does a course called Mindstore that's *absolutely fantastic*. And you can cherry

The total concordance lines for high SEC women are fewer in number:

N **Concordance**
1 group in May last year and it's been *absolutely fantastic*. We meet once a
2 in anything like that before but it was *absolutely fantastic*, it was so uplifting it
3 from that mess with the scan has been *absolutely fantastic*. (1.14.03)
4 chemo nurses and the chemo staff are *absolutely fantastic*. They're so

This intensifying phrase is used more by high SEC men, though it would usually be associated with women's style. We also find the use of 'absolutely fantastic' combined with features of repetition:

> I always knew that option B was not an option, option B being death, I wasn't prepared to accept it. After I had a kick up the bum from my employee by email right at the start of this and everybody started rallying round and saying 'If you want to fight this we'll fight with you [says his own name],' they did you know and they really got behind me you know. And that's probably all the counselling that I needed was the support of a great group of friends you know and my wife has *been absolutely fantastic throughout* this. (LC02, male, 53, lung cancer, university lecturer)

Although the black humour and colloquial style here might be thought of as somewhat masculine, the repetition of 'option', 'fight', 'you know'

and 'they' contribute to an emotionally expressive style in which the speaker represents himself as an active agent.

What we have suggested in this section is that many adjectives – especially positive ones – are used with a similar frequency by low SEC women and by high SEC men who disclose their positive feelings about their experience of illness using hyperboles and intensifiers that are more characteristic of women than of men in analyses that aggregate the SEC groups, and which in the literature on gender differences are often identified as markers of feminine style. They use adjectives and adverbs that are more commonly used by women as part of their cultural repertoire for performing illness. This suggests that verbalisation of sex roles are not influenced by gender alone, but also by SEC, permitting high SEC speakers to modify their communicative style according to their perceptions of the requirements of the setting. The communicative setting for illness appears to be perceived by high SEC men as one in which a feminine discursive style is often likely to be rhetorically effective.

5.2.4 High SEC women

Tables 5.1–5.4 show that high SEC women are the only group that use more negative than positive emotion adjectives (23.47 compared with 22.13) – using 8 out of the 11 negative adjectives for which significant differences were found between genders. High SEC women also use the following adjectives significantly more than low SEC women: 'miserable'; 'scary'; 'traumatic' ($p < 0.0001$); 'unpleasant' ($p < 0.01$) and 'awful'; 'angry'; 'afraid'; 'stupid' and 'anxious' ($p < 0.05$). The only adjectives that low SEC women use more than high SEC women are 'upset' and 'silly' ($p < 0.05$). Macaulay observes that

> ...the middle class speakers show no hesitation in making their attitude clear, and one of the ways in which they do this is through the use of adverbs and evaluative adjectives. This is the sense in which they are more explicit. In whatever way it came about, they have been socialised to feel confident in expressing their opinions and even their prejudices. This has become their *habitus* to use Bourdieu's term. (Macaulay, 2005: 184)

Our data suggest that negative evaluations are more powerful in expressing opinions confidently than positive ones and this may explain why high SEC women prefer to take a more critical stance

towards health providers by being explicit in their criticism but sparse in their praise – in such a way their language has an ideological force. By withholding a positive evaluation, high SEC women are often revealing their feelings rather than being concerned about the effect that this will have on others. These negative evaluations are also often part of a style that employs high modality in, for example, making criticisms of the health service. In the following extract a high SEC woman criticises the lack of treatment for people with epilepsy:

> And also as long as they took you on, knowing you have epilepsy in this case, whatever disability, then they have to make suitable you know reservations for the person. And they can't just sack you, they can't just push you out the door, am I'm so, because I know people are going through it now and will go through it and won't stand up for themselves or won't realise that they have every right to stand up for themselves. You know *it's terrible,* it really is. Its just going on every day all over the country, I'm sure it is. (EP22SP, female, 39, epilepsy, recruitment consultant)

This directness in criticising the medical system contrasts with the greater use of positive adjectives by low SEC women who may be offering appraisals that they think will be approved by both the interviewer and their unknown audience of people encountering illness experience.

Another reason why high SEC women use a higher proportion of negative adjectives than other groups is that they are more prepared to reveal their emotional state by describing their feelings directly. One way that we investigated this was by looking at the phrase 'I was feeling' in each of the samples matched by SEC; the most interesting finding was the difference in the use of the phrase by high and low SEC women. 'I was feeling' is used more by high than by low SEC women ($p < 0.001$); we can see this by comparing the complete concordance lines for each group:

Low SEC women (0.45 per 10,000 words)

N	Concordance
1	[um] Told me it was, the pain that *I was feeling* and all the other symptoms
2	similar and it was all exactly the way *I was feeling* and in a sense it was a

3 and [um] so I, it was one of the days *I was feeling* sort of sorry for myself
4 everywhere [laughs] for some reason, *I was feeling* extremely sorry for myself
5 it from him, but I had to tell him how *I was feeling*. And he said to me, [um]
6 to start with, trying to express the way *I was feeling*, because I couldn't say it in
7 it was, that was all I could explain how *I was feeling* at the time. The pain, you
8 I wasn't happy with the way in which *I was feeling* and you know I went to my
9 and quite nauseous but not all the time. *I was feeling* it quite a lot but I'm not at

High SEC women (1.04 per 10,000 words)

N	Concordance
1	help me more because by this stage *I was feeling* extremely isolated very
2	I did take anti-depressants because *I was feeling* very bad about things. I
3	taking onboard that a lot of the pain *I was feeling*, there is no physical cause
4	that, that sort of discipline because *I was feeling* my back sore and [um] and
5	there's an awful lot that [um] why, why *I was feeling* pain it wasn't a physical
6	and I didn't take it ... and I realised *I was feeling* really bad ... and so I took
7	I was supposed to be doing because *I was feeling* depressed. If it was for my
8	one thing after the other, how miserable *I was feeling*, and about, you know, how
9	had I not had the therapy. Even though *I was feeling* better. Yes. She was
10	was in '96. I was on antidepressants. *I was feeling* bad, but I was functioning
11	of my heart. This was exactly how *I was feeling* at this given moment. And I

12 tasks to use up the adrenalin that *I was feeling*, and I found them too much
13 it, and I had to sign a consent form, but *I was feeling* so ill... and the
14 tough going. Yes it is. I mean as I said *I was feeling* so bad and nothing else
15 see how my thoughts and the way that *I was feeling* was linked. And started to
16 it. I didn't have any more seizures but *I was feeling* very unhappy and very
17 saw a doctor and they did the ECG and *I was feeling* really rough by then and
18 thing because this was going on and *I was feeling* totally... I remember
19 occupational health, we discussed how *I was feeling* and decided to retire on ill
20 morning my husband was out and *I was feeling* really well and I am quite
21 the tracheotomy. I can remember *I was feeling* it, and I can remember in
22 at all possible in the afternoon because *I was feeling* so sort of drained and tired.
23 when I was in hospital because *I was feeling* so awful. So I had a chat to
24 I might be off sort of thing. And so *I was feeling* very, very positive a month
25 several things were going wrong and *I was feeling* rotten and then [name]
26 like that, believe me, not the way *I was feeling*.... The more there is above

The phrase expresses intensely negative emotional and physical states in approximately equal proportions. The higher use of the phrase by high SEC women could be interpreted as suggesting that they are more centred deictically than low SEC women; by this we mean that they are more prepared to treat their emotional or physical state as the primary topic of the interview. A possible explanation is that this is because they are less concerned with losing face in the interview situation than low SEC women – seeing the interview as an opportunity to recount their experiences of how they felt at the time of the experience, without any need to conceal this by taking into account what others might think of them.

5.2.5 Low SEC men

Tables 5.1–5.4 show that low SEC men use fewer expressive adjectives – whether for negative or positive emotions than any other group; they only use 28.69 emotion adjectives per 10,000 words as compared with 36.40 for high SEC men, 45.60 for high SEC women, and 46.13 for low SEC women; they use 17.71 positive and 10.98 negative adjectives per 10,000 words. This suggests that low SEC men conform more to traditional masculine sex roles that place constraints on the use of a feminine discursive style than do high SEC men. However, it is worth noting that there was evidence of some expressivity both as regards negative and positive emotions. For example, they use a number of adjectives more frequently than high SEC men; these include 'awful', 'silly', 'afraid', 'stupid', 'poorly', 'frightened' and 'miserable' from the negative group; however, of these only 'silly' was significant ($p < .01$). In one-third of the total instances 'afraid' is prefaced by a negative form exhorting *against* being afraid:

> But if you're worried *don't be afraid* I know the Big C you think oh I'm going to die, that's not true. Go to your doctor and he'll get everything organised for you and if you have got cancer you're not going to die, not necessarily. I survived, went through all the treatment and through the Macmillan nurses daily, came in and helped, done everything and I'd just like to say thanks and I hope this tape helps you a lot when it comes out. Thank you. (LC05, male, 55, lung cancer, assembly spray paint worker)

However, there are cases where low SEC men indicate a very high degree of emotional expressivity as in the following extract where a man describes how he feels after chemotherapy:

> It's a most *horrible* and I just wouldn't wish the feeling on anybody, you know [um] you just, you want to do things you go and do them and you get to the point when you know you can't do it and you know I have a damn good cry, I cry every day you know and that helps, *don't you ever be afraid* to cry even if you're a man you know there's no shame of it well I don't think so anyway. (PC33, 72, male, prostate cancer, council highways engineer)

It is worth noting here that apart from emotion adjectives, emotionality is also conveyed by the repetition of verbs 'do' and 'cry', imperatives and the use of negative forms ('wouldn't', 'can't', 'don't', 'no shame')

reminding us that there are linguistic resources other than adjectives for expressing emotion. However, the exhortation not to express fear could be interpreted as encouraging a traditional 'hegemonic' masculine constraint on emotional expression.

There was only one negative adjective that low SEC men used more than any other group and that was 'silly'. One of the most common uses was in the expression 'sounds silly' – which again supports the view that for low SEC men there are greater tensions between the things that they would like to say and those that they feel permitted to say; the idea of sounding silly suggests the constraining influence of others who are evaluating their discourse. Consider the following:

> I was like, if I could meet the walking target, you know. Like halfway down the track first and back and then three quarters of the way down the track and back and then to the first bend in the track and back and that was, that was more like it, you know achievements *sounds silly* but those were like achievements and there were days you couldn't do it. (CP08, male, 53, chronic pain, horse breaker)

Here the speaker is thinking that what he is labelling as 'achievements' might not seem so to others – suggesting the presence of others' evaluations is one that is constantly influencing the thoughts that he articulates. 'Stupid' was used in a similar way but with a more intense meaning. Typically, 'silly' and 'stupid' are colloquial adjectives that constitute a positive politeness strategy whereby an insult may index solidarity with the addressee, as in the following:

> My wife gets a bit fed-up sometimes 'Oh my God here he goes again.' And one other small example only recently we was in the supermarket and I was sat down in the empty checkout chair and a lady I know or a woman I know was up beyond with the wife and I just shouted 'Excuse me madam would you like to come down this one?' and *this silly woman* started picking her shopping up and she looked at me and she said 'Oh you *silly bugger*,' she said (laughs). (LC22, male, 59, lung cancer, builder)

There is a similar positive politeness in this speaker's use of black humour:

> And I took my top off and laid down and looked at this massive great thing about my head and I said 'Here,' I said 'What's this Madam

> Guillotine?' and they said '*Don't be stupid* that's not going to hurt you,' and I said 'Yeah I know about that.' So they put my head in this head rest and they said 'Are you alright?' I said 'Yeah fine.' (LC22, male, 59, lung cancer, builder)

Generally, 'silly' and 'stupid' imply a shared evaluation of a situation or activity because they are both colloquial in terms of formality and direct in terms of style.

A positive adjective that low SEC men use more than other groups is 'confident' (not significant); however, analysis of the context suggests that it is more commonly anxieties over their lack of confidence that are of concern in the experience of illness – in particular depression:

> I couldn't say I'm depressed because I'm *not socially confident* enough to be able to do the things that I want to, or have a relationship or find a relationship. And you know, things like relationships I think were very much part of my social and emotional progress, you know once I finally started [um] being *a bit more confident* in my approaches to women you know, which you have to fake to a certain extent, [um]. (DP09, male, 35, depression, computer technician)

Confidence is severely affected by illness, perhaps particularly by depression, and it is something that these men are especially in need of restoring to perform masculine identities and is an alternative to adopting a more feminine identity characterised by uncertainty and lack of self-assuredness. In general terms low SEC men employ colloquial forms and humour as ways of avoiding a direct style of emotion expression that may challenge a normative masculine identity.

5.3 Age and emotion

5.3.1 Overview

We undertook analysis of the same positive and negative adjectives for emotional expression that occur with high frequency in the interviews in relation to groups organised by age and gender. Tables 5.5 and 5.6 show the findings for negative adjectives.

The findings by age show that women use considerably more negative adjectives than men (37.23 per 10,000 words for women as compared with 25.95 for men) and that younger people use them slightly more than older people (33.41 per 10,000 words as compared with 29.77 for older people ($p < 0.01$)). When comparisons are made according to age

Table 5.5 Keyword negative emotion adjectives compared by gender and age (tokens per 10,000 words)

	Men		Women		Gender comparison
	Old	Young	Old	Young	(p <)
Terrible	1.17	0.24	2.67*	1.76	.0001
Frightened	0.36	0.19	1.59	2.18*	.0001
Silly	0.46	0.52	1.34*	1.22	.001
Scary	0.05	0.33	0.40	0.88*	.001
Angry	0.41	0.66	0.80	1.51*	.01
Traumatic	0.10	0.09	0.30	0.46*	.01
Stupid	0.05	0.38	0.60*	0.42	.05
Nervous	0.41	0.14	0.45	0.63*	.05
Group total	3.01	2.55	8.15	9.06	
Gender total	5.56		17.21		.0001

Note: *show the group that used this adjective the most frequently.

Table 5.6 Non-keyword negative emotion adjectives compared by gender and age (tokens per 10,000 words)

	Men		Women		Gender comparison
	Old	Young	Old	Young	(p <)
Worried	1.89	2.65	1.79	2.56*	n.s.
Awful	1.94	1.66	1.99	2.06*	n.s.
Upset	1.08	2.70*	1.34	1.93	n.s.
Afraid	1.03	0.33	1.04*	0.08	n.s.
Alone	0.56	1.09*	0.85	0.59	n.s.
Weak	0.51	1.09*	0.55	0.92	n.s.
Miserable	0.56	0.24	0.20	0.71*	n.s.
Anxious	0.51	0.43	1.24*	0.29	n.s.
Poorly	0.46	0.19	0.35	0.63*	n.s.
Unpleasant	0.26	0.47*	0	0.29	n.s.
Unhappy	0.31	0.43	0.15	0.46*	n.s.
Group total	9.11	11.28	9.5	10.52	
Gender total	20.38		20.02		n.s.
Combined total for tables 5.5 and 5.6	12.12	13.83	17.65	19.58	.0001

Note: *show the group that used this adjective the most frequently.

(by combining the two older groups and the two younger groups) two negative adjectives used statistically more frequently by younger people ($p < 0.01$) are 'upset' and 'scary', and a further four are 'worried'; 'angry'; 'weak' and 'unpleasant' ($p < 0.05$). Older people use three adjectives significantly more than younger people: 'terrible', 'afraid' and 'anxious'. In total there are eight adjectives for which significant differences are found by gender comparison and nine adjectives when compared by age. This implies that age, as well as SEC, has an important interaction with gender in the expression of negative emotions.

Younger people use 53 per cent of all negative adjectives and older people 47 per cent; women use approximately 59 per cent while men use only 41 per cent – suggesting that it is the combined effect of age and gender that governs use of negative emotion adjectives. Younger women express more negative emotion than other groups accounting for 31 per cent of all the negative adjectives and five of the adjectives for which significant differences are found between genders: 'frightened', 'angry', 'scary'; 'traumatic' and 'nervous'; older women used three of the adjectives for which significant differences are found: 'terrible', 'silly' and 'stupid'.

Tables 5.7 and 5.8 show the findings for the use of positive emotion adjectives according to gender and age.

Table 5.7 shows that women use 'lovely' more than men, while men use 'perfect' and 'tremendous' more than women ($p < 0.0001$). Women

Table 5.7 Keyword positive emotion adjectives compared by gender and age (tokens per 10,000 words)

	Men		**Women**		**Gender comparison**
	Old	**Young**	**Old**	**Young**	**(p <)**
Lovely	0.77	0.38	2.19*	0.88	.0001
Perfect	0.36	0.52*	0	0.08	.0001
Tremendous	2.15*	0.28	0.30	0	.0001
Lucky	1.33	1.37	2.19	2.39*	.01
Wonderful	1.59	0.71	2.94*	0.55	.05
Fine	2.05	4.12	3.38	4.75*	.05
Fortunate	0.77	0.90*	0.45	0.38	.05
Group total	9.02	8.28	11.45	9.03	
Gender total	17.30		20.48		0.001

Note: *show the group that used this adjective the most frequently.

Table 5.8 Non-keyword positive emotion adjectives compared by gender and age (tokens per 10,000 words)

	Men		Women		Gender comparison
	Old	**Young**	**Old**	**Young**	**(p <)**
Great	4.82	4.88	5.57*	2.98	n.s.
Happy	2.36	3.17	3.33*	2.60	n.s.
Fantastic	0.56	0.52	0.59	0.97*	n.s.
Brilliant	0.77	1.23	0.69*	1.13	n.s.
Caring	0.61	1.09*	0.59	0.67	n.s.
Alive	0.36	0.80*	0.75	0.38	n.s.
Excellent	0.88*	0.57	0.49	0.42	n.s.
Pleasant	0.20	0.09	0.45*	0.21	n.s.
Determined	0.41	0.38	0.49*	0.13	n.s.
Sympathetic	0.31	0.28	0.10	0.55*	n.s.
Confident	0.41*	0.19	0.25	0.25	n.s.
Terrific	0.15	0	0.40*	0.04	n.s.
Group total	11.84	13.20	13.70	10.33	n.s.
Gender total	25.04		24.03		n.s.
Combined total for tables 5.7 and 5.8	20.86	21.48	25.15	19.36	n.s.

Note: *show the group that used this adjective the most frequently.

use 'lucky' more than men ($p < .01$) and 'fine' and 'wonderful' more than men ($p < 0.05$), while men use 'fortunate' more than women ($p < 0.05$).

The findings for the analysis of positive adjectives by age shows that men and women use positive adjectives with similar frequency and that older people used more positive adjectives than younger people (46.01 per 10,000 words as compared with 40.84 per 10,000 words, $p < 0.001$). This complements the findings for negative adjectives which younger people used more than older people. However, younger women use positive adjectives with the same frequency that they use negative adjectives at approximately 19 per 10,000 words; this is not the case for other groups who all use more positive adjectives – again this fits with the findings for negative adjectives which we found were used more by younger women than the other groups. Men's positive adjectives account for nearly half (49 per cent) of all the positive adjectives – as compared with only 41 per cent of the negative adjectives.

When the two younger groups and the two older groups are combined together, younger people use two positive adjectives significantly more than older people; these are 'fine' ($p < .0001$) and 'brilliant' ($p < .05$). Older people use five positive adjectives significantly more than younger people: these are 'wonderful' and 'tremendous' ($p < 0.0001$); 'lovely' and 'terrific' ($p < .001$); and 'great' ($p < .01$). In total seven positive adjectives are used significantly differently by gender, which is the same number of adjectives for which there are significant differences when groups are compared by age – again indicating the importance of examining the interaction between age and gender. However, these adjectives are not the same in each case because significant differences are found for the adjectives 'brilliant', 'great' and 'terrific' *only* when groups are compared by age rather than when they are compared by gender.

5.3.2 Younger men

Younger men use four negative adjectives significantly more than older men – 'upset' ($p < .001$) 'alone', 'weak' and 'scary' ($p < .05$). Younger men also use one positive adjective significantly more than older men: 'fine' ($p < .001$). These findings suggest that age influences emotion expression in men – with younger men tending to be more emotionally expressive than older men when using negative adjectives. For example, younger men are prepared to express negative emotions such as feelings of loneliness as in the following:

> *Being alone* is really hard, when you're down it's really, really hard. And forcing yourself to actually say, 'Yeah, I want to go out', because you do, there's something telling you, 'Oh, what's the fucking point you know?' So try and do whatever that voice is telling you not to do. Do you see what I mean? (DP04, male, 31, depression)

The young man finds no need to suppress feelings of loneliness and the emotional difficulty that they cause – he is quite prepared to express such negative feelings – though it is notable how, almost in a need to reaffirm masculinity, he refers to the other voice – the one he exhorts the hearer to reject with a swear word that characterises traditional masculine style: 'What's the fucking point you know?' The admission of loneliness potentially undermines masculine notions of being self-sufficient and independent, and is affirmed by the speaker as necessary to recovery. There is evidence in the language of younger men

that learning to be 'feminine' by being open about negative feelings is something that is positively experienced.

Younger men employ 'upset' more than the other groups; however, when we examine the contexts of use, we find that in over half of these instances (33 out of a total of 57) they are referring to the feelings of another person – usually feminine – to whom they are attached. This shows in the following concordance lines for younger men for an expression we have identified as characteristic of low SEC women – 'very upset':

N	Concordance
1	she completely denied that and got *very upset* and that's another reason I
2	pick up the pieces of somebody who is *very upset* and it's takes a while to, to do
3	wrong with them. And it makes them *very upset* and it certainly upset my
4	putting yourself in danger.' She got *very upset* and flustered and left.
5	to deteriorate there and mum got *very upset* and agitated and eventually
6	a kitchen knife. And [my sister] got *very upset* with that – needless to say –
7	discussion and argument and she'd get *very upset*. And part of the stressful
8	was happening I think she would be *very upset*. But I know that I have to do
9	or something can help. When she was *very upset* I often found that it was
10	had happened. [00:52:39] She was *very upset* the day that she was there,

None of these are preceded by a first person pronoun. For example, in the following a young father is talking about his one-year-old daughter's feelings:

> And I remember once when I'd had the attacks last year, she came in to see me, she was fine when she came in but just the association that she has in that when I went back, it was just for a check-up, I said, 'I'm just going to hospital', she *got really upset* and started crying. '*Why are you upset'*, 'You're going to hospital', 'I'm only going to visit',

> you know she couldn't understand that I'm, I'm going in and out in a day just for a test and *she got quite upset* and that was sad. (HA05, male, 37, heart attack)

In the following extract a younger man is concerned about his mother's reaction to having to be taken into a care home:

> I think almost inevitably if I'd have given her the option of going she wouldn't have wanted to so she would *have got upset* whatever had happened. *She was very upset* the day that she was there, staying there and the first couple of weeks when *she was very unhappy and upset* and distressed, which according to the staff in the home is perfectly normal. (ALZ29, male, 34, carer of mother who has Alzheimer's)

The emotions described are entirely those of his mother rather than himself. In the following extract a younger man is talking about his own and his partner's reaction to seeing a scan of a 13-week-old foetus:

> I thought, 'wow look – that's our baby, and it's moving, it's fantastic'. I couldn't believe it, I was just smiling and grinning the whole time. [laughs] [um]. I had to keep my emotions a bit in check because P ... was still *a bit upset* about what they'd told her. So she, I think *she was a bit disappointed* because *she wasn't as happy* as she felt she really could have been, [um] which was a bit of a shame. (EAP34, male, 32, ending a pregnancy)

Here the speaker rapidly shifts from an account of his own positive emotions to an account of how he has to keep these feelings suppressed because his wife was 'upset' – his own emotions towards the pregnancy are mediated through those of his partner ('she was a bit disappointed' and 'she wasn't as happy') so that he needs to control his feelings so that they do not conflict with hers. This suggests an emotional dominance of the woman's response and acceptance that her reaction is at the emotional centre of the event (as implied by deictic centring). The same control of his own emotions because of their possible effect on her emotions continues in the following:

> And just *being really upset*, and also just trying to console P ... because she was in a right old state. And [um] I think I was trying to, [um] I was trying to –, one part of me was trying to stay strong and just console her and help her as well. [um] So [pause 6 secs] Yeah ... I think

> mostly I was just trying to keep her calm and keep her focussed. (EAP34, male, 32, ending a pregnancy)

Here we see the sort of emotional pressures that can be experienced by younger men; the speaker feels that he needs to control his emotions out of concern for those of his partner. It may be that he is displaying a type of emotionally heroic self-sacrifice, doing what others might think is the right response – even if this involves suppressing his own emotions – indicated through the repetition of 'console'. We could even think of this as a type of emotional hygiene by which the man has to tailor his feelings to serve the emotional needs of his wife through acts of consoling. The same concern with his wife's reactions shows in the following:

> They did take some polaroids, which I wish they hadn't because they were rubbish, they're not very good at all. [um] And ... they took a handprint and a footprint, which [um] one of them got a bit smudged actually – one of the footprints got smudged, and so P ... was *a bit upset* about that and asked for another one, but she never got one and *she was a bit upset* about that, that she never got this nice little footprint that she wanted. (EAP34, male, 32, ending a pregnancy)

The speaker does not express his own feelings about the photographs but is concerned about the effect that these will have on his partner – who it seems is continuously 'a bit upset'. His own feelings are only expressed more colloquially in the masculine expression 'they were rubbish' (rather like the swearing by the man in the earlier example) while the emotion term 'upset' refers to his partner's reaction. We find a similar suppression of emotion by a man out of consideration for the effect it might have on his wife – even though it is himself who is experiencing the illness – in the following account by a man suffering from a heart condition:

> I don't think I can fully talk to my wife sometimes about my concerns because [sigh] I think she overly *worries* about it. On some things she, *she gets then frightened* and worried about it, and then I *only then get upset for her,* which doesn't help me. So the point of trying to share it with somebody helping me, it just defeats, all I'm doing is telling her something that *upsets her* and I'm thinking where was the benefit in that, that, that's not to say if there's something we need *to worry* about and do something about, that I certainly shouldn't be hiding something like that from her. But some of the concerns that you

> might just want to chat to somebody or you know, *get off your chest*, I wouldn't do it with my wife now because of having seeing her react. (HA05, male, 37, heart attack)

Here the emotional reaction of a wife is presented as constraining the person who is experiencing illness from giving vent to his feelings about his condition – and her anticipated reaction exerts a constraint on him. All the emotion adjectives in this excerpt (except perhaps for 'I only then get upset for her') concern the feelings of his wife rather than the speaker himself. Here we find a new explanation for younger men's emotional expressiveness: they are concerned about the effects of their emotional expression on a deictically centred woman. They are sometimes constrained emotionally because they see this as impacting negatively on their partner's emotions. However, we have no evidence that this ideological belief is actually the case. Gender ideology tends to perpetrate myths about the desires of the other gender, and in this case the ideology of how younger men *are supposed to* perform emotionally may not correspond with either their own emotional needs or those of their partners.

5.3.3 Younger women

Young women express more negative emotion than other groups accounting for 31 per cent of all the negative adjectives and five of the adjectives for which significant differences are found between genders: 'frightened', 'angry', 'scary'; 'traumatic' and 'nervous'. They talk about being 'angry' about their illness, with people such as medical professionals or family members and with themselves. Sometimes they just get angry:

> You've got people who care, you know, but they don't understand and you do get down and you do get *upset and angry* and, you know, sometimes I get so [sound of breathing] you know, tense and *angry* but what can I do with that, you know what I mean? I just have to keep it because I don't want to take it out on anybody else because it's nobody else's fault but my own. (HA33, female, 37, heart attack)

Sometimes they get angry with their illness because they see it as an assault on their gender identity:

> It hurts, it hurts like hell, it really does. [inaudible aside] [laughing]. It really does hurt. [Um] [pause 3 secs] You suddenly feel very worthless inside. To me the way he has done, I feel that my illness has made me

> *ugly, unattractive, unwomanly, [um] that's where I get angry*. How dare it take that away from me? *How dare it stop me being a woman?* And it does also make you think, oh have I done something wrong? Is it my fault I'm ill? (LD25, female, 41, living with dying, end-stage COPD)

Here we see how loss of appearance is equated with loss of self-esteem – although the rhetorical questions and high modality indicate that in fact the speaker no longer experiences uncertainty about this. Younger women talk about being 'frightened' over ten times more frequently than do younger men (2.18 times per 10,000 words compared with 0.19 times); this occurs in particular patterns such as 'not frightened to ask' as in the following:

> I will ask for help if I want it so they would sort of, you know, throw it at me which I think is important. Some people can be over caring at times [um] and that isn't necessarily always good but as long as you're *not frightened to ask* for help and I'm *not frightened to ask* for help. (RA14JC, female, 43, rheumatoid arthritis)

Here we find in the use of first person pronouns 'I', 'me' combined with a clear statement that the speaker is not frightened to ask and in several instances the speaker imagines an audience and exhorts them to communicate openly about their illness and its treatment. We find, then, that the strategy of deictic centring and high modality that is initiated in pronoun choice can then be continued with the choice of expressive adjectives. One possible explanation of why deictic centring occurs so much more frequently in younger women's language is because the experience of childbirth positions their bodies as being at the centre of an experience (one that in all likelihood they would prefer not to undergo); note the frequency of adjectives expressing negative emotions in this woman's description of scans:

> *Interviewer*: Yes. Okay. So when you're, when you're going in for your scans, you're feeling okay and you've got your husband with you and whatever, *what do you feel about the scan*?
> *Respondent*: I was, I was *apprehensive* going into the scans. The first scan I had this time, this sounds *very silly*, I was *very nervous* on the first scan because I, I'd done a pregnancy test at home which was positive. I went to the doctors fully expecting him to do me a pregnancy test, which he never did. So I was *nervous* about the first scan going

> in and being told, 'What are you here for? You're not pregnant.' So that was very *worrying*. (EAP08, female, 29, ending a pregnancy)

Here the speaker emphasises her personal emotional response to a possible pregnancy through repetition of both first person pronouns and a sequence of four emotionally expressive adjectives: 'apprehensive', 'silly', 'nervous' and 'worrying'. The emotional response to the situation becomes the discursive topic, rather than the details of the medical scenario. However, a related explanation of the higher emotional expressivity of younger women is because the state of their emotions is explicitly addressed by the interviewer. The question 'how do/did you feel?' occurred four times more frequently in the interviews with women as it did in the interviews with young men; this leads us to ask whether one of the reasons why young women come over as more emotionally expressive is because this is part of how femininity is socially constructed in interaction. Had younger men been invited to express themselves more about their feelings, they may have done so. The same asymmetry occurred in the interviews with older men and older women; older men were only asked 'how do/did you feel?' five times less frequently than older women were asked this question.

5.3.4 Older men

Older men's style is particularly communicated by an adjective that also characterised high SEC men – 'tremendous'. This is one of two adjectives that older men use significantly more than younger people: 'tremendous' and 'wonderful' ($p < 0.0001$). 'Tremendous' is an adjective that expresses strong masculine emotion and it is sometimes repeated for emphasis as in the following:

> Now I felt in myself that it was going to be a question of time that got me right, I wasn't having to deliver at work which was *a tremendous* blessing. Excellent. Yes, yes it was a *tremendous* burden lifted off my shoulders. But I have to say, I was treated *extremely* well at work when I became ill. [er] I can't speak too highly of them. And also my church was *exceedingly* good to me. Once they knew how I wanted to be treated, they just left me alone to get on with it you know, and that's really what suited ... kept me in the swing of things, enabled me to get up in the morning. (DP03, male, 68, depression)

The repetition of 'tremendous' combined with 'excellent' and with boosters such as 'highly' and 'exceedingly' produces a style characterised by hyperbole in this man's account. An early claim made by Lakoff (1975) was that women were more likely to use such 'empty' adjectives for emotional emphasis – yet here we find an older man doing this with 'tremendous'. We find a similar style in the use of 'wonderful' which occurs frequently in the phrase 'absolutely wonderful' as in the following extract:

> I was, when I came out of the anaesthetic, people always say, you know, 'When you come out of the anaesthetic you will feel *absolutely awful*'. When I came out of the anaesthetic I felt *absolutely wonderful*. I hadn't felt so well for so long, you know. And I remember I said to one of the, the surgical team who had been involved in the operation came to see me and he said, 'How are you?' I said, 'It's *absolutely wonderful*. The only thing that's missing is the beer'. And he said, 'Well, we can fix that'. And he came back with a can of Guinness, you know. And it was *absolutely wonderful* [laughs]. (IC16, male, 67, intensive care)

The use of hyperbole here is one that we already noted in the language of high SEC men and low SEC women in phrases such as 'absolutely fantastic' and 'absolutely brilliant'. Older men are keen to display their enthusiasm for a range of entities in these interviews; they refer to a range of things as 'wonderful' including support from people such as family members or health-care staff or experiences that improve their condition.

Sometimes 'tremendous' qualifies negative adjectives as in the following account of an academic career that was cut short by chronic pain leading to feelings of loss and anger on the part of the speaker:

> I think the feelings about not working have gone on all the time and it's only since I reached retirement age I've stopped feeling guilty that I wasn't going to work. [um]. But certainly what predominated with me was always a sense of loss, *tremendous sense of loss*. [um]. I was very busy at work. I probably was reaching the, the top of my career, I was hoping to apply for a Chair [er] at the University. ... And [um]. I think there was hardly a University I wasn't lecturing at, at some point [um] on the work that I was doing. And all this was suddenly taken away from me. [um] ... I know I felt *this tremendous anger* that I had this taken away from me. I had this *tremendous sense of*

> *loss*. And I had this *tremendous feeling of guilt* that I wasn't going off to work each day. And not only the loss, lose the work but apart from two or three colleagues, who I'm still in touch with, I lost a whole range of relationships [er] right throughout the country. And this was difficult to cope with [um]. (CP30, male, 66, chronic pain, university teacher and author)

This speaker communicates strong emotion by use of the pattern 'tremendous' + negative feeling. It is a powerful style that nevertheless retains a masculinity that fits with the identity of a successful academic whose aspirations have been curtailed by illness, leading to feelings of frustration, which he has had difficulties in accepting. While men's higher earnings in high-status professions is an aspect of gender and equality that is usually thought of as favouring men, we should not forget that the impact of illness is likely to be greater for older people whose lives and values have been constructed as high achievers in the work place. Feelings of loss of power, whether in terms of status or earnings, and in all likelihood both, are greater for those who were once confident, powerful and certain of the future.

5.3.5 Older women

Older women use 'terrible' more than twice as frequently as older men and over ten times more frequently than younger men. It seems that part of their feminine style is in evaluating degrees of physical suffering and that 'terrible' is their most intense negative evaluation, characterised often by repetition:

> I was really pleased I was here you see because lots of people die in the middle of a heart attack. I was amazed and pleased, amazed because of what I'd gone through with the *terrible* pain, it is *terrible* pain. (HA15, female, 84, heart attack)

In other cases intense evaluations of experience are with synonyms:

> Because they're not going to take my gall bladder out, because – they crushed the gall stones, twice – put the tube down. That scared the life out of me. Through crushing the gallstones – damaged the pancreas – that's what caused it. And that pain of pancreatitis is *dreadful*, really *dreadful*. I don't know what was worse, giving birth or having that, but it was *terrible*. (IC10, female, 76, intensive care)

Older women often represent themselves as knowledgeable about the amount or degree of physical or mental suffering entailed by particular conditions as this knowledge arises from their extensive physical experience of such suffering. This gives them the authority in the domain of illness to be highly expressive and to intensify evaluations – just as knowledge of the health system gives high SEC women the authority to evaluate negatively. Further evidence is offered by the positive evaluations of older women, where they use 'lovely' three times as frequently as older men, and nearly three times as frequently as younger women, and 'wonderful' that they use fives times more than younger women:

> I had, that operation they actually put [um] two screws in my back and [um] I thought it was wonderful. You know I thought this was going to be my new life. That, that's the strangest thing with back pain you always think that there's this *wonderful* cure waiting there for you, you know, that [um] somebody's got this magic wand that they are going to wave and you are going to be okay. But it wasn't. (CP17, female, 63, chronic pain)

> I've got plenty of support like that, which I'm well pleased. I mean, my two grand daughters, they're *wonderful*. You know, they phone me up. I know if I need anything they'd be here. (IC10, female, 76, intensive care)

It seems, then, that there is evidence in the strength and intensity of the evaluations offered by older women that they represent illness as a domain of expertise about which they should be expected to demonstrate forceful opinions; consider the following admission of an older woman of the appeal that illness holds as a topic for older women:

> Oh I'm always interested, *terrible, terrible* I'm you know if anybody talks about their illnesses I just, I enjoy talking about, it sounds *terrible*, I enjoy talking about illnesses, no I don't mean that, I mean its, I don't know, common ground. Even though it may not be an illness that I've experienced but, but I don't know for me it's a talking point! (laughs). (EP23SP4, female, 46, epilepsy)

Here the use of 'terrible' though ironic and self-depreciating indicates the speaker is aware of the inverted nature of illness discourse: other topics are less appealing because they do not give older women the same authority as providers of emotional wisdom.

5.4 Summary

In this chapter we have found in the use of expressive adjectives some particular linguistic strategies through which certain groups of men – characterised by their SEC and by their age, as well as by their sex – perform discursive identities that are more commonly associated with femininity. We have noted similarities between the use of adjectives by high SEC men and low SEC women, in which they are more emotionally expressive using adjectives such as 'happy'; 'wonderful'; 'lucky'; 'fantastic'; 'excellent'; 'confident' and 'perfect' with a frequency and in a similar discursive style to women. We have also noticed how some younger men talk freely about feeling 'upset' and 'alone' in a way that older men do not often express, though also noted that there are tensions for younger men between how they are supposed to respond emotionally to their female partners when they are expressing their feelings. Older men also show evidence of tensions between expressing their feelings in a more contemporary style that employs hyperbole – as in 'absolutely fantastic' and more traditional styles for masculine expressiveness in the choice of adjectives such as 'tremendous'.

Independently of the variables of age and SEC, women are much more confident about expressing negative feelings towards aspects of their experience of illness than are men who are generally more hesitant and anxious about being open about such experiences. Younger women employ high modality in talking about their emotional responses to illness, high SEC women also employ high modality in talking about their feelings and older women see themselves as authorities on illness and suffering; all female groups demonstrate that their status as women implies that they have the right to provide forceful evaluations of their suffering, their treatments and the personnel who provide them. Younger men, in contrast, are more hesitant in expressing feelings and one possible explanation of this is because neither they nor older men were asked as frequently about their feelings during the interviews, indicating the extent to which gender discourse is partly constructed in interaction. Since emotional expression is considered by some authorities to be potentially therapeutic for people experiencing illness this would suggest that there should be equal encouragement for this.

6
Experience of Support: Gender, Class and Age

6.1 Research on support

In many of the excerpts we have examined in previous chapters we have inferred the potential importance of support for people experiencing illness. They are not able to lead their lives as they had previously so may need assistance with material considerations arising from a physical inability or from the pain experienced in doing tasks; or they may need psychological and emotional support in dealing with the impact of illness. Illness may affect their level of self-confidence, their mood, the extent to which they are able to engage in satisfying social relationships or in hobbies and activities that previously brought them pleasure. Increasingly, the world of people with illness may appear to be contracting as social contacts become more restricted, physical mobility becomes reduced or volition declines. Physical illnesses are likely to impact more on their physical mobility, whereas mental conditions may influence their psychological disposition towards social interaction. The boundary between the physical and mental is never watertight and there is likely to be leakage in that physical illnesses can have psycho-emotional effects just as mental illnesses can affect physical health since the person may take less exercise, have a less healthy diet or rely more on alcohol. In this chapter we make support the primary topic of interest by exploring how women and men from different age and SEC backgrounds talk about the support they received or did not receive while experiencing illness.

Research has identified some important differences between men and women in their perceived need for support. We discussed in Chapter 1 literature indicating that masculine socialisation may contribute to the reluctance of men to seek health support. They may be constrained

from so doing by varying degrees of influence from a conventional masculinity which evaluates help-seeking as not fully commensurate with being a real man (Addis and Mahalik, 2003; O'Brien, Hunt and Hart, 2005). Levels of suffering among men may need to be high in order to warrant help-seeking in the face of masculine stoicism. This has been traced to a socialisation of boys and young men that emphasises self-reliance, independence, physical and mental strength and bravery in the face of adversity. Stereotypical masculinity views pain as something that a man needs to deal with by himself since help-seeking is inherently feminine, suggesting a relationship of dependency on a stronger and more self-sufficient other. Traditional masculine attitudes towards risk also encourage men to demonstrate risk-taking behaviours (e.g. high-risk sports) and a lack of concern about their health may be one of these. As Connell (1995: 51) points out in a discussion of sex role theory:

> One of the few compelling things that male role literature and Books About Men did was to catalogue Problems with Male Bodies, from impotence and ageing to occupational health hazards, violent injury, loss of sporting prowess and early death. Warning: the male sex role may be dangerous to your health.

Social roles that encourage a reluctance to disclose physical pain for boys inevitably have consequences for adult men; Jean Bonhomme, president of the National Black Men's Health Network said: 'when a boy at age 8 scrapes his knee, he's told "big boys don't cry" ... That teaches him not to listen to what his body is telling him. What's going to happen when that boy is 50 years old and having chest pain?'[1]. From the perspective of social constructionism, Courtenay (2000) argues that American men typically construct their masculinity by displaying a lack of concern with their health and engaging in risk-taking behaviours as this facilitates their construction of themselves as the 'stronger sex'; however, he also acknowledges that some men reject these social prescriptions of masculinity.

There is also some evidence of variation between types of illness condition in relation to help-seeking. Mental health challenges conventional masculinity because it leads to behaviour perceived as feminine such as crying, or other displays of neediness; it may therefore

[1] Navy & Marine Corps Medical News, 26 May 2000.

be less acceptable under traditional masculinity for a man to seek help for a mental health condition than for a sexual health problem that impedes his ability to perform sexually (O'Brien, Hunt and Hart, 2005). Women's experience of pregnancy, childbirth and caring for sick children has made it more acceptable for them to seek medical help both for their own conditions and those of their family.

A great deal of literature exists to indicate the value of support for people experiencing illness that it is not possible to review in detail here. One of the strands of this research concerns where people go to seek support. Various sources of support exist and these range from formal and institutional sources of support such as medical professionals – doctors, nurses, specialists, providers of therapy, physiotherapy and so on – through intermediary sources of support such as support groups (face to face or computer mediated), to less formal sources of support comprised of family or friends. Studies of support groups can either be on particular illnesses (often cancer, e.g. Docherty, 2004) or compare the use of support groups by people experiencing different illnesses (Davison, Pennebaker and Dickerson, 2000). Most studies are interested in identifying the functions of support groups; for example, Cella and Yellen (1993) found that cancer support groups provide advice on practical information, on the 'normal' progression of illness as well as emotional support and a sense of social solidarity. Another traditional source of support, the family, can itself be a broad category comprised of very close relations such as husband, wife or partner, or inter-generational family such as parents, or children, through to more distant family ties of aunts, cousins, grandparents and so on. Similarly, friends can range from life-long friendships, through close relations with neighbours, to looser relationships, for example, with work colleagues, members of the same club, school or other institution.

Married men tend to disclose information regarding their medical symptoms and treatment options with their wives, rather than rely on a wide social network. In general there is evidence that women draw on a wider range of social networks – for example, research has shown that men rely on female partners and other women to whom they are close who persuade them to obtain support (Norcross, Ramirez and Palinkas, 1996; Seymour-Smith, Wetherell and Phoenix, 2002; Tudiver and Talbot, 1999; Umberson, 1992; White and Johnson, 2000 all cited in O'Brien, Hunt and Hart, 2005). Women draw on wide informal social and family networks when ill, whereas men deal with things on their own more, perhaps with the support of their wives (when they have them), or in collaboration with doctors. Harrison, Maguire and

Pitceathly (1995) show that women with breast cancer are more likely to confide in several people, while men with prostate cancer tend to confide in just one other person (usually their marital partner). Indeed, it seems that often wives place pressure on men experiencing symptoms to seek medical assistance – which raises the question of where the increasing number of men who are living alone go to seek support when experiencing health problems that may themselves be aggravated by divorce, separation or relationship termination?

There may also be gender differences in the type of support sought by men and women. In a secondary analysis of qualitative interviews with 97 people with cancer interviewed for the Healthtalkonline project (45 breast cancer; 52 prostate cancer) and of archived postings to the online forums/message boards of the two most popular UK-based breast and prostate cancer web sites, Seale, Charteris-Black and Ziebland (2006) showed that women's concerns orient much more towards the exchange of emotional support, including concern with a wider range of people. Men's interests were more in obtaining information on symptoms, treatments, medications and prognoses rather than on obtaining emotional support. Similarly, Kiss and Meryn's (2001) review of studies comparing these two cancers shows that men with prostate cancer have been consistently shown to be less likely to attend support groups or to take up opportunities to share feelings with others, preferring an informational content in their communications.

The interaction of gender with age is also important as regards men and women's efforts to obtain support and many sociological and social-psychological studies describe gender differences amongst older people in their capacity to maintain supportive social networks. Differences in the social networks of older men and women have been construed as conferring a relative advantage on older women, who have been shown to have wider social and support networks than older men (Arber and Ginn, 2005; Arber, Andersson and Hoff, 2007; Russell, 2007). By implication, older men are disadvantaged and deficient in this respect, especially if the protective effect of a female partner to make social arrangements and maintain supportive kin and friendship networks is absent (Arber, 2004). This finding is associated with a rethinking of an earlier perspective that constituted older men as a 'privileged gerontocracy' (Applegate, 1997: 4) because of their economic advantages and greater likelihood of being married or partnered until the time of death. The consequences of these patterns of advantage and disadvantage are particularly felt with ageing, as illness and disability develop.

Allan (2005), for example, reports that women are better at making new friends in later life. Chappell (1989) shows that older women have more expressive and supportive bonds and intimate contact with others, whereas older men are highly dependent on their wives for such things. Barnes and Parry (2004) found older women's friendships to be more intense, affective, reciprocal and mutually supportive than men's, who were more dependent on partners and, in some cases, children for these things. Jerrome (1993) found older men's friendships to be sociable rather than intimate, involving less self-disclosure than older women's friendships. Wenger et al. (1996) found older men on loss of a spouse were more likely to feel lonely, isolated and depressed than older women in the same situation. Perren, Arber and Davidson (2003) found low levels of membership of informal groups by divorced or never-married men. These have contributed to a 'deficit' view of older men, who are less likely to be able to draw on wider sources of informal social support if this is unavailable from an immediate family member. However, Seale and Charteris-Black (2008b) found that older men with cancer demonstrate a greater involvement with medicine as an expert system than younger people or women of the same age. This stems from their social confidence when interacting with doctors and their interest in treating their illness as a 'problem' to be fixed with medico-scientific solutions – a characteristic we have associated in Chapter 3 with a general reliance on reification in men's traditional discourse.

In this chapter we seek to gain insight into support for people experiencing illness by asking a range of questions for which keyword and key concept analysis might provide insight. First, we want to know whether there is any evidence for gender, class or age differences in the experience of support when experiencing illness. Second, we ask whether there is evidence for gender, class or age differences in the sources of support. Third, we ask whether there are gender, class or age differences in the mode of communication (e.g. speech or writing) that is preferred when experiencing illness.

We are not in a position to identify direct evidence to establish how far support strategies were successful, since this would require longitudinal data; however, where views are expressed on successful support-seeking strategies we report on these.

6.2 The experience of support

6.2.1 Overview

There were difficulties in establishing direct evidence of how men and women in this study experienced support because it is likely that

those who were interviewed for the Healthtalkonline project – which is intended to support those experiencing illness – will themselves have an interest in support since they have volunteered to be providers of support by transmitting their experiences of – among other aspects of illness – the support they received. There was a lack of keywords and key concepts that corresponded directly with experience of support other than words derived from 'support' and closely related terms such as 'care'. There were also some key concepts identified by Wmatrix analysis that could be related to the social dimension of support because they referred to human categories – for example, 'People: Male' and 'Belonging to a Group' were key concepts for men and 'Kin' was a key concept for women (see Appendices 1 and 2). There were also key concepts that could be related to modes of communication during illness – such as 'Talk' which was a key concept for women.

A corpus-based approach that we employed was to explore the collocations for various nouns and verbs from lexis that is semantically related to the concept of 'support' that we will refer to as 'support-related lexis'; we investigated all morphological variations of the lemmas given in Table 6.1.

The table shows that there is only a small statistically significant difference between genders in the extent to which they use support-related lexis in describing their experiences of support. For individual lemmas contributing to the total, there are none which reach statistical significance. For example, the frequency ranking of the support lexicon 'help', 'care', 'support' and 'cope' is the same for each gender. The high overall frequency is perhaps not surprising since one of the purposes of the interviews was to elicit their experience of support. Interviewers were

Table 6.1 Comparison by gender of support-related lexis in the full matched sample (men compared with women) (tokens per 10,000 words)

	Men	Women	Gender comparison (p <)
Help*	14.93	15.90	n.s
Care*	10.06	11.13	n.s.
Support*	5.81	6.24	n.s.
Cope*	3.65	3.31	n.s.
Support group	1.26	1.13	n.s.
Total	35.71	37.71	.05

Note: *indicates all lemmas; for example, 'help'* includes: 'helpful', 'helped', 'helps', 'helping', 'helpless' and 'self-help'.

provided with a handbook giving them instruction on the procedures and the content of the interview; this included questions to elicit data on the experience of, and sources of, support such as:

> What sort of support have you had from family and friends?
> Have you had to support them? How?
> When you discovered you had..., what information were you given?
> Who gave you the information? Was it enough?
>
> Staff: what do you think of the people who have cared for you? Have they been supportive? Have they given you enough information?
>
> (Healthtalkonline interview guide)

Interviewees could have chosen to discuss support in varying degrees of detail according to gender, whereas in fact they did not – so we can infer that the concept of 'support' was equally important to people experiencing illness irrespective of their sex, at least in these interviews.

People experiencing illness employ the verb 'cope' when referring to psychological or physical efforts in overcoming difficulties relating to illness, so interviewees evaluate how far they are able to 'cope' with their illness; however, there is no particular difference between genders either in the frequency with which they use this verb or the sort of physical tasks they refer to; for example, in the following extract a male and a female speaker both refer to tasks related to their need for a car:

> It's the lack of energy that is the hardest thing *to cope with*, for me anyway, because I was always quite a fit bloke, I'm used to doing all my own DIY and my own gardening and things. And of course you, what you do feel is pretty useless because even a job like cleaning the car is beyond me now. If I clean the car it takes me nearly two hours to clean the car. So that is the hardest thing of the illness I think is the uselessness of it because the body still wants to do it and the mind still wants to do it but I *just can't cope with it.* (LC18, male, 55, lung cancer, engineer welder)
>
> So I do spend quite a lot of time when I'm selecting a car. So ideally when I, you know, I go out and think, 'oh I really like this car' and I get there and I can't, *I can't cope* with the, the handles are ridiculous. I can't open the doors. *I can't open the boot*. I can't reach the boot door when it's open. (RA14, female, 43, rheumatoid arthritis, part time HR consultant)

In both cases the speakers express some frustration through using a negative form of 'cope' and the first person pronoun is used to express

the living experience of this frustration with incapacity. However, within the broad notion of support some expressions were used differently by genders and these are discussed in the next section.

6.2.2 Gender specific use of support-related lexis

Very few phrases and collocations were found to be specific to particular groups (although in general the need for support was not); for example, a collocation that *only* occurred in the interviews with men was 'support mechanism':

N	Concordance
1	the family is the immediate, the most important *support mechanism* that everyone has [um] and to
2	[Um] With relationships, it's just another *support mechanism*, you know, someone to confide
3	I've realised how much I was missing that as a *support mechanism* to make me feel happier about
4	go to work at some stage and there was no other *support mechanism* because of.
5	I think it will partly depend on the sort of social *support mechanism* you've got around you.

Conceiving of support as a 'mechanism' seems to focus on the processes of support provision that is in keeping with the general orientation towards nominalisation and scientific and technical language in masculine discourse; there seems to be an underlying mechanistic metaphor for social processes. To explore nominalisation we decided to search the root form 'support' in a sample 200 lines from each corpus in the full matched sample to see whether there were differences between genders according to the part of speech used; the results are shown in Table 6.2.

Table 6.2 'Support' – comparison of parts of speech in the full matched sample (men compared with women)

	Men	Women	Gender comparison (p <)
Noun/compound noun	152	133	.05
Adjective	31	45	n.s.
Verb	17	22	n.s.
Total	200	200	

As anticipated from earlier patterns identified in Chapters 3 and 4, men used more nominal forms whereas women used more verbal and adjectival forms; the results for nouns were significant with men using more nouns than women ($p < 0.05$). Primarily 'support' was construed as a broad-ranging concept but with a principal sense of providing affective or emotional encouragement. Interviewees were asked about 'emotional support' and only men usually viewed it as positive; in over half of the lines in which women refer to 'emotional support' they are critical because of its deficiencies:

N	Concordance
1	a week who I thought would be my *emotional support*. She's a lovely lady
2	I don't feel that I get [pause 2secs] the *emotional support* from her that I thought
3	so at the moment I'm not getting the *emotional support* that I need, I know
4	to start with. I felt I didn't need sort of *emotional support* and that kind of thing
5	making sure everybody's got enough *emotional support*. Making sure
6	a specialist in cancer. There was no *emotional support* whatsoever, none at
7	mum. My mum is kind of, still the most *emotional support* person. [Um] But
8	Mmm. Mmm. My mum was the *emotional support*, and she was the one

Taking an expanded context for line 6:

> The aftercare wasn't particularly good. I mean the district nurse was lovely but she's not a specialist in cancer. *There was no emotional support whatsoever,* no support at all, but fortunately I am a strong person, maybe I wouldn't have needed, maybe that's why I didn't get it. (LD26, female, 75, living with the dying, orthoptist, colorectal cancer)

There are no instances of men criticising the emotional support they were given. Another woman also comments on the lack of need for 'emotional support':

> The Macmillan nurse has been very helpful which I was a bit reluctant about to start with. *I felt I didn't need sort of emotional support* and that

> kind of thing but she's extremely practical and gets, she's very nice, she's a sort of go-between who gets things done. (LD07, female, 82, living with the dying, captain in the war office, breast cancer)

This tendency of women to adopt a critical attitude in relation to institutional providers, with a stronger sense of their rights in relation to health care, is something that we noted in the analysis of 'system' in Chapter 3 and that we related to high SEC women in Chapter 5. Women are possibly therefore more likely to evaluate the quality of support whereas men generally view all support as positive, although the evidence we have adduced for this is suggestive rather than conclusive. However, an equivalent frequency of use of support-related lexis implies that there are few overall differences between the genders in their need for support.

6.2.3 Socio-economic classification (SEC)

Comparisons were made of the support-related lexis in the sample of interviews that controlled for the variable of class and the findings are shown in Table 6.3.

Comparisons were made for the influence of SEC for each of the words in the support-related lexicon and no significant differences occurred for any of the individual words when the two high SEC groups were compared with the two low SEC groups. Low SEC men and women tended to talk a little more about 'help' whereas high SEC men and women talked more about 'support' but this was not statistically significant. The overall finding was that the experience of being in need of 'help' when experiencing illness is only mildly associated with low SEC.

Table 6.3 Comparison of support-related lexis by social class (SEC) (tokens per 10,000 words)

	High SEC		**Low SEC**		**SEC comparison (1 + 2 compared with 3 + 4) (p <)**
	1 Men	**2 Women**	**3 Men**	**4 Women**	
Help	13.33	16.22	17.34	16.95	n.s.
Care	12.21	11.84	12.66	9.34	n.s.
Support	5.54	5.69	4.97	4.80	n.s.
Cope	3.09	2.62	2.61	3.36	n.s.
Total	34.17	36.37	37.58	37.81	n.s.

6.2.4 Age

A similar comparison was made by age and the results are shown in Table 6.4.

The findings for the effect of age were different primarily in relation to the use of the word 'support' which was used more by younger people than by older people ($p < 0.0001$), with younger men in particular using this word more frequently than other groups and older women using support-related lexis less frequently. For example, younger men referred to 'support' in the context of 'family' a total of 16 times and in the context of 'friends' 12 times, whereas older women only referred to 'support' in the context of 'family' twice and in the context of 'friends' 3 times. The following extract illustrates how younger men talk about 'support':

> But there are emotional spells, you have your ups and downs. You aim to control those but I am just so grateful that *I've a supportive family and supportive friends* who take a great interest in the problem itself and my progress ... If my *family and friends weren't so supportive* I think I would have taken advantage of the offer of counselling, but fortunately I feel that I've had counselling through *family and friends and their support*. And I think it wouldn't actually, it wouldn't hurt to seek the advice or approach somebody who is qualified in that field. (EP08, male, 26, epilepsy, temporary office administrator)

Table 6.4 Comparison of support-related lexis by age (tokens per 10,000 words)

	Older		**Younger**		**Age comparison (1 + 2 compared with 3 + 4) (p <)**
	1 Men	**2 Women**	**3 Men**	**4 Women**	
Help	16.23	15.92	18.00	15.13	n.s.
Care	20.43	11.44	15.92	16.14	n.s.
Support	6.18	3.53	8.29	5.91	.0001
Cope	4.65	2.19	3.08	4.23	n.s.
Total	47.49	33.08	45.29	41.41	.05
	80.57		86.7		

This indicates that the concept of 'support' is one that is especially valued by younger men and suggests that they do not comply with the traditional masculine reluctance to seek support in illness. This complements the findings in Chapter 5 that younger men were more emotionally expressive than older men. However, we did not find evidence for the deficit view of older men in relation to support that has characterised some of the literature we referred to in Section 6.1; indeed older men used 'support' and 'care' much more than older women ($p < .0001$).

Indeed perhaps what is most striking from Table 6.4 is that older men refer to 'care' far more frequently than do older women. Although this is part of a wider pattern since overall older women employ support-related lexis the least and are an outlying group – some particular expressions account for this. For example, older men refer to 'intensive care' around twice as frequently as older women – reflecting the higher preponderance of coronary heart conditions among older men. Older men also have a much higher use of the word 'carer' – using it over four times more frequently than older women. On closer examination this occurs because of the high frequency of 'carer' in particular interviews with older men – since the word is used in a similar overall number of interviews with older men and older women. We may infer from this that some older men find a new social identity as being a carer; although it is also a role that adds meaning to their lives, it is one for which they may also need support as expressed in the following:

> Setting their hair: that was a real trial for me when I achieved that. And in the case of a woman looking after a man, shaving him, coping with incontinence, with wandering, with aggressive behaviour, false accusations: 'You're not my husband.' And non-recognition, that's very hard one for any carer and it's very, very common in my experience. You get used to it in the end because you know the person doesn't know, but you'd be surprised that occasionally, and I came across this just recently at a carers' meeting, a chap who had once recently been recognised as who he was by his wife, and how touched he was; he cried at the meeting. (ALZ33, male, 78, carer of dementia, civil servant)

The concept of being a 'carer' strikes older men as worthy of comment perhaps because it is something that is relatively new in their experience, since previous caring for children may have been done primarily by their wife; this may explain why they talk about being a 'carer' more

than do older women. However, it is not an easy role to take on; the same speaker asks during the interview to recite a poem he has written about 'being a carer' that expresses both the demands that being a carer places on an older person and the need that he has felt for support in taking on this role:

> Oh to be a carer now the need has arose
> You're guaranteed a full time job
> With little scope for repose.
> Oh to be a carer in the middle of the night
> Your loved one shouts or has wandered off
> And you're full of anxious fright.
> Oh to be a carer desperately in need of a hug
> You take your loved one into your arms
> But the response is a puzzled shrug...
> Oh to be a carer when your patience is all but at an end
> You need someone else to talk to
> Ensure that you have such a friend.
>
> (ALZ33, male, 78, carer of dementia, civil servant)

Interestingly, the role of 'being a carer' seems to bring out for older men a range of characteristics related to support that are associated with traditional feminine roles; it is a discovery of a more 'feminine' identity including the experience of a strong sense of dependency on others – one that older men perhaps have not had the opportunity to develop when pursuing competitive careers in order to support families financially – that also accounts for their interest in 'being a carer'. This complements the findings in Chapter 5 that older men can be emotionally expressive through the use of hyperbole in adjectives such as 'tremendous'. This contrasts with the findings of research such as Barnes and Parry (2004) that found older women's friendships to be more intense and affective. In the following an older man talks about the need for a shoulder to cry on in a relationship of mutual support with other carers:

> And I think it's quite important that one does help each other, a shoulder to cry on, we're both, we understand each other. A carer can speak to another carer as well because they can understand. As I've said before, I think it's very good for a sufferer to speak to another carer and a carer to speak to another sufferer and get a greater idea. (EP04, male, 51, epilepsy, teaching assistant)

The concept of 'being a carer' seems to offer older men a new and acceptable social role for a set of activities that were previously assumed as necessarily part of a woman's role – however, with the separation of gender as a social construct from biological gender, there are clearly opportunities for a social role in which gender is unrelated to the human need for help and assistance. Younger men tend to experience themselves as the beneficiaries of support while older men identify with a social role as a provider of support – and this social role is validated by the concept of 'being a carer'.

6.3 Sources of support

In this section we explore the second question we asked at the end of Section 6.1 that concerns the influences of gender, class and age on sources of support. We will first consider key concepts indicating men's traditional sources of support, then key concepts for women's traditional sources of support, then we consider sources of support that are not associated with gender. Finally, we undertake an analysis of the collocation 'very supportive'.

6.3.1 Men's sources of support: 'People: Male' and 'Belonging to a Group'

Two concepts identified by Wmatrix as characterising men relate to non-family sources of support; they are 'People: Male' and 'Belonging to a Group'; these were also supported by keyword analysis that showed 'guy', 'man', 'mates', 'chap' and 'bloke' were keywords for men. Table 6.5 shows the findings for the lexis classified within the concept 'People: Male'.

There is a highly significant difference between the use of lexis in the semantic field of 'People: Male' ($p < 0.0001$) with men using this lexis nearly twice as frequently as women. In particular, men refer more to 'guy/guys', 'man/men', 'chap/chaps', 'lad/lads' and 'bloke' while women refer more to 'boys', 'boy', 'Mr' and 'male' with similar frequency. Based on her study of men's narratives, Coates (2004: 137) finds that

> ...men's stories depict a world where solitary men pit themselves against the other (this may be another man or it may be a machine or circumstances generally) while women's stories depict a world where people are enmeshed in relationships and are part of a wider community. This difference ties in with men's tendency to depict a world populated entirely by men, which contrasts with the mixed world of women's stories.

Table 6.5 Men's key concept 'People: Male' in the full matched sample (men compared with women)

	Men		Women		Gender comparison
Lexical items	**Tokens**	**Tokens per 10,000 words**	**Tokens**	**Tokens per 10,000 words**	**(p <)**
Man	178	18.6	124	11.7	.0001
Guy	141	14.8	56	5.2	.0001
Men	103	10.8	37	3.5	.0001
Boy	59	6.2	66	6.2	n.s.
Chap	59	6.2	29	2.7	.001
Guys	54	5.7	9	0.8	.0001
Mr	31	3.2	24	2.2	n.s.
Bloke	23	2.4	5	0.5	.001
Male	20	2.1	31	2.9	n.s.
Boys	16	1.7	48	4.5	.001
Gentleman	16	1.7	2	0.2	.001
Blokes	11	1.1	3	0.3	.05
Macho	11	1.1	4	0.4	.05
Chaps	8	0.8	4	0.4	n.s.
Lad	7	0.7	4	0.4	n.s.
Lads	6	0.8	2	0.2	n.s.
Total	743	77.9	448	42.1	.0001

Our data, while supporting the view that men's illness accounts depict a world that is peopled by men (as well as by their partner), do not indicate that men are necessarily enmeshed in competitive struggle with other men; indeed, the experience of illness seems to be one in which men often rely on the support of other men – who are not their family relations. Along with 'bloke', 'guy' is used as an affectionate term that implies some emotional proximity; in the following extract it clearly marks out the person's individuality more than his professional status:

> And then [um] my consultant who [uh], who [uh], the first time I ever met my consultant [uh] he was dressed in a, a black suit, a truly awful tie, I mean its, I can remember the ties, a terrible taste in ties, he's a *really nice guy* but he just really needs to, yeah I'll try and buy him some ties. But [uh], his ties are awful, he's a, *he's a funny guy*

and he did, he did find that very funny. (YPC09, male, 24, teenage cancer, pharmacologist)

I've had no bad experiences with my GP at all. *He's a nice guy.* (CP08, male, 53, chronic pain, horse breaker)

Similarly, 'chap' indicates an unnamed male source of support:

I have a very vivid memory of a friend of mine and his mistress coming to the hospital and he had, he produced this yellow rose and said '[name removed] I've brought, I've brought this rose, it's off one of the roses you planted for me.' I couldn't remember, I couldn't even remember where he lived. I recognised him, but I couldn't remember, I couldn't remember what his name was. And he was a *chap* who he'd worked with me as a gardening assistant for about two or three years ... (DP13, male, 69, depression, retired gardener)

One of the best websites that we got is a website called Bloch Cancer, blochcancer.org, it's an American site and it's run by *a chap* who is a multi millionaire and he set the site up to help people who were suffering from cancer. And this particular site has got every known form of cancer. (LC02, male, 53, lung cancer, company chairman)

Such uses imply that when a man is referred to as a 'chap', he is a non-intimate other – one who does not have a name but can nevertheless provide emotionally distant support. A similar type of distancing takes place in the use of the plural form 'mates' by younger men as in the following:

No, they've, the, the thing with *my mates* is that I've always told em if, if anything [er] actually happened with this, [um] if it did go for they'd just treat me as normal. And that's what they have done. (YPC16, male, 23, teenage cancer, law student)

[um] sort of the summer that I was diagnosed. So I started a new school and because one of the kids that went off to the other school, his parents worked at the school I'd just left so he knew, *then he told his mates, who started to tell my mates* so they already knew but they wondered why I'd not told them when I hadn't even thought of telling them because I was only just coming to terms with it myself. (YPC11, male, 18, teenage cancer, university student)

Although 'mates' implies a more intimate 'other' than 'chap' the generic use could be interpreted as a younger man's distancing strategy. This also occurs with other plural forms for potential male sources of support such as 'lads':

> And on the day of, during the second year of exams which were fairly important because you've got to pass those to get to the final part of two years, I crashed out in the dining hall. And *one of the lads* said to me at the end of the last exam, a law exam, we were walking down the steps, 'Well,' he said 'we were actually betting on whether you were gonna make it right the way through.' And they all knew about it. So my friends were aware that I had epilepsy. (EP34, male, 32, epilepsy, graphic designer)

Table 6.6 Men's key concept 'Belonging to a Group' in the full matched sample (men compared with women)

	Men		Women		Gender comparison
Lexical items	**Tokens (> 10)**	**Tokens per 10,000 words**	**Tokens**	**Tokens per 10,000 words**	**(p <)**
Group	307	3.22	305	2.88	n.s.
Together	198	2.07	227	2.13	n.s.
Unit	76	0.80	85	0.80	n.s.
Team	71	0.74	54	0.51	.05
Association	64	0.67	27	0.25	.0001
Society	67	0.70	40	0.38	.01
Groups	77	0.81	89	0.84	n.s.
Community	58	0.61	38	0.36	.01
Members	44	0.46	27	0.25	.05
Member	45	0.47	26	0.24	.01
Club	38	0.40	20	0.19	.05
Organisation	21	0.22	18	0.17	n.s.
Public	40	0.42	34	0.32	n.s.
Organisations	15	0.16	11	0.10	n.s.
Gather	15	0.16	14	0.13	n.s.
Joint	18	0.19	29	0.27	n.s.
Network	14	0.15	20	0.19	n.s.
Units	15	0.16	6	0.06	.05
Clubs	14	0.15	4	0.04	.01
Total	1,197	12.56	1,074	10.11	.0001

As with 'mates' the use of 'lads' can imply a sense of belonging to a group rather than an individual source of support. The use of such generic terms to refer to unspecified people brings us to the other key concept for men identified by Wmatrix: 'Belonging to a Group'.

Keyword analysis showed that the following words were keywords for men: 'association', 'club' and 'sufferers'– the first two of these were also identified by Wmatrix under the key concept 'Belonging to a Group'; Table 6.6 shows the findings for this concept.

The lexis identified by Wmatrix as relating to the concept 'Belonging to a Group' was used significantly more by men ($p < 0.0001$). One finding for this concept is that the social world of men appears to be more institutional: men refer to 'club' or 'clubs' 52 times – these were generally sports clubs including football, cricket, golf, rugby, sub-aqua and tennis. In contrast, women only use 'club' or 'clubs' 24 times and quite a few of these are in reference to clubs to which family members belong; the only sports that are explicitly mentioned in relation to themselves are 'golf' and 'health'. Evidence of a more group-oriented sociability among men is in the use of 'association' which they use more than twice as frequently. Four different men referred to the 'Ileostomy Association'. This also fits a more general pattern in which men tend to see themselves as part of a wider community of 'sufferers'; men use 'community' much more than women and the collocation 'other sufferers' does not occur at all in the woman corpus, but is quite common in the men's corpus:

N	Concordance
1	to look up things and perhaps chat to *other sufferers* and things on the chat
2	to turn to, whether it's friends or *other sufferers* or specialists. Their initial
3	to me and it happens to many *other sufferers*, especially with temporal
4	this has happened. I know there are *other sufferers* who have been greatly
5	do find that in certain, I'm not as bad as *other sufferers*, but I do find that there
6	going through. But also carers to talk to *other sufferers*, to realise that perhaps
7	I think its therefore carers speaking to *other sufferers* will help. It doesn't mean
8	I think its also helpful for carers to meet *other sufferers* so that they know that the

What this suggests is that although both men and women rely primarily on their partners for support (when they have them), men have a more abstract notion of themselves as belonging to a broader and intangible community of 'sufferers' for which various institutional forms of support are available, whereas women are more concerned with seeking direct personal forms of support either from family members or from specialists. Arguably, this is in part a product of the method by which the Healthtalkonline organisation finds people to interview. Men involved in support organisations may be more likely to be contacted by Healthtalkonline. Men not so involved may be missed out of the networks to which Healthtalkonline researchers have access. In relation to women, on the other hand, Healthtalkonline networks for contacting potential interviewees may be more informal.

6.3.2 Women's sources of support: 'Kin' and 'family'

6.3.2.1 Analysis of family

Keyword analysis showed a semantically related group of keywords for women relating to the family including 'husband', 'mum', 'children', 'daughter', 'mother', 'sister' and 'son'. We can see in Appendix 2 that 'Kin' was a concept identified by Wmatrix as characterising women's language. The only 'family' keywords in this semantic field for men were 'wife' and 'daddy'. The findings for words that occurred more than 30 times in the female corpus under the concept 'Kin' are shown in Table 6.7.

Women experiencing illness use a word in this semantic field approximately 30 per cent more frequently than men experiencing illness; this is highly significant ($p < 0.0001$). All the 20 words listed under the concept of 'Kin' are used significantly more frequently by women except 'wife', 'family', 'parents', 'dad', 'father', 'brother', 'married' and 'relatives'. The following words are used more than twice as frequently by women: 'mum', 'daughter', 'son', 'sisters', 'daughters', 'mothers', 'parent' and 'sons' indicating that women use words for closer family relations much more frequently than men.

A particular collocation for women is as follows:

N	Concordance
1	1:01:07:20 I [um] I'd normally *talk to my mum*. [um] I think [ah] they
2	had had sex or not asked me if I would *talk to my mum* about it. And I sort of
3	back to any of them. No, they tried to *talk to my mum*. And, but and my mum

4 I went with my mum and they looked to *talk to my mum* and not me. And they
5 mum. I'm quite close to my mum and I *talk to my mum* a lot. And my daughter.
6 something wrong with me. But I tried to *talk to my mum* about it. She didn't

N Concordance

1 [Tuts]. [Em] my-my I generally sort for *talked to my mum* and then my mum got
2 to make me feel any better. So. [Um] I *talked to my mum*, and nurses.
3 me, or about the treatment, he always *talked to my mum*, or he took my mum

Table 6.7 Women's key concept 'Kin' in the full matched sample (women compared with men)

	Men		Women		Gender comparison
Lexical items	**Tokens**	**Tokens per 10,000 words**	**Tokens (> 30)**	**Tokens per 10,000 words**	**(p <)**
Husband	45	0.47	806	7.58	.0001
Wife	786	8.24	41	0.38	.0001
Family	584	6.12	684	6.43	n.s.
Mum	226	2.37	547	5.14	.0001
Mother	201	2.11	375	3.53	.0001
Daughter	130	1.36	308	2.90	.0001
Son	107	1.12	297	2.79	.0001
Sister	159	1.67	280	2.63	.0001
Parents	220	2.31	236	2.22	n.s.
Dad	119	1.25	141	1.33	n.s.
Father	133	1.39	140	1.32	n.s.
Sisters	16	0.17	91	0.86	.0001
Brother	73	0.76	88	0.83	n.s.
Wed	0	–	78	0.73	.0001
Married	64	0.67	60	0.56	n.s.
Daughters	14	0.15	48	0.45	.0001
Mothers	10	0.10	47	0.44	.0001
Parent	16	0.17	37	0.35	.05
Relatives	34	0.36	36	0.34	n.s.
Sons	12	0.12	32	0.30	.01
Total	2,949	30.91	4,372	39.79	.0001

The only line showing this collocation in the male corpus was the following:

N	Concordance
1	suppose. And I think, I left the doctor to *talk to my mum* in the living room and

Women view their 'mum' as a confidant, while men think of their parents as a single entity – 'mum and dad' occurs 22 times in the male corpus whereas in the larger female corpus it only occurs 13 times (not statistically significant). Sisters are also an important source of support for women. Consider the following lines:

N	Concordance
1	but my mum. I was even funny about *talking to my sister* or my dad, and it, it
2	to talk to. See I could always *talk to my sisters* [um] but I think for
3	I should ask, I don't know. I think she's *talked to my sister* about it They have

N	Concordance
1	around here and I'm thinking 'oh' and I'd *said to my sister* call home because the
2	know. You know, how would I know. I've *said to my sister* I do get out of breath
3	word I remember is the word 'me'. And I *said to my sister*, not the one directly
4	here, it's kind of like seaweed. And I *said to my sister* 'Can you smell that

There is only a single instance of the verbs 'say' or 'talk' to my sister in the male corpus:

N	Concordance
1	phoned me at work and at that stage I *talked to my sister* on the phone and just

While there was no significant difference between how often men and women referred to 'family', there were differences in some compound forms: men referred much more frequently to their 'family doctor' – 15 times as compared with only 3 times by women ($p < 0.01$) – indicating

that the concept of a 'family doctor' is more important to men as in the following:

> But the fact that *my doctor, my only family doctor* and the consultant from the hospital with whom I became very friendly, and still am, I like to think certainly aided my recuperation. (HF01, male, 65, heart failure, butcher)

Here the fact that the doctor has an association with the whole family is indicated by repetition of the compound form. Men used the expression 'family members' ten times whereas it was only mentioned twice by women ($p < 0.01$). One explanation might be that, as we have noted in Chapter 3, men have a greater tendency to use abstractions and to generalise as a way of avoiding; it could therefore be interpreted as further evidence of men's discourse of distancing and avoidance. Overall, corpus and key concept analysis shows strong evidence of women's greater reliance on the family as a source of support.

Table 6.8 shows the findings for references to 'family' by SEC and age. This indicates that there were significant effects of age and SEC, with younger people referring to 'family' more than older people ($p < 0.05$), but the most pronounced effect was that of SEC with low SEC groups referring to 'family' much more than the high SEC groups ($p < 0.0001$). The two low SEC groups refer to 'family' 7.9 times per 10,000 words while the high SEC groups only refer to 'family' 4.4 times per 10,000 words. This indicates that the SEC variable is more important than either age or gender in relation to the family as a source of support.

Table 6.8 Comparison of references to 'family' by SEC, gender and age (tokens per 10,000 words)

	High SEC		**Low SEC**		**SEC comparison (1 + 2 compared with 3 + 4)**
	1 Men	**2 Women**	**3 Men**	**4 Women**	
Family	4.09	4.81	7.64	8.03	$p < .0001$
	Older		**Younger**		**Age comparison (1 + 2 compared with 3 + 4)**
	1 Men	**2 Women**	**3 Men**	**4 Women**	
Family	6.64	4.19	7.10	6.37	$p < .05$

While the overall effect of age was only at a low level of significance ($p < 0.05$), younger women talked more about the family than older women ($p < 0.01$); however, there was no significant difference between younger and older men. This is a reminder of the fact that a focus on gender should not divert attention away from other social variables whose relationship with the language of illness may be as important.

6.3.2.2 Analysis of non-family

The evidence of lexical frequency indicates that men rely more on non-family sources of support such as other men or groups and clubs; in this section we examine other non-family related lexis.

First, we consider the use of 'friend'/'mate' (combined) by SEC and age as shown in Table 6.9.

There were no significant overall differences in the use of 'friend' and 'mate' according to SEC; however, within genders, there was a difference with high SEC men more likely to refer to 'friends' or 'mates' more than low SEC men ($p < 0.05$). There is some evidence that low SEC men have more support from the family and this finding suggests that high SEC men have more support from friends and social networks; this would fit with their greater geographical mobility and the increased likelihood of their living further away from family members. There was also a small difference according to age with older people referring to

Table 6.9 Comparison of reference to 'friend/mate' by SEC, gender and age (tokens per 10,000 words)

	High SEC		**Low SEC**		**SEC comparison (1 + 2 compared with 3 + 4) (p <)**
	1 Men	**2 Women**	**3 Men**	**4 Women**	
Friend/s Mate/s	9.31	7.79	7.18	8.88	n.s.
	Older		**Younger**		**Age comparison (1 + 2 compared with 3 + 4)**
	1 Men	**2 Women**	**3 Men**	**4 Women**	
Friend/s Mate/s	8.83	8.58	6.20	8.59	< .05

'friends' or 'mates' more than younger people ($p < 0.05$); however, this was primarily because older men refer to 'friends' significantly more than younger men ($p < 0.01$) while older and younger women refer to 'friends' with similar frequency; this may be because younger men lack some of the social capital of high SEC men.

6.4 Modes of communication

A number of previous studies have identified reported speech as characterising female language use; Tannen (1989) argued that the reporting of dialogue was one aspect through which women added more detail to their language and Johnstone (1990 and 1993) found women reported more dialogue than males and also talked more about the act of speaking. In a study of 11 hours of mixed-gender informal conversations, Harrington (2008) found females used 50 per cent more reported speech than males in both groups of 2 and 3 interactants.

Keyword analysis indicated that 'talk' and 'phone' were keywords for women and Wmatrix identified a key concept for women: 'Speech: Communicative'. In this section we explore the preferred mode of communication in relation to the variables of gender, SEC and age. We chose to analyse 'talk', 'phone', 'write' and indicators of the reporting of communication. Table 6.10 shows the findings for all forms of these lemmas by gender, SEC and age.

Table 6.10 Comparison of communication verbs by gender, SEC and age (tokens per 10,000 words)

Comparison by gender in full matched sample

	Men	**Women**	**Gender comparison (p <)**
Talk*	1,322	1,626	.01
Phone*	306	491	.0001
Write*	134	319	.0001
He said/ she said	867	1,430	.0001
Quotation marks	1,529	1,967	.0001

Note: *indicates all lemmas, for example, 'talk'; 'talked'; 'talking' and so on.

Continued

Table 6.10 Continued

Class matched sample

	High SEC		Low SEC		SEC comparison (1 + 2 compared with 3 + 4) (p <)
	1 Men	2 Women	3 Men	4 Women	
Talk*	12.95	15.71	12.71	14.03	n.s.
Phone*	3.05	3.56	2.51	6.42	.001
Write*	1.08	2.69	1.00	1.77	n.s.
He said/ she said	9.12	14.06	9.55	21.22	.0001
Quotation marks	16.24	17.00	22.41	29.94	.0001

Note: *indicates all lemmas.

Age matched sample

	Older		Younger		Comparison by age (1 + 2 compared with 3 + 4) (p <)
	1 Men	2 Women	3 Men	4 Women	
Talk*	12.88	12.60	11.23	12.96	n.s.
Phone*	3.27	2.93	2.60	2.73	n.s.
Write*	3.01	3.08	0.76	2.18	.0001
He said/ she said	10.67	14.43	3.89	6.76	.0001
Quotation marks	7.30	18.71	10.84	14.71	n.s.

Note: *indicates all lemmas.

The first section of the table shows that overall women use verbs related to communication more than men ($p < 0.0001$) with the exception of 'talk' and its variations which was used with a similar frequency. Effectively this supports the findings of Wmatrix for the women's key concept 'Speech: Communicative'. However, in the following sections we will explore the interaction of gender with the variables of SEC and age for each of the individual verbs that we examined from this semantic area.

6.4.1 Use of 'talk'

The importance of talk for people experiencing illness is indicated by the high frequency of this word for all groups; like 'support', it was a topic on which interviewers explicitly sought to elicit information; however, there is no statistical difference in the frequency of 'talk' on the basis of SEC or age. Talking is generally considered beneficial by the majority of people experiencing illness. The following speaker gauges his evaluation of health professionals with reference to how freely and for how long they are prepared to talk with patients – noting considerable variation between them in this respect:

> ...and it's a matter of having this nurse with us. She's a lung cancer nurse and she's, she *can talk* to us all, she's the sort of nurse that you *can go and talk to* and she's *got time to talk* to you, that's what I like. And you know up until I met this nurse none of the other nurses had got time. It seems as if they'd got a set *time to talk to you* and once that time was up that was it finished. But *she hasn't got a time limit when you talk to her.* It's the same with the GP, the GP that I'm under when we visit our GP I think our time limit is five minutes when we visit the GP and if you want *to talk to him* about anything extra we have to book a double appointment for ten minutes *of talking to him.* And that's our GP that is. And it happens with all the family that does. So really you can't go down and *hold a conversation* with the GP for any length of time because he's got his limits there like you know. (LC27, male, 66, lung cancer, excavator driver)

Measuring the amount of 'talk' implies that for some people it constitutes a type of social capital through which identities are construed and perspectives on illness worked through although duration is also a measure by which many professional groups such as lawyers charge for their work. In the case of illness this may be particularly problematic as the nature of the condition may imply timelessness – the experiential nature of changed physical and mental states being subjectively immeasurable. However, 'talk' with professionals seems more valued than talk with unqualified others as in support groups; for example, when we look for 'support group' within a 5-word distance either side of 'talk' there are only 4 lines in the 200 interviews and one of these is critical of support groups:

> Yeah I don't, I don't think, well it's not for me. I don't know I'm sure support groups work for other people but [um] on the other hand if

> they need a support group to talk to people in similar situations it means they're not talking to the people who they really need to talk to. And therefore I, I, it doesn't work for me. The people these people need to talk to first and foremost are the people who love them and the people who are on their side and the people that, who may be fearful for them. And to talk this thing in the open. And people go around taking, 'Oh the Big C'. Its cancer. (LD14, male, 59, living with dying, actor, prostate cancer)

Views on talking vary according to the illness condition. For mental illness 'talk' is seen as a crucial part of the therapy:

> ... in my case it was a relief being able to talk about things that I'd never never been able to talk about to anybody else. And I think that the fact that I didn't know this person and was never going to meet them again as long as I live, it didn't matter that they knew the things that I was going to say. [um] And it wouldn't matter, it wouldn't ... make any difference to them because they don't know me from Adam. But I think in a sense it's a relief that you can talk about something that is really ... you don't realise that that is what has caused everything. But you, when you talk about it and divulge [um] things, it ... you suddenly get this kind of relief and you don't always know exactly what it is when you first start. And it's only through regular therapy sessions that you suddenly find yourself talking about things that you never ever expected you were going to talk about. (DP27, female, 43, depression, part time carer)

As well as varying according to illness, one speaker notes that the desire to talk about an illness condition is something that varies considerably between individuals; this point is made by one interviewee:

> Well it all depends on the person doesn't it in that, it's very obvious I'm one of those people I'm willing to talk about the illness [er]. I was going to say I want to talk about it, I don't know that I do but it does play a big part in my life obviously nowadays. [um] Other people want to keep these things to themselves, they don't want to talk about it. I would say if you want to talk about it and you don't have family, well do the next best thing, look to support from your friends, that's what you have to do don't you. My experience is that [er], certainly when you're ill, people are very kind. (LD21,

male, 66, living with dying, head of ship hydrodynamics research, oesophageal cancer)

This excerpt reveals that the high frequency of a particular lexeme such as 'talk' is not in itself indicative of the importance of the concept to the speaker: while corpora only provide positive evidence of a phenomenon, high use of a word may simply be in response to a prompt or to contest an established point of view – hence the need for subsequent qualitative analysis.

6.4.2 Use of 'phone'

Table 6.10 shows that women spoke about 'phoning' more than men ($p < 0.0001$), but within this there were interesting variations between groups according to SEC and age regarding modes of communication. While there was no significant difference overall between high and low SEC samples, low SEC women discussed 'phoning' much more than other groups (including low SEC men). We might have anticipated a preference for phoning as arising from gender alone – however, there is an interaction between gender and SEC since low SEC women talk about 'phoning' around two and a half times more frequently than low SEC men and nearly twice as frequently as high SEC groups. However, high SEC women do not talk about phoning significantly more than high SEC men. For some low SEC women phoning is seen as a life or death matter:

> And, that was what it took for me to pick up the phone and phone my counsellor. She'd given me her number, she said to me I could call at any time, day or night. She'd never made it an issue, [um], she said, you know, 'If you ever need me you phone me.' And I always thought, yeah yeah, whatever, you give me your business card and you know brush this to one side and but I thought, I've got no-one else to phone, I have to phone her because she'd be so upset because she's put so much into me, she'd be so upset with me if I did this. So I picked up the phone and I phoned her, she was on the other end of the phone, and I sat on the phone to her for two hours crying my eyes out. And told her the situation, told her what a mess I was in, and she begged me not to do what I had planned on doing. (DP15, female, 24, depression)

It seems that phoning is especially beneficial for low SEC women as the feeling of being in contact with another individual – without necessarily

any pre-arranged meeting, as, say, for a cup of coffee – helps them deal with feelings of loneliness or isolation that may arise unexpectedly and without warning when they are faced with the emotional response to the diagnosis of a serious illness:

> ... and she said to me 'if you want to talk, I'm on the phone' she said 'you will bore your family to tears, but if you want to talk, phone, because I've been through it, I know, I'm the one to talk to, not them' and I can't, I must say that's the best thing that was ever said to me, and I've known several ladies since, in my classes, obviously they've all, we've discovered they've got cancer and I've always said to them 'I'm on the end of the phone, I've been through it, I'm okay, I'm still here, phone me and we'll talk', and I've had some wonderful conversations, it's fantastic, it's good to talk. (LD41, female, 58, living with dying, fitness instructor, ovarian cancer)

It is perhaps part of the mindset of these speakers that they see themselves as being at the centre of a social world mediated through the phone. However, this may conceal – or even be a reaction to – their exclusion from centres of material power such as the workplace.

6.4.3 Use of reported speech

Our findings show both that women used more reported speech than men, that in particular low SEC people reported more speech than high SEC people and that older people reported more of their conversations than younger people (see Table 6.10). Because of the very high frequency of the reporting verb 'said', it is best explored through analysing the most frequently occurring three-word clusters; those that occurred most frequently are as follows:

	Men	
Clusters	**Tokens**	**Tokens per 10,000 words**
1 And he said	203	2.13
2 As I said	195	2.04
3 And I said	188	1.97
4 Said to me	129	1.35
5 And she said	105	1.10

	Women	
Clusters	**Tokens**	**Tokens per 10,000 words**
1 And I said	409	3.85
2 As he said	353	3.32
3 And she said	222	2.09
4 Said to me	215	2.02
5 I said I	147	1.38
6 I said to	135	1.27
7 As I said	124	1.17

These clusters indicate that while both genders report what the speakers themselves said the most frequently, men report conversations with men nearly twice as frequently as they report conversations with women and women also report conversations with men more than one and half times more frequently than they do conversations with other women. For both genders, then, conversations with men are reported more frequently by people experiencing illnesses than are conversations with women. Women also report their own words over twice as frequently as men; for example, 'and I said' is the most frequent cluster for women occurring nearly four times per 10,000 words, whereas for men 'and I said' occurs only around twice per 10,000 words ($p < 0.0001$).

Low SEC people report conversations much more frequently that high SEC people who, as we shall see, talk much more about writing. This indicates a difference in involvement in oral culture. Low SEC women report conversations more than other groups ($p < 0.0001$) as indicated by their greater use of both quotation marks and the collocations 'he said' and 'she said'; this shows an especially strong interaction of gender with SEC. Here are some examples of the collocation 'she said' followed by quotation marks from low SEC women:

N	**Concordance**
1	day and I asked her what she had and *she said* 'It's actually, it's not all that
2	I'd been for tests and everything and *she said* 'Nothing will show up. They'll all
3	will show up. They'll all be clear.' *She said* 'I can guarantee they will be.'

4 isn't there. Although the pain is real, *she said*, it's the only way I can describe
5 nothing wrong, go away' and so on and *she said* 'No, I'm not here for that
6 since changed her medication. So *she said* to me 'Don't take it just before
7 apart from the constipation. [um] But *she said* 'Don't worry, if that doesn't
8 my back was really bad you know and *she said* she saw, my friend saw a lady,
9 I know that sounds a bit silly, but *she said* basically, when she lays down
10 me whether it was benign or not and *she said* 'Oh they can probably tell if it's

However, there was also an influence of age with the older groups reporting conversations with the expression 'he said' or 'she said' more than the younger groups ($p < 0.0001$).

6.4.4 Use of 'write'

Examination of a keyword for women – 'write' – shows that writing is a central mode of communication that leads to a view of illness experience as purposeful and the response to illness as requiring self-reflection, introspection and imaginative response. 'Write' occurs 3 times per 10,000 words in the women's interviews but only 1.4 times per 10,000 words in the men's interviews ($p < 0.0001$). When examining the effect of social variables we find that the most important one is age, with older men referring to writing as often as older women and nearly three times more frequently than other groups – here we find that a feature that might at first appear to be accounted for by gender is better explained with reference also to the age variable. Writing requires a degree of introspection in order to formulate thoughts into syntactically organised phrases with appropriate lexical choices that convey a 'meaning' that corresponds with the writer's thoughts. In fact writing seems to be central in a transformational response to illness.

The type of texts that women describe themselves as writing include letters – to family members, to medical professionals and to the local press; poems; short stories; novels; and a 'reflective diary'. These may broadly be described as expressive rather than functional texts (even though letters of complaint may, for example, be combining both purposes). Older men also claim to write a range of texts that include

essays; letters to MPs; stories; movie scripts and books. The act of writing can also be a way of engaging others who are close to the person experiencing illness; in the following a terminally ill woman describes a poem that her son has set to music:

> [Um] my son and I have been busy, helping him to come to terms with it, I wrote a poem and then I wrote it as a song and he's set it to music.
>
> I'll read the poem, yes, I'll read the poem for you. It's a poem I originally wrote out to be given to the boys when I went. My son found it and said it had to be left out before I went because everybody had to know it. It's called I Will Be There.
>
> I will be the wind in the trees
> The sun ray when it kisses your cheek
> And when it snows and that lump falls on you from above
> It will be me throwing snowballs as we used to.
> And when the day is dark, sad and it's raining
> Those are just my teardrops what's wetting your face
> And on the frosty morn, when beautiful pictures form on the grass
> It will be me letting you know I was with you last night.
> You will never be alone
> Although you can't see me
> I will be there.
>
> (LD25, female, 41, piano teacher, end-stage COPD)

There is also evidence of men writing for heuristic purposes; in the following extract a terminally ill man develops an acceptance of his illness by writing an evaluation of his life:

> I also had to come to terms with the prospect of dying…I was expecting to live into my late seventies or early eighties and here I was at 57 with possibly only six months to live, so that was a bit, a bit outside my plans.
>
> [um], luckily we've had the sort of life where we have tried to pack as much in as possible. I call it 'luck' but that was our decision, so maybe it wasn't luck. And what I did was write a balance, what I call 'a balance sheet of life'. I, I wrote down, I wrote down all the things I regretted that I would be missing and they just amounted to eight, eight things basically. But I also wrote down all the achievements, all the happy memories and that came to over a hundred things. So I

> was able to look at this and say 'OK if I've gotta die, I've had a damn good life.'
>
> And this was a very good starting point for me because I was able to accept that, I was able to reconcile myself to the possibility of dying and then get on with the fight to try and stay alive and this was a very good starting point for me. (CRC26, colorectal cancer, male, 57, management consultant)

Here the act of writing is a means of restoring a sense of purpose in being alive, since the act of writing is both an act of acceptance and also, paradoxically, the beginning of resistance to illness. Once again there is evidence of an older, high SEC man resisting traditional gender styles by embracing a more transformational perspective that typically characterises women. Writing as a means of understanding the nature of illness through self-reflection is well summarised in the following:

> '... the one question I had to ask was, did I, well, did I almost die?' And they said to me, 'Yes.' I said, 'OK.' I said, 'Could I have died?' They said, 'Yes.' I said, 'OK.' That was the hardest question for me to ask. But I had to know. I think you just have to find out. Part of the recovery for me was finding out everything that happened and I had to write it down. I've never been a person to keep a diary but I had to write it down. Do I look back on the diary? No. It's, this is probably the first time. I don't look back on it, I remember, I know what happened. But at that particular time I needed to write it down and to find what happened. I think that's the best thing, just to know exactly what happened to you and, ... Yeah, make sense of it, yeah because I think ICU makes you not in control of your life, you know. So, I suppose for me to gain control of my life, I needed to know what happened? (IC15, intensive care, female, 38, finance officer)

Here the speaker describes how the process of writing contributed to an understanding of what has happened in the experience of illness and claims that this understanding in turn contributed to a recovery from illness. The act of writing contributes to knowledge which has a positive therapeutic outcome. A similar account of the transformational role of writing is given by an older man:

> ... I started to read and read and read and read and read and then I started to write philosophical articles. [um] And I got really, really interested and so because I was really, really, interested and focused

> on what I was reading and writing I wasn't thinking about the pain and so from about 1994 onwards [er] I was completely wrapped up in this thing and so life became bearable. (CP48, male, 61, chronic pain, writer and driver)

Here the act of writing is a way of coming to terms with and overcoming the effects of illness.

6.5 Summary

In this chapter we have identified a range of phenomena relating to support in illness experience. We found very few differences between men and women overall in their use of lexis related to support, with both genders expressing the need for support and the pressures on their ability to cope during illness. However, some views that were expressed on the support offered during illness could be accounted for with reference to models of gender; this could be either the influence of traditional gender discourses, or alternatively of new versions of masculinity and femininity.

For example, we have seen that men following traditional paradigms typically find sources of support from their membership of social groups and their contact with other men, while women following traditional influences rely more on the family – as well as on a wider social network that includes many different types of people. Women are sometimes critical of emotional support while some men view 'support' mechanistically. There is also some evidence of the influence of SEC and age interacting with gender. Some older men talk more in general about 'care' and find a new social role through being a 'carer', and younger men talk a lot about their need for 'support' indicating that younger men seem to be more under the influence of what have traditionally been considered feminine styles than are older men. High SEC men rely more on their friends than high SEC women and low SEC men; both older and younger men rely more on support groups than older and younger women. SEC and age are also important influences in the preferred mode of communication with low SEC women preferring to use the phone, while older people find writing a means of coming to terms with the emotional demands of illness.

7
Illness Type and Gender

7.1 Introduction

In Chapter 6 we demonstrated how analysis of key concepts such as 'Belonging to a Group', 'Kin' and 'Speech Communicative' could provide insights into how gender, social class and age might influence the way that support was experienced by people with illness. We begin this chapter by outlining some of the differences in the language employed by people experiencing specific illnesses and general conversation irrespective of their gender, age or SEC; in this respect we are focusing on a variable in our study that we have previously controlled for – the actual type of illness that was experienced. In the next part of the chapter we investigate whether key concept analysis can identify differences in the lexis of people experiencing different types of illness since health professionals, carers and others with an interest in health conditions may wish to have insights into whether there are preoccupations that are specific to particular illnesses. To illustrate the insights that can be gained into a specific illness the main part of the chapter investigates the language of people experiencing coronary heart disease. We analyse in detail their concern with lifestyle change and self-transformation. In the last section of the chapter we return to the theme of gender by examining the interaction of gender with coronary heart disease and explore both similarities and differences in how men and women with coronary heart disease interpret the transformative project of the self.

7.2 The language of illness experience

To explore possible differences between the language of people experiencing different types of illness and everyday spoken conversation

we compared lexical use in each of the Specific Illness Corpora (see Chapter 2, Section 2.6.4) with a large reference corpus – the spoken demographic section of the British National Corpus (BNC)1 to establish if and how they may differ. Identifying lexical commonalities in the experience of illness provides a way of establishing a rationale for a 'language of illness experience' through lexical convergence, while identifying lexical divergence indicates characteristics that are specific to particular illnesses. Where the same concepts are 'key' for *different illness types* when compared with the BNC, this provides evidence that the language used in the illness experience in general differs from everyday conversation. For example, the concepts 'Change' and 'Disease' characterise *all* types of illness experience as they are concepts that people with different types of illness experience share when their language is compared with an independent 'control' corpus. However, other concepts are only 'key' *in a single illness* when it is compared with the BNC control corpus and this indicates that the language used by people experiencing that illness has its own lexical characteristics. For example, carers of people with dementia have a key concept 'Kin' because they talk about the family as a source of support more than do people experiencing other types of illness. This procedure therefore allowed us to identify similarity and variation in lexical use for different types of illness.

We identified concepts that were key ($p < 0.0001$) when each Specific Illness Corpus is compared with the spoken demographic sample. Table 7.1 provides an overview of these shared key concepts.

Table 7.1 shows that 20 concepts are shared by all of the 4 Specific Illness Corpora; these are the expected concerns of people experiencing illness such as 'Disease', 'Medicine and medical treatment' and 'Difficult'. Nine concepts are shared by three of the four Specific Illness Corpora. Taken together these 29 shared concepts show lexical evidence that there is sufficient lexical convergence between different types of illness to speak about 'the language of illness experience' as being distinct from everyday conversational English.

A further 13 concepts occur in 2 Specific Illness Corpora showing some lexical correspondences between heart disease and cancer in relation to 'Anatomy and Physiology', 'Smoking' and 'Fear and Shock' and between carers of dementia and depression for the concepts 'Understanding' and 'Mental Objects'. When the Specific Illness Corpora are compared with a general conversation sample we can

[1] A description of this section of the corpus is given in Appendix 4.

Table 7.1 Shared key concepts* – Specific Illness Corpora and the BNC spoken demographic

Concepts	Heart disease 747,495	Depression 483,994	Carers of dementia 686,714	Cancer 1,650,361
Medicines and medical treatment	X	X	X	X
Disease	X	X	X	X
Degree: Boosters	X	X	X	X
Thought, belief	X	X	X	X
Cause and effect/ Connection	X	X	X	X
Alive	X	X	X	X
Helping	X	X	X	X
Change	X	X	X	X
Difficult	X	X	X	X
Degree	X	X	X	X
Degree: Compromisers	X	X	X	X
Time: General	X	X	X	X
People	X	X	X	X
Objects: Generally	X	X	X	X
Time: Beginning	X	X	X	X
Frequency	X	X	X	X
Important	X	X	X	X
Worry	X	X	X	X
Able/Intelligent	X	X	X	X
Success and failure	X	X	X	X
Sad		X	X	X
Speech acts	X	X	X	
Failure	X	X	X	
Happy	X	X		X
Mental actions		X	X	X
Social action		X	X	X
Personal relationship: General		X	X	X
Personality traits		X	X	X
Comparing: Different		X	X	X
Anatomy and physiology	X			X
Fear/shock	X			X
Smoking and non-medical	X			X
Likely	X			X
Linear order	X			X
Time period	X			X
Degree: Compromisers	X	X		
Decided			X	X
Detailed			X	X
Knowledgeable			X	X
Expected			X	X
Understanding		X	X	
Mental objects		X	X	

Note: at $p < 0.0001$ level.

identify that the common preoccupations of illness experience are with the more 'objective' physical aspects of illness 'Medicines and Medical Treatment', 'Disease', 'Cause and Effect' as well as with emotional responses to the experience – 'Degree: Boosters', 'Worry' and the experience of 'Difficulty', 'Change' and 'Helping'. There is an important social dimension to illness experience indicated by the concept 'People' – illness has a rippling effect that influences the social support network of the person who is experiencing illness.

We then identified key concepts for only a single illness (also at $p < 0.0001$) as this assists in identifying concepts that are distinct to particular illnesses; for example, concepts such as 'Numbers' and 'Measurement and Weight' characterise the concerns of those experiencing a heart condition, while concepts such as 'Strong Obligation', 'Kin' and 'Residence' characterise the lexis of Carers of Dementia; these findings are summarised in Table 7.2.

'Carers of dementia' is the most lexically unique of the Specific Illness Corpora – accounting for 17 of the 29 key concepts for only a single illness. On closer examination these may be readily matched with the concerns of carers, for example, the key concept 'Residence' identifies that 'home' is a word used very frequently by this group and typically occurs in phrases such as 'nursing home', 'residential home', and so on since decisions about care – and in particular residential arrangements – are likely to predominate among this group. Similarly, the key concept 'Calm' identified a high use of 'respite' which turned out to be in the notion of 'respite care' – temporary arrangements for relief of the carer. Other Specific Illness Corpora have only three to five unique key concepts at this significance level. However, Depression is excluded from many of the combinations of two shared concepts and has five unique concepts indicating a degree of difference from other types of illness. One of its unique concepts is 'Dead' which contains words relating to suicide – a concept that is not discussed in the other Specific Illness Corpora and is highly characteristic of the condition.

So we can conclude that while the Specific Illness Corpora show evidence of many broad areas of conceptual relatedness, there are some concepts that are specific to the type of illness condition. From evidence of language use, Cancer remains a prototypical disease since it has more conceptual overlap with other illness types (see Table 7.1) and fewer unique concepts (see Table 7.2), closely followed by Heart Disease, while the Carers of Dementia sub-corpus has a lexicon specific to the concerns of those carers reflecting their perspective as carers; similarly, the Depression sub-corpus is characterised by lexis that provides an account of preoccupations associated with that condition. For the

Table 7.2 Unique key concepts* – Specific Illness Corpora and the BNC spoken demographic

Concepts	Heart disease 763,457	Depression 483,994	Carers of dementia 686,714	Cancer 1,650,361
Numbers	X			
Measurement: Weight	X			
Time: Beginning	X			
Degree: Diminishers	X			
Work and employment		X		
Dead		X		
Evaluation: True		X		
Generally, kinds, groups		X		
Interested, excited, energetic		X		
Strong obligation			X	
Calm			X	
Open: finding, showing			X	
Kin			X	
Residence			X	
Inclusion			X	
Professional			X	
In power			X	
Probability			X	
Architecture			X	
Trying hard			X	
Speech communicative			X	
Belonging to a group			X	
Comparing: Usual			X	
Evaluation: Good/Bad			X	
Infrequent			X	
Suitable			X	
Degree maximisers				X
Degree minimisers				X
Healthy				X

Note: * at $p < 0.0001$ level.

purposes of understanding more about how key concept analysis can provide insight into specific illnesses we will now focus on the language of people experiencing heart disease.

7.3 Heart disease

7.3.1 Key concepts: Measurement and time

To explore the language characterising people experiencing heart disease we examined lexical frequencies in the specific illness corpus for heart disease (see Table 7.2). We found that the major preoccupations of people with heart disease are 'Weight and Measurement', 'Numbers', 'Time: Beginning' and 'Degree: Diminishers'. The characteristic lexis for the first of these key concepts includes 'weight', 'pressure', 'overweight' and specific measurements of weights such as 'number + stone', which is unsurprising given that excessive weight is a major cause of heart disease and loss of weight contributes to recovery. Perhaps less obvious is the finding that the measurement of time is also salient to these people, this shows in their use of words referring to numbers ('one', 'two' etc.) and to units of time (minute, second etc.). We would like to suggest that one explanation of this is because the experience of heart disease brings about an acute awareness of mortality.

Number words follow an interesting pattern in the corpus: the frequency of a word from the lexical field for numbers is approximately inverse to the actual size of the number so that the lower the number, the more frequently it occurs: 'one' occurs more frequently than 'two' and so on. An exception to this pattern is for decimal units since 'ten' is more frequent than 'nine' and 'twenty' is more frequent than 'x-teen' and 'thirty' is more frequent than 'eleven'; the following list shows this inverse relation between the size of number words and their frequency in the corpus:

Number word	**Tokens**
one	535
two	339
three	253
four	136
six	111
five	110

ten	95
seven	51
eight	44
twelve	49
twenty	36
nine	28
fifteen	26
eighteen	23
fifty	19
hundred	18
thirty	17
eleven	10
sixteen	3
thirteen	2
nineteen	1
fourteen	0

There are various explanations of the greater saliency of lower numbers: one is that since the fingers may be used for counting, bodily experience therefore determines a primary number lexicon of 'one' to 'ten'; another explanation is that lower numbers carry a lighter conceptual load. What is of importance here is that people with heart disease use number words more than people with other types of illness condition and more than they are used in general conversational English. It is worth noting that 'Numbers' and 'Weight and Measurement' are themselves conceptually related because measurement – whether of weight, time or space – involves numbers and it is therefore worth considering the types of entity that are measured by numbers; Table 7.3 summarises findings for the number 7.

Table 7.3 The use of 'seven' by people with Heart disease

Entity following '7' or 'seven'	**N**
Time period (e.g. week, years old)	65
Other (e.g. 'holes' of golf, 'tablets')	58
Unit of measurement of quantity	9
Total	132

The most common periods were years (n = 16), days (n = 7) and weeks (n = 3); in the following there are three separate units of time (in italics).

> I feel now that what I've done was the right thing and here I am seven *years* later, alive and well, or at least I think I am [laughs]. But no, the impact at the time, the first few *days* in hospital and coming home in the *month* of December and over Christmas and trying to get in to the spirit of things and live a normal life, knowing that at the back that you were afraid but then the rehab solved my problem, and that's why I whole heartedly support it. (HA06, male, 70, heart attack)

In this extract temporal references become a way of structuring salient experiences for people experiencing heart disease; the speaker produces a narrative about his condition by positioning significant events on a conceptual time line – perhaps sequencing in time is what it means to him to be living 'a normal life'. Similarly, the following key concepts relating to time all show as being statistically significant when the Heart Condition corpus is compared with the spoken demographic section of the BNC ($p < 0.0001$):

Time: Period
Time: Beginning
Time: General

When we look at particular clusters for individual time words such as 'morning' we find that people suffering from a heart condition use the phrase 'wake up in the morning' five times more frequently than people experiencing cancer ($p < 0.0001$) – so this seems a particular preoccupation of people experiencing heart illness. Here are the concordances for this phrase:

N	Concordance
1	Well I would, I will say I get, I *wake up in the morning* and I think right
2	I went for a long time, and I still do, I *wake up in the morning* and I think you
3	miles a week in my fifties and I could *wake up in the morning* and take my

4 it myself but I know that once I *wake up in the morning*, 6 o'clock time,
5 in to a slide, so that.slide.. And when I *wake up in the morning* having had a
6 Difficult to say really because when I *wake up in the morning*, I'm thrilled to be
7 [um] And I used to go to the, you know *wake up in the morning* at 9 o'clock
8 if I went to bed one night and didn't *wake up in the morning* that would be the
9 at night I don't know whether I'm gonna *wake up in the morning*. So I won't be
10 you think oh my God, am I going to *wake up in the morning* or am I going to
11 very worried that you're not going to *wake up in the morning*, for instance,

A possible explanation for the use of this phrase by people experiencing a heart condition is that they have an overriding concern with their own mortality as each night presents the prospect of a potential death, and each morning brings the potential for a rebirth; to take a fuller context of a use of the phrase:

Interviewer: How else has it changed your life?
Respondent: [um] Difficult to say really because when *I wake up in the morning*, I'm thrilled to be alive, you know what can I do today? Because before the heart attack, I was having a very, very active life, dancing four or five times a week. We had twelve to fourteen holidays a year. We travelled all over the world and the country and everything, so we were very, very active but since the problem, you know we've virtually had no holidays, no, nothing if you like, so just get back to our previous lifestyle, I'm very, very thankful and I'm also very, very keen on boating. I've got a canal boat and I spent a lot of time on the canal boat and it'll be nice just to get back canal cruising again and just doing everything that I used to do. (HA31, male, 69, heart attack)

The speaker views waking up in the morning as the prelude to an engagement with a lifestyle that has changed from centring around

dance and foreign travel, to one in which the less strenuous pleasures of narrow-boating become valued activities. The same impression of well-being is offered in the following extract but from a more religious perspective:

> *Interviewer*: How do you view the future now?
> *Respondent*: [coughs] How do I feel about the future, [um] well when I first had that, knew I'd had the heart attack *I'd wake up every morning* and I'd thank Jehovah for getting me through the night. [um] And that's how I went for a long time, and I still do, *I wake up in the morning* and I think you know thank you you've given me another day. [um] So I've no long term plans, I haven't made any. (HA01, female, 63, heart attack)

From the more religious perspective of this woman, each day comes as a relief to be alive and so that waking up in the morning is experienced as being born again. Walton (2002) found that men in particular were afraid of death and anxious about the effect that this might have on their families and the following extract shows such as the informant's preoccupation with his mortality but that this can also change over time:

> *Interviewer*: And when you wake up in the night, why are you waking up?
> *Respondent*: I don't know. I just wake up. [pause] At one time, you know when you first have a heart attack you don't go to sleep. You know, you think oh my God, *am I going to wake up in the morning* or am I going to have a heart attack during the night? The frightening thing is, it is very frightening. But [er], that's not what keeps me awake now. It's just that, I mean I know I'm okay, you know what I mean, I know I'm not going to really, after *a year* of it, *just over a year*, I know that it can be controlled up to a point. (HF18, male, 66, heart failure)

Here the speaker is shifting from a high state of concern with imminent mortality (indicated by repetition of the question and of the adjective 'frightening') to a state where he is beginning to gain psychological control over his condition through a belief that each day won't necessarily be his last and this is indicated lexically through the shift

in the duration of the periods of time referred from 'morning' to 'year'. Similarly, in the following, I have italicised words that are from the lexical field of time:

> ... and I've thought well, what happens when I'm lucky enough to get to sleep at *night* I don't know whether I'm gonna wake up in the *morning*. So I won't be any different. And certainly, it won't affect me it'll affect who I leave behind. I know that, that's where the problem is. I don't welcome it, I would never welcome it, no I'm not *looking forward* to it at all. (HF14, male, 56, heart failure)

Time, then, becomes especially salient to those experiencing the possibility of not having very much of it – both as a means for ordering experience and gaining psychological control over their condition. The future becomes more immediate as life plans are condensed into shorter units of time. For people with life-threatening conditions even small units such as seconds and minutes become important measures of the passage of time. A phrase that characterises people with heart disease is 'two or three minutes' as in the following concordance lines from the Heart Corpus:

N	Concordance
1	She usually takes one tablet and about *two or three minutes* to swallow and then
2	to swallow and then another one *two or three minutes*. It takes her about
3	started and just stopped, most times in *two or three minutes* and it clicked off,
4	watch the start of this match and within *two or three minutes*, whether it was the
5	when I started; now I can relax within *two or three minutes*. You know how to
6	and in the arm; it probably lasted for *two or three minutes*. I just sat still
7	called an ambulance probably within *two or three minutes* dialled 999. And
8	but if I have to stand for more than *two or three minutes* my old legs get

Here we can see that small units are important in measuring the time taken for medication to take effect or the need for speed in treatment.

A preoccupation with time also shows in the phrase 'ten minutes' occurring over twice as frequently in the Heart Corpus as it does in the Cancer Corpus; it can either be in relation to the proximity of medical assistance:

> And she did this, and the ambulance came, it came quite quickly, it was *no more than about ten minutes*, and they were very good, gave me oxygen and so forth because I'm asthmatic as well and got me down to the hospital, the local. (HA35, female, 80, heart attack)

Or in the need to measure time while undertaking activities related to well-being:

> I try to take my time to do everything and anything. But over and above that, over and above that I don't [er], I take things very easily, very slowly. And [er], if I don't do it *ten minutes* I'll do it in *twenty minutes*. But I will do it eventually. (HF15, male, 85, heart failure)

The idea of how long it should take to do things is a very important part of managing heart disease and often requires a change in the attitude towards time, for example, as regards the amount of activities that are done within a period of time; this shows in the following extract:

> And then the heart manual talks about adjusting your lifestyle really [um] and that's been really good. To be able to, *to space out your work* really and I, I always wanted to get everything done at once, this was me you know, *fit as much in a day* as I can until *it's time to go to bed* or until you drop you know [laughs] and you can't do any more and [um] after a heart attack you realise the futility of that really. How it's you know not a really clever thing to be able to say you do, nobody thanks you in the end for doing a lot more [um]. *Pace yourself through the day* you know, give yourself chances to rest. (HA14, male, 51, heart attack)

Here awareness of time is a strategy for gaining control over the health condition since there is a contrast between a lifestyle prior to an angina attack that was characterised by trying to do too many things in the time available and one in which adequate time is allowed for activities. A rise in self-awareness regarding time is vital in the management of the condition because it contributes to a style of life that is no longer stressful. As we will see in Section 7.4, concern with time and

the importance of learning how to change attitude towards time is a particular preoccupation of men with heart disease.

7.3.2 Lifestyle change and self-transformation

A consequence of heart disease is it offers people an opportunity to engage in what has been referred to as the 'reflexive project of the self' (Giddens 1991: 214); in this section we will explore similarities in how men and women experiencing heart disease talk about changing their lifestyle as a result of their illness; we will demonstrate how a self-reflective perspective brought on by illness experience is not gender specific and how the linguistic resources for expressing a potential for self-transformation are equally available to women and men. This is a prelude to Section 7.4 where we explore differences between the sexes in their interpretation of what constitutes self-transformation. In this section we illustrate how the experience of a heart attack offers – for both sexes – the opportunity for a complete reassessment of lifestyle, while in Section 7.4 we explore what forms of activity are experienced as being transformational for men and women. A group of key concepts for people experiencing heart disease concerns the need for risk assessment leading to changes in lifestyles – especially by modifications of habits of eating, drinking and exercising – and contributing to improved health possibilities.

Risk assessment occurs in the calculation of chance; the following concordance lines show various numbers in relation to 'chance' for this illness type for the most common number in chance calculations which is 50:

N	Concordance
1	time; I think you've got to have this 50/*50 chance* of dying. They don't quite put
2	'Well I consider you would have a 50/*50 chance*'. So I said, 'Alright you do 50
3	and son, were told that I'd only got a 50/*50 chance* and if this cardiologist went in
4	that it might be alright. But it was a 50/*50 chance* and apparently my husband

Chance calculations were much less common among 'Carers of Dementia' and people experiencing depression; though they do occur in the Cancer Corpus. Heart disease, as we have suggested, brings about feelings of imminent mortality which leads to the measurement of risks that are related to lifestyle changes or treatment options.

An understanding of risk may be a prerequisite for behaviour to be modified; in the following account, a man explains how he gave up smoking because of a risk calculation:

> But the only, I mean when I had my heart attack, they told me to stop smoking and I did. I stopped smoking straight away because they said it gave me *a 50% chance* of living longer. So I thought well *a 50% chance* is better than *no chance*. I mean I've seen people in there, because there's quite a few people in the hospital who've had a heart attack at the same time sort of thing. And they were nipping out for the odd fag and I'm thinking well you know, why do it? They've told you that it gives you *50% more chance* of getting over the heart attack if you don't smoke. I think to pack in smoking you've got to be frightened to death, you have, you've got to be frightened to death to pack it in! (HF18, male, 66, heart failure)

Here it is clearly fear of death that motivates the risk assessment, and the emotional intensity is heightened by repetition of chance calculations. We also find a strong sense of chance or fate in metaphors relating to gambling and games of chance as in the following:

> Well just to almost when *the cards are dealt in life,* how come *I've got such a rough deal* here with this, given that I'd done everything, and again repeating myself, I didn't believe there was any heart condition in the family or anything like that and I thought well, 'why is this happening to me, given I'd done everything that these people tell me to do or as much as I could'. (HA19, male, 62, heart attack)

A cluster of related concepts that are key for people with heart disease relate to their potential for a change of lifestyle that would improve their survival chances. Their major preoccupations are with the *causes* of heart disease, especially those over which they have some *control* – these fall into two main categories: *avoiding* activities that have in some way contributed to their heart condition – patterns of eating, drinking and smoking – and *accepting* activities that could improve their overall state of health and prevent these conditions from reoccurring in the future. These include a better diet and engaging in sports and exercise. We might refer to these respectively as negative and positive actions; negative actions are avoiding or reducing an activity that they once did, while positive actions are engaging in an activity that they previously did not do. Change of lifestyle entails both positive and negative actions and contributes to a discourse of self-transformation.

A key concept for men that we will examine in more detail in the following section is 'Sport'. In the following account of going to a gym a man demonstrates a growing awareness that exercise is not just an end in itself but is a means to taking an active role in restoring health that can be engaged in at any time of life:

> Most people of my age are naturally a bit resistant to the idea of using a gym. I hadn't been in one for over fifty years and it seemed foreign territory. However the only kit you need is a pair of trainers and there's a very friendly and helpful atmosphere. Prior to falling ill, no one could have been more scathingly anti-gym than myself. Now I regularly attend the local gym twice weekly. This is not because I have some abstract target of fitness for its own sake, but because I realise that if I want to remain fully mobile and active I have to put a bit of effort into it. (HA04, male, 62, heart attack)

Here the speaker starts with a generalisation about the social preferences of an age defined group; then there is a contrast between a self before illness who shared ideas of resistance to gyms that are represented as normal ('most people my age'), with a self that has been transformed by the experience of illness into becoming a devotee of the local gym. The sort of change of perspective that can be brought about by illness has been summarised as follows:

> ... illness constitutes an 'ontological assault' on people's sense of who they are ... It is a 'breach' in the orderliness of everyday life, and highlights the taken-for grantedness of the 'normal' and unseen experience of narrative coherence (ibid.) ... 'when people talk or write about their experiences of chronic or serious illness, they often characterize themselves as becoming "a totally different person" '. (Benwell and Stokoe, 2006: 139)

In some cases exercise is simply one among a number of lifestyle changes through which a person with a heart condition represents him or herself as an active agent in becoming a 'new', more dynamic person. In the following account the speaker describes illness as if it were an opportunity to *rediscover* a dynamic self which he contrasts with a previous 'bad-tempered' self:

> As I say I didn't, what surprised me is I'm *definitely not what you'd call a couch potato;* I get plenty of exercise, I go for long country walks and

> cycle quite a bit. So that really surprised me but once I'd recovered *I got to do more, more of that kind of thing* just to keep up my, *keep up my fitness*. Yes, well another fault I had, I used to get bad-tempered and irritable in queues and traffic jams, that kind of thing and I thought well it's not worth bothering about; if you don't want to wait just go somewhere else, or just generally calm down, don't, you'll get to it eventually, it's not worth getting upset over. Yes it did worry me, a bit at the time. I thought well, if you just carry on the way you have been eating, just eating, not changing your diet, putting on more and more weight. I thought you'd probably get to the stage where you're not wanting to exercise, you'd get too fat, too overweight. You'd feel less inclined to go out and get some exercise. So it's getting worse. If you go out on a heavy drinking binge, that's only going to get worse as well. A lot of it came from within me, ... Oh yes. It's, *actually I've done quite a bit with it since I've joined*. What I've done quite a lot of is *I've organised guest speakers to come*. *I've had* various people, *I've had* people talking about local history and somebody that collected antique clocks and then one, one month *I got a nun from York* ... (HA16, male, 53, heart attack)

Here there is a narrative development from a 'real' dynamic self (in italics), the permanence of this self being indicated linguistically by the use of the present and present perfect tenses; this is contrasted with an 'ill' self that got bad-tempered, put on weight through eating and drinking too much – marked linguistically by 'used to'. The negative or 'ill' self is addressed by the dynamic self leading to positive actions (such as organising speakers to a cardiac rehabilitation group). The contrast between the 'dynamic' and 'ill' selves is indicated by a dialogical style in which the 'ill' self is addressed as if he were another person. The negative self is distanced through the use of second person pronouns while the first person pronoun refers to the dynamic self with whom the speaker identifies: 'I thought well, if *you* just carry on the way you have been eating, just eating, not changing *your* diet ...' This, we suggest – using Frank's (1995) term – is a restoration narrative in which a man restores his sense of dynamism through becoming an active agent who controls how much exercise he takes and what he eats and drinks, rather than an inert body to which things happen.

A discourse of self-transformation demonstrates reflective self-awareness and is accompanied by high modality. In the following account the speaker introduces a spatial metaphor 'going downhill' that is extended to emphasise a contrast between a negative state of physical

health and a positive attitude of the self that accepts this physical condition indicated by modal expressions such as 'I know':

> I mean *I know* I'm going **downhill** from now, that's definite. And I'm coping with it quite well. I'm understanding the case and you know the whole, *the whole, the whole* surroundings of my *case* and accepting it and *accepting* things as they come. But *I know* I'm heading **downwards**, and I warn my wife that I'm, I'm you *know* I'm *going* **downwards** rather than, starting to go **downhill** basically. But I can't do much about it, *I can't, I can't* make it any better than this. All that I can do is try and expand the period as much as possible by monitoring my diet and my lifestyle. (HF34, male, 35, heart failure)

The contrast between mental attitude and physical state – between the self and the body – is reinforced through extensive repetition of words (in italics): he emphasises a positive mental attitude through repetition of 'whole' – implying a holistic approach to his condition accompanied by psychological acceptance, and this contrasts with physical deterioration communicated by repetition of the spatial metaphor 'down' (in bold) based on a concept PHYSICAL DETERIORATION IS DOWN. Although the basic attitude is one of fatalism, a positive mental attitude shows in the awareness of the potential for control over those elements of the physical that can be controlled – 'diet and lifestyle' as well as the high level of certainty with which his views are expressed. In the following excerpt the same speaker continues a discourse of control – in which he positions himself at the core of the lived experience – and develops an extended metaphor STRESS IS A FLUID IN A CONTAINER (indicated by bold):

> And there's absolutely no stress in my life any more, I just don't take any *stress*. Wherever it comes *I just* ***drain it.*** I mean I have, a super power ***in draining*** any *stress*, it's amazing, just like ***pressing a button and flush everything out***, literally. If you get anything, if *you do get anything*, even at work, if there's something bad and you know, you have to take a major decision, I just take it so easily, whatever the consequences I don't care, ***press the button*** **and** ***everything goes out.*** I *don't take any stress* at all whatsoever in my life which is good, that's very important; I think I built it up gradually, you know, since I got over the first trauma I said to myself, 'I managed to *get out of* that, *I can* do everything else; *I can* handle you know all future problems'.

> And I've been, *I've been* doing really well ever since. (HF34, male, 35, heart failure)

The ability to control his mental response to stress is communicated by metaphors that represent himself as an active agent who controls the amount of fluid in the container by 'pressing a button' in order to gain control over his life by releasing the 'liquid' stress and can 'handle all future problems'. Agency is also communicated by repetition (in italics), by the very frequent use of first person pronouns and by the use of hyperboles such as 'amazing', 'major', 'all future problems' and intensifiers such as 'literally', 'so easily', 'whatsoever', 'really' and so on as well as the use of modal verbs such as 'can'. In the following extract the speaker communicates agency and strength of conviction by the use of repetition (in italics) combined with directive imperative verb forms (in bold):

> I mean even my wife when she's stressed out on anything, now she's *worrying* about the labour and I say, '*Just* ***don't worry*** now, let's leave it till the very last minute, and then *we'll worry* then, *just* ***don't worry. Take*** it easy, ***take*** things as they come and **deal** with them there and then.' And *it's working, it's working*. I've seen the worse and whatever will happen in the future can't be as bad as the past. (HF34, male, 35, heart failure)

The final sentence contrasts the future and the past – reinforcing the contrast between dynamic and ill selves and agency is communicated by high modality. The regaining of control over his life leads him to get a sense of well-being because he no longer has any fear of what is for most people experiencing illness the greatest source of fear – death. This fear of death cuts across genders and in the following extract; it is voiced by a woman:

> So you know the only bad thing that can which can be *worse* is dying and this is you know everyone, I'm expecting this, I mean I'm a patient with heart failure so anything can happen, any day, any time, I'm prepared to it. So you know I'm not afraid of it. If it happens then fine, *if it's going to happen* in the next 5 minutes I'm not going to freak or panic. I know it's *going to happen* sometime, but I don't know when but *I'm prepared for it*. So I don't, *I don't* take this as an issue in my life. (HF08, female, 69, heart failure)

Repetition of both the inevitability of death and her sense of preparedness for it (indicated in italics), and the use of negative forms indicating high levels of certainty establish the primary transformational theme of this woman: she has become someone who can heroically look death in the face; notice also the reference to '5 minutes' and the idea of time running out in a very short period that we have seen characterises this illness condition. The same speaker then goes on to describe how a sense of well-being enables her to cope with her illness by taking active control of her life:

> ... and that relaxing is is so good and so important so I try and do that at home and try not to think 'jobs' and not to think 'what I've got to do tomorrow', I try and think of scenes, and I love music, so I'll have music on sometimes which is very therapeutic ... Meditation, [um] I do try and read Seneca or whatever you know and think oh Chinese philosophy it's it's a little bit sort of daft at times, but you you go through it, its all part of your I think ... your healing process mentally and emotionally and you for even for just ten minutes you take you get out of yourself and getting out of yourself is all part of your healing and strengthening and I think that's one of the reasons why I was/have been able to cope with my condition because I've been diversifying and doing things I haven't done before, you know reading certain books, I like poetry, so I read poetry and I've been reading psychology. But its just something that takes you away from your condition and you accept it. (HF08, female, 69, heart failure)

Here we see interesting shifts in modality from high modality expressed in the use of present tense verb forms, the use of the distancing 'you' but also low modality in hedging expressions such as 'it's a little bit sort of daft at times', and 'just' and verbal expressions such as 'I think'. But there is also evidence in men's language of a similar shift towards a perspective rooted in a sense of well-being, acceptance, agency and deictic centring in which changes in diet are only part of a much more complete change in attitude towards life:

> ... well (name removed)'s always been very careful about my diet since I've been married, always tried to give me a good, balanced, variety diet and that has continued and contributed a great deal to my well-being at present for which I'm very grateful ... as I say I think the standard of life is very good and it has been, once I got to the stage of saying 'I'm not a sick man' and I don't feel I'm a sick man; once I'd got to that stage which took about two years. The specialist at the

> hospital said, 'I think its gonna take about two years,' no 'I think its going to take about eighteen months before you get properly on your feet' – but it took two years and then I began to feel I was getting better. And although there was no improvement in the condition, I'm better able to cope with it, and that was wonderful. I think it's an appreciation of what life is, life's got to be enjoyed and you, one has to develop the things that one can do and do them well. I think the privations if you like (and I don't think that there've been many), the privations have opened up opportunities to do different things, like I'm interested in history, I'm interested in autobiography, we do crosswords quite a bit and [er] ... the privations have given me time to do that, which is a very good thing. (HF02, male, 82, heart failure)

Here a discussion of changes in diet are the prelude to a clear statement of an acceptance of limitations expressed using modal shifts from high modality in the adjectival evaluations 'great', 'very good', 'wonderful' and so on to low modality in the use of 'I think' in the latter part. There is also a focus on measurement of time necessary for recovery that we have seen is characteristic of people with heart disease. Finally, there is a transformational awareness in the propositional content because what were previously viewed as hardships or 'privations' become the basis for his understanding of what makes life worth living: reading, doing crosswords and so on. Once again the sense of coping with life arises from getting a feeling of control over those things that can be controlled: what he eats, how he spends his time, and it is this shift of perspective towards the living self – accompanied by shifts in modality – that facilitates a rejection of the identity of the ill self (although he implies an awareness that from others' perspectives he may be seen as 'a sick man') – and that defines a discourse of self-transformation and well-being.

7.4 Interaction between heart disease and gender

7.4.1 Overview

Emslie and Hunt (2009) provide a comprehensive review of qualitative literature on heart disease in relation to gender, which is not possible to cover in detail here; however, we will summarise some of the points that they identify. They review literature on heart disease that emphasises its effect on men:

> Coronary heart disease (CHD) is the leading cause of death for men and women in industrialized countries (Mackay and Mensah, 2004).

> Men develop CHD around 10–15 years earlier than women, which contributes to their shorter life expectancy (Fodor and Tzerovska 2004; Sharp 1994). In the UK in 2004, CHD accounted for 21% of all death in men and 15% percent of all deaths in women (Allender et al., 2006). (Emslie and Hunt, 2009: 155)

Some research has been oriented to the effect of gender construction on heart disease; for example, traditional masculinity has been associated with a higher incidence of heart disease, whereas men who perceive themselves as having a more feminine identity are less prone to the disease (Hunt et al. 2007). A theory was developed in the USA between the 1950s and 1970s that men with type A personalities – associated with traits such as ambition, and urgency about time – experience more hostile interpersonal relationships and are more prone to heart disease. Traditional masculinity is linked with stoicism and self-control that may lead to a delay in seeking help for this condition. However, as Emslie and Hunt point out, it may also be the case that claiming to delay seeking help may be part of the construction of traditional masculinity by men:

> Thus, one way for men to resolve possible tensions between their private experience (e.g. seeking help promptly) and public discourses of 'what it means to be a man' (e.g. being strong and silent about health and illness) is to describe how they are forced to seek medical help by female partners and relatives. (Emslie and Hunt, 2009: 182)

Given that our data were collected by interviews, men and women were certainly given the opportunity to perform gender, and it may be that some findings of key concept analysis access this performance; however, it seems likely that people are less aware of the frequency with which they use particular words and so it may be that an approach based on this reveals aspects of such a performance of which men and women are less aware.

7.4.2 Key concept analysis of gender and heart disease

In this section we will address differences in the language of men experiencing heart disease when compared with women experiencing heart disease. We will recall that there were four unique concepts for the Heart Corpus when it was compared with BNC, and we have analysed Time, Numbers and Measurement and Weight in the previous section. To explore the extent to which these concepts arise from illness

type rather than gender, we divided the Heart Corpus into two further sub-corpora: one comprised of 53 interviews with men (543,443 words) and the other of 22 interviews with women (204,052 words). We will refer to these as the Men's Heart Corpus and the Women's Heart Corpus respectively. The key concepts for this illness type (Time, Numbers and Measurement and Weight) are *not* key in this comparison – indicating that these concepts characterise the specific illness type rather than gender.

There are other concepts identified by Wmatrix when we compare the Men's Heart Corpus with the Women's Heart Corpus; the key concepts for men include 'Location and Direction', 'Sports', 'Cause and Effect', 'Business', 'Government', 'Warfare and Weapons', 'Entertainment' and 'Difficult'. The key concepts for women are 'Pronouns', 'Kin', 'Thought, Belief', 'Exclusivisers, Particularisers' and 'Degree Boosters'. What we notice from Appendices 1 and 2 is that these were also key concepts in the full matched corpus. So, while there are differences between the language of men and women with heart disease, these are not significantly influenced by the specific illness. The implication of this is that there is little interaction effect between the specific illness – coronary heart disease and the gender variable.

However, there are some minor interactions of gender with illness type. For example, we have seen in Section 7.3.2 that men with heart disease are especially preoccupied with 'sports' and 'exercise' as practices of self-transformation. Although in Chapter 3 we interpreted sports talk as a strategy through which men avoided talking directly about the emotional aspects of illness experience, we find that it is nevertheless a form of men's emotional engagement with positive experiences, even if it does involve avoiding talking about negative ones. 'Sports' constitute a much higher preoccupation for men than for women with heart disease – the lemmas 'exercise' and 'gym' are used around twice as frequently by men, and others, such as 'golf', do not occur at all in the interviews with women. A possible explanation is that sports is one activity contributing to masculine identity that can be continued after diagnosis of a heart condition while many other aspects of their life that formerly contributed to their identity are no longer available. Emslie and Hunt (2009: 177) identify a theme in the research on men's experiences of heart disease that 'Many men described a series of losses after cardiac diagnosis, including loss of physical strength, emotional health, paid work, financial security, independence, self-esteem, control, leisure activities, social life, pleasures (alcohol, certain food, smoking, sex and social life…' Sports may contribute to men's enjoyment of life after a

heart condition diagnosis and to a dynamic sense of self, as illustrated by the expressions in italics:

> We looked at our finances and I decided we can afford to both retire, so we have and enjoyed life. So now I *go to the gym three times a week*. If you hadn't been here today, *I'd have been swimming* only because we're going on holiday shortly and *I think going snorkelling again*, so I need to get my *swimming powers* back again. We enjoy life, in fact I don't know now how I found time to go to work and looking back, if I hadn't had my heart attack and survived it, I'd have probably still have been working *instead of enjoying life* [laughs]. Now that encompasses ten years in what, a few minutes. (HA29, male, 64, heart attack)

Here a transformational perspective is indicated by taking actions towards health improvement that are centred on sports. There is also evidence for gender interacting with illness type in the key concept 'Entertainment'. Men with heart disease talk four times more frequently than women with heart disease about 'playing', eight times more frequently about 'partying' twice as frequently about 'taking it easy'. For men, 'play' typically collocates with a sport, and in particular golf, while for women it has other collocates as a comparison of the following concordances shows:

Men's concordances for 'play'

N	Concordance
114	golf.' And at three months I started *playing* golf and I'm round to playing
115	'at three months you should be able to *play* golf.' And at three months I started
116	[laughs] But [um], so I had this goal to *play* golf again and at six weeks also the
117	surely I'd sneak another golf club in and *play* with a [inaudible]. And after, just
118	and we'd play nine holes, or she'd *play* nine holes and when we got to a
119	again. With my wife mainly and we'd *play* nine holes, or she'd play nine holes
120	that at six weeks I shall be able to not *play* golf but I should be able to walk on
121	useless. 00:33:25 But my goal was to *play* golf again and they told me in the

122 but I enjoy the company of the people *playing* golf. I enjoy the chat as we go
123 and bigger and I had a goal in life. I *play* golf, I'm no good at golf. My
124 miles round and every day that I don't *play* golf I go and walk round two lakes in

Women's concordances for 'play':

N	Concordance
1	of a religious faith? I mean has that *played* a part. I'm just interested in how
2	park or something. Watch a bit of telly, *play* a bit of scrabble, you know. Have
3	he's been down to the, you know being *playing* outside that he'll come home,
4	Sally in the pub (it's a game that he *plays*), and I actually said to him, 'Do
5	goes out a couple of times a week, he *plays* Aunt Sally in the pub (it's a game
6	he acts normally then, he doesn't start *playing* 'oh-woe-is-me' sort of thing
7	if he plays up, she says, 'He's *playing* up,' he gets sort of obnoxious
8	1) [35:50:16] if he *plays* up, she says, 'He's playing up,'
9	with BAPS which is the Benson Area *Play* Scheme, [name of scheme], he was
10	support groups, would you think that's *played* a part in helping you cope? H

Men typically play golf, while women typically talk about men playing sports as we can see a male pronoun is used in half of the concordance lines. Golf is a defining activity of traditional masculinity, especially for men with heart disease, and for some men constitutes a defining activity in which they engage, usually – though not always – with other men, and contributes to the construction of a gendered identity. In the following account we see elements of interaction between golf (in bold) and numbers (in italics):

> ... as soon as I had the surgery, as soon as I got up, a little way, a little way, bigger and bigger and I had a goal in life. I **play golf**, I'm no good at **golf**. My handicap is the **golf clubs**, but I enjoy the company

> of the people **playing golf.** I enjoy the chat as we go round. I enjoy the exercise but I'm absolutely useless. But my goal was **to play golf** again and they told me in the little book, the heart booklet, which I've read, that at *six* weeks I shall be able to **not play golf** but I should be able to walk on the course. So at *six* weeks I started walking on the course again. With my wife mainly and we'd play ***nine*** **holes**, or she'd play ***nine*** **holes** and when we got to **a green** and **I'd putt** and then slowly but surely I'd sneak another **golf club** in and play with a [inaudible]. And after, just after *six* weeks I started to **hit the golf ball** again, although people have said, you know 'careful of your chest.' But the people in the rehab said 'it's a swinging movement rather than a stretching.' ... But it was that goal and they said, 'at *three* months you should **be able to play golf**.' And at *three* months I started **playing golf** and I'm round to **playing *fourteen* holes** now, **out of the *eighteen***, including going up the hill that used to worry me. (HA12, male, 66, heart attack)

Here certain characteristics of masculinity interact with a particular health condition: there is a need for a sense of belonging, a need for having a clearly identifiable goal that is measurable in time and with numbers (referring to holes on a golf course). The same speaker demonstrates strongly goal-oriented values in the following:

> And another thing of course *is to have a goal. I had this goal* to play golf because it's an enjoyment I enjoy, it's something I play with my wife and my brother and. Funny enough the doctor who must live in the village where I play golf, he must have shares in the golf course because when you go round that golf club, three quarters of the seniors I play with, have all had heart attacks and had by-passes. And the doctor has said, 'go and play golf, it's an easy thing to do, it's a good thing to do, it relaxes you and it gives you exercise and fresh air.' So people haven't got to play golf but I think they need to keep fit, *they need to have a goal*, they need to do something to occupy themselves. (HA12, male, 66, heart attack)

Here an anecdote is framed within a discourse of masculine purposefulness. Note how the man shifts from a statement of personal behaviour, a statement about 'people' in general and incorporates masculine humour. Authority is attributed to the doctor as his words are reported. Golf – in traditional masculinity – is a major way for men to occupy their time that combines the various purposes of getting exercise, interacting socially and enjoying themselves; these are especially

important objectives for men experiencing heart disease which may have arisen from deficiencies in one or more of these areas. The practice of measurement and the fixed, and clearly defined, objectives of golf replicate the pattern and practice of their working life – it is presumably no coincidence that golf is the sport of choice for businessmen.

Unlike some other sports speed is not a central aspect of golf. A search of the full matched sample shows that concepts relating to speed occur more frequently in the male corpus; the word 'pace' occurs twice as frequently in the male matched sample as in the female matched sample, the word 'speed' occurs four times more frequently in the male matched sample. Goatly (2007) cites a number of examples of how speed has become symbolic of success in the modern period and the value placed on time saving in modern society. Speed is a salient power-related concept in modern society and is associated with typically masculine measures of success such as ownership of fast cars and the speed of financial transactions. Awareness of the culturally masculine association of speed with success may be beneficial for men in raising self-awareness; this is evident in the notion of self-pacing:

> Prior to my heart attack I was telling the agency the previous week how many days work I wanted the following week and that was no problem, I was always getting the work that I wanted. And [er] as a consequence I could, you know I felt I could *pace* myself, I don't have to go back working five or six days a week. (HA10, male, 63, heart attack)

There is considerable evidence in this corpus that men discussing health and illness need to learn not to be driven by external pressures relating to speed and competition, but to respond to their own needs by becoming more aware of their feelings when experiencing the life events associated with illness, to be able to alter states of body and mind and develop a dynamic sense of self.

Women's accounts of heart disease show how the illness has initiated a period of learning and self-awareness that might otherwise not have occurred and has led to a change in lifestyle that is the basis for regaining control; the following excerpt illustrates this sense of agency and was identified through the higher frequency of the expression 'help yourself' (in italics) in the Women's Heart Corpus where it occurred four times more frequently:

> Well from my own experience I think I've been fortunate. It's in a way opened a new life for me, I probably enriched my life, I've

> been able to ask the questions and get the answers from my own particular condition of DCM, [um] I feel **you shouldn't** be afraid. There is still plenty of life there, you could have another ... you know threatening disease or illness come on you, so if its heart failure at least you can understand it and come to terms with it and provided the medication's right and you're coping and you're watching your diet and you're exercising, plenty of fresh air and exercises, nothing strenuous ... so you can always *help yourself* and get moving and heart failure wouldn't be any real problem, **you should** be able to cope quite, at least I think quite successfully. If you recognise the things you can do and *help yourself*, because only you can *help yourself* anyway. (HF08, female, 69, heart failure)

Women experiencing illness, as here, treat it as an opportunity for self-transformation through self-reflection and proactive physical and psychological responses leading to a dynamic sense of a self that then takes on a high level of modality in advising others (notice the use of 'you should' in bold); however, the activities are less oriented to sport and more to areas such as diet and lifestyle.

Changes in consumption are often central to the transformational selves that characterise people suffering heart disease and account for their use of key concepts relating to food and drink. However, since the expression 'help yourself' occurs over four times more frequently in the Women's Heart Corpus we suggest that these are associated more with women, although as we have seen in the analysis of the previous narrative, men too develop transformational identities. In the following account by a woman there is evidence of this transformational self:

> And so I try and behave and eat *properly* and do everything I'm supposed to do that I, I've got to do that. Because they can help you to a certain extent but you've got to help yourself, and be aware of things that you, no matter how much you like something, [laughs] I have the occasional fish and chips, *I always loved*. The sisters on the ward, she said to me, 'Well,' she said to me 'once a year or so,' she said, 'go on, have them. Eat the fish. Taste the batter. Have a few chips and you'll feel satisfied.' And about once a year when we go down south that's what I do. But I can make up my mind that I, such a thing isn't good for me and I don't, I don't have it. I was never in to fried stuff anyway. I've got one of these grilling machine things and they're *good*, we grill everything or else. Fish, *I love fish*. I have a *nice* oily fish. [laughs]. It is, I mean I do whatever I feel will be, or

> I try to do whatever *I feel will be good*. Like everybody else I slip by the way sometimes I'm sure. But, then I think if I'm doing what I, *the best I can*, well that's all, that's all you can do. (HA35, female, 80, heart attack)

The feminine style here reflects in the greater use of first person pronouns, and the recounting of an anecdote accompanied with reports of what 'she said' and a range of strong positive evaluations (in italics) expressing high modality; these linguistic strategies all illustrate the women's transformational discursive style that we identified in Chapter 4. However, there is no conflict between an ill self and a dynamic self that characterised the men we looked at in Section 7.3.2 and so the style is that of a monologue rather than that of a dialogue.

As we have seen in Section 7.3.2 men with heart disease also engage in a discourse of self-transformation – even though the sense of tension between past and present selves suggests that it is more difficult for them to do so; there may be an important age variable here since, as Evangelista, Kagawa-Singer and Dracup (2001) note, men who were near to retirement age found the impact of a heart condition less than those of working age and so many of the conflicts of identity experienced by men are linked to the shock of shifting from a work-based identity to one that has to operate in a less structured environment. Older men can interpret their illness as part of the ageing process and therefore accept the limitations it imposed (Lukkarinen, 1999) and so have fewer identity conflicts. Even so in the following account by an older man there is a contrast between an over-active self prior to the heart attack with a diet conscious and dynamic self after the heart attack:

> I tend to be that sort of person, you know, stiff upper lip and get on with things. So no I didn't mention it. People knew I was a bit tired but as I say, my son was being married around that time and there was a lot of pressure. I put it down to that. I was doing all sorts of things; playing football, cutting trees down, painting. I was doing a lot. So prior to the heart attack, doing an awful lot but that's the way I am. Well I decided to give up cheese because my little dog and I, every night used to have cheese; he still has a little bit of cheese. I don't have cheese. I don't have crisps. I've given up coffee as well actually. Tea instead. Drink lots and lots of water. When I was in hospital recovering from my surgery, I drank a lot of water and I'm convinced it helps. I also looked up the effect of alcohol and came to the conclusion that red wine is one of the best alcoholic drinks you

> can have. I'm told it's to do with the skin of the grape, which has got beneficial by-products. So I decided if I want red wine, I'll have a glass of red wine. And if I go out to a function or party now, I won't refuse the food that's offered, I'll take it. So in moderation take what you want but be a little bit careful of the saturated foods and salt. (HA21, male, 69, heart attack)

The speaker starts by describing the self *before* the heart attack as performing a traditional masculine identity with 'stiff upper lip' and undertaking a range of heroic activities 'cutting down trees ... doing an awful lot' and with no mention of diet. *After* the heart attack, he has taken on a more feminised identity, using words such as 'little' (repeated) and is now closely monitoring the minutiae of his diet, expresses himself passively in the expression 'I am told', and goes into detail in outlining the health benefits of red wine. A contrast is created between the previous masculine self that passively experienced stress and a present dynamic, feminine self that is in active control of this stress. These changes represent the growing awareness of a dynamic self that towards the end of the excerpt engages in dialogue with an imagined hearer when he switches to the imperative form 'take what you want'. He then goes on to recommend a source of information that has been beneficial to him:

> Well a lot of the information I got was from the British Heart Foundation booklets. They produce eighteen booklets. They're clear, concise, well written and I strongly recommend them to anyone because when you have heart problems for the first time, you don't know anything about the subject really. You barely know that you've got a heart and its function. But these booklets in simplistic terms explain it to you and it's the only real source of information in the early stages and as I say, I strongly recommend it. I looked on the Internet as well. British Heart Foundation again, have got a superb web site. (HA21, male, 69, heart attack)

Notice here there is a characteristic masculine distancing switch to the third person pronoun 'they' when referring to a source of information and then the second person pronoun 'you' for the transmission of this information; there is then a switch back to the first person when he transmits a recommendation, using high modality and displaying knowledge acquired by the post-heart attack, dynamic self. In this discourse we find a blend of the traditionally masculine discourse of

distancing and avoidance with the more transformational discursive style associated with femininity.

7.5 Summary

The analysis in this chapter has illustrated that transforming the self, although primarily a project embarked on by women, can also be undertaken by men when they are sufficiently challenged by the prospect of a very serious and life-threatening illness such as a heart condition. The difference seems to be in the degree of illness that is necessary to provoke a response and the extent to which lifestyle is changed – rather than in the general nature of a transformational response. Some men, like many women, are able to conceive of illness as an opportunity to realise a dynamic self when experiencing a relatively mild heart condition. Others are more constrained by traditional masculinity and require a greater shock before they become proactive in developing such a dynamic sense of self and for such men this involves a greater shift in identity from an 'ill' self to a dynamic self. They are also more likely to look to activities such as sport for engagement with this new sense of self. The value for all men of adopting a discourse of self-transformation is that it may improve their long-term chances of survival and go some way towards reducing the significant gap in longevity between men and women.

8
Conclusion

We have sought to investigate how the language used to describe the disruption usually entailed by illness reinforces or challenges cultural norms for performing a gendered identity. We have employed corpus linguistic methods such as keyword and key concept analysis to analyse language use in a corpus of interviews about illness experience with men and women. We have identified both conformity with, and divergence from, traditional gender roles; in particular, we have found greater evidence of divergence from traditional ways of doing gender among men as compared with women experiencing illness and have interpreted this with reference to SEC and age as well as to gender and illness type. We have identified conformity with traditional masculine identities through reification, deictic distancing, the use of abstract and nominal forms, swearing and sports talk. We have suggested that a traditional masculine identity is expressed through a discursive style of distancing and avoidance although this is not necessarily unemotional in nature. Men following such a discourse demonstrate personal control over their illness, by keeping it at a distance and maintaining a strong, stoical front in the face of illness. Women following a feminine discursive style demonstrate an attitude characterised by expressing a lower degree of certainty about, and commitment to, the possibility or necessity of what they are saying, but also the ability to shift to a high level of certainty for purposes such as criticising health services or passing on knowledge about illness. Both men and women following traditional styles – whether oriented more to self-control or to social relationships and emotional expressivity – find these appropriate linguistic responses to the uncertainties entailed by illness.

However, within age and SEC groupings we have also identified other non-traditional ways of doing gender. For example, we have found that

high SEC men sometimes display themselves as particularly emotionally sensitive and elaborate in their expression of emotions using adjectives otherwise characteristically femininity such as 'happy'; 'wonderful'; 'lucky' and 'fantastic'. We have also noticed how some younger men employ a 'feminine' style when they talk about feeling 'upset' or 'alone' and when they use the bracketing function of 'you know' and expressions such as 'I need to talk'. Older men also show evidence of tensions between expressing their feelings in a more contemporary style of exaggeration – as in 'absolutely fantastic' – and more traditional styles for masculine expressiveness. It may be that the constraints of traditional masculinity weigh more heavily on middle-aged men who need to sustain a work place front as part of their role in being financially responsible for a family; this may place more constraints on the range of masculinities that they adopt.

Feminine discursive styles are less traditionally constrained because women demonstrate the ability to switch between levels of modality. Women typically engage more fully with the experience of illness – either by expressing their uncertainty, or, by clearly stating their needs, desires and advice. However, there is also the influence of SEC and age, such as when high SEC women withhold positive evaluations and are critical of the health system in a way that low SEC women are not. Younger women and high SEC women employ high modality when expressing their emotional responses to illness, while older women see themselves as authorities on illness and suffering. Regardless of age or SEC, though, women tend to demonstrate that they have the right to evaluate their suffering, their treatments and the personnel who provide them. Women are more confident about expressing negative feelings towards aspects of their experience of illness than are men, who are generally more hesitant and anxious about being open about such experiences, suggesting that illness continues to be a woman's domain. This explains why women employ high modality, as well as low modality, and are able to place themselves at the centre of the lived experience; this shows linguistically through what we have described as deictic centring and in their use of expressions such as 'I knew something was wrong' and 'I need to talk'. Younger men, in contrast, are more hesitant in expressing feelings, although one possible explanation of this is because men generally are asked less frequently about their feelings during patient experience interviews.

While in general there were few differences between men and women in their use of lexis related to support, since both men and women expressed the need for support, we found differences in the patterns of

support-seeking behaviour. These could be either from the influence of traditional gender discourses, or of new versions of masculinity and femininity. Men influenced by traditional masculinity find sources of support from their membership of social groups and their contact with other men, while women following traditional influences rely on the family – as well as on a wider social network that includes many different types of people. The influence of SEC and age interacting with gender has produced newer versions of masculinity. Older men often talk about the personal value attached to being a carer – for some this even provides a new social identity, and younger men talk about their need for 'support' indicating the influence of what otherwise characterises a feminine style. However, it is not clear if such men are simply performing gender in a way that demonstrates awareness of contemporary values. It may, however, be difficult to access a level beyond what is empirically measurable in language. Raising questions about 'performance' may in itself imply a type of dualistic thinking that distinguishes between the superficial performed self and the 'real' person underneath. If, as some modern theories of identity suggest, there is no underlying core, then we are perhaps obliged to take people's performances of identity at their face value rather than question them from an apparent position of objectivity.

Women display more self-reflection, and proactive agency in response to illness and for this reason we have proposed that their discursive style is transformational. However, the analysis of heart disease illustrated that the project of transforming the self, while mainly linked to women, may also be pursued by men when their health is seriously threatened by life-threatening illnesses such as heart disease. The difference seems to be in the degree of illness that is necessary to provoke a response – more 'feminine' men, like many women, are able more readily to respond to the challenge of illness by seeing it as an opportunity to realise a more dynamic identity when experiencing only a minor illness. However, other men – perhaps those more under the influence of traditional masculinity – require a considerable shock before they become embark on a more proactive response to illness that involves developing a dynamic sense of self. There seems to be an inherent value to many men of adopting a more feminine discourse of self-transformation as this may increase their long-term chances of survival and go some way towards reducing the significant gap in longevity between men and women. This should be encouraged by

continued efforts to argue for the health benefits of more feminine styles for doing illness by encouraging both men and women to engage in developing a language to talk about difficult experiences such as illness. We hope that this book will have shown some of the ways in which this is possible.

Appendix 1

Men's Key Concepts (Full Matched Sample)

The following table shows the 18 most frequent key concepts and their corresponding lexical items for the 99 men who were interviewed as compared with the women in the full matched sample. Explanatory notes are given below.

Key concepts	Lexical items
Difficult	Problem/s; difficulty/ies; burden; awkward complications; complicated; crisis inconvenience; hard work
People: Male	Man/men; guy/s; chap/s; bloke/s; male; boys; gentlemen; macho; lad/s
Numbers	One; two; three; four; six; five; ten; seven; twenty; eight; twelve; nine; thirty; hundred; fifteen; forty; eighteen; fourteen; fifty; fifth
Important	Important; major; serious; main; significant; primary; emergency; matter; values; key; mean a lot; acute; priority/ies; importance; comes down to; central; turning point; was somebody
Sports	Exercise/s; sport; exercising; gym; bout; game; golf; rugby; goal/s; cricket; swimming; tennis; riding; sports; skiing; games
Mental object: Means, method	Way/s; system/s; somehow; procedure/s; pattern/s; approach; technique/s; solution; method/s;
Success	Make/s/ing it; successful/ly; overcome; success; effective; beat; came through; solve/ing; win; overwhelming; beating
Business: Generally	Company/ies; business; office; firm

Continued

Key concepts	Lexical items
Time: Period	Year/s; day/s; month/s; week/s; night; hour/s; morning; minutes; period; secs; wait; Monday; while; Friday
Places	Local; area; place/s; site; city; village; abroad; national; base; location; countries; park; territory; foreign
Easy	Easy; simple; easily; manageable; ease
Belonging to a group	Group/s; together; unit; team; association; society; community; member/s; club/s; organisation/s; public; middle class; gather; joint; network; units
Location and direction	This; there; where; here; in; out; back; on; end; away; off; around; course; somewhere; position; left; anywhere; away from; top; outside
Degree: Approximators	About; almost; fairly; in a way; nearly; as much as; or so; more or less; virtually; pretty much; just about; something like; round about; close to; practically; roughly; closely around
Relationship: Intimacy and sex	Gay; girlfriend; sexual; love; boyfriend; sexually; hug; go out with; fuck
Science and technology in general	Psychologist; scientific; science; radiation; technical; technically; psychology; clinical psychologist
Time: Beginning	Start/s/ed/ing; beginning; began; begin; initial; set/ting up; sources; the early days; form/ing; moved into
Discourse bin	Um; you know; er; yes; yeah; sort of; no; uh; oh; I mean; obviously; I think; anyway; of course; right; basically; kind of; sorry; as I said; or anything

Key concepts are those used more by men than by women interviewees ($p < 0.0001$) with words of frequency > 10 (or top 20 words where > 20 words). There were a total of 37 key concepts at this p level. Key concepts are sequenced by 'keyness' and words are also sequenced by keyness except for lemmas where various forms are grouped together.

Key concepts that were also 'key' when compared with the BNC sampler spoken are shown in bold ($p < 0.0001$).

Appendix 2

Women's Key Concepts (Full Matched Sample)

The following table provides an overview of the concepts and lexical items that are used more by the 99 women who were interviewed as compared with the men in the full matched sample. Explanatory notes are given below.

Key concepts	Lexical items
Thought/belief	Think; feel; thought; felt; feeling; thinking; suppose; believe; find; found; feelings; imagine; trust; attitude; guess; feels; in my head; believed; thinks; consider
Knowledgeable (Knowing)	Know; remember; knew; information; aware; specialist; knows; knowing; oncologist; news; knowledge; look back; looking back; conscious; informed; heard of; recognise; recall; warning
Strong obligation (Needing)	Have to; had to; need; should; must; 've got to; needed; having to; needs; supposed; necessarily; responsibility; 's got to; have got to; has got to; needing; 'd got to; essential; duty
Pronouns	I; it; that; you; my; they; me; he; she; we; what; them; her; is; which; something; this; your; who; him
Negative	n't; not; nothing; not really; negative; no way; n't really; none; not at all; anything but; negatively; no; nt really; n't at all; non; nor; not; neither
Kin	Husband; family; mum; mother; daughter; son; sister; parents; dad; father; sisters; brother; wed; married; daughters; mothers; wife; parent; relatives; sons

Continued

Key concepts	Lexical items
Speech/ communicative	Said; say; told; talk; saying; talking; point; says; talked; speak; spoke; mentioned; spoken; story; interview; conversation; mention; chat; response; voice; talks; communicate; speaking
Degree boosters	Very; really; so; more; a lot; much; very much; particularly; such a; that; extremely; far; any; incredibly; seriously; nice and; long way; more and more; desperately; tremendously
Exclusivisers; particularisers	Just; only; especially; if anything; alone; purely; overall; utterly; right down to; sheer; one bit; solely; chiefly; exclusively
Fear shock	Frightened; scared; shock; fear; frightening; scary; terrified; afraid; shocked; fears; panic; horrified; shy; petrified; panicked; terrifying; frighten; scare
Time: New/young	Baby; younger; babies; newer; toddler; babyish; freshers; tot; baby boy; baby stuff; breast-feeding; baby girl
Judgement of appearance	Awful; horrible; uncomfortable; unpleasant; nasty; mess; dirty; run down; unbearable

Key concepts used statistically more by all women interviewees than by all men interviewees ($p < 0.0001$) with words of frequency > 10 (or top 20 words where there are > 20 words). Key concepts are sequenced by 'keyness' and words are also sequenced by keyness.

Key concepts that are also 'key' when compared with the BNC sampler spoken are shown in bold ($p < 0.0001$).

Appendix 3
Significance Levels for Log-Likelihood Test

$p < 0.05$; critical value = 3.84
$p < 0.01$; critical value = 6.63
$p < 0.001$; critical value = 10.83
$p < 0.0001$; critical value = 15.13

See http://ucrel.lancs.ac.uk/llwizard.html for an explanation of the log-likelihood test.

Appendix 4
Demographic Sample of the British National Corpus

The spoken demographic sample of the British National Corpus is a section of the BNC corpus that represents spoken conversation from a sample that is controlled for the demographic variables of age, social class and sex; it is profiled below.

Age-groups in the BNC

	Texts	Word-units	%	Sentence-units	%
Respondent age 0–14	26	267,005	6.30	41,036	6.72
Respondent age 15–24	36	665,358	15.71	97,993	16.04
Respondent age 25–34	29	853,832	20.16	121,752	19.94
Respondent age 35–44	22	845,153	19.96	126,690	20.74
Respondent age 45–59	20	963,483	22.75	136,530	22.36
Respondent age 60+	20	639,124	15.09	86,556	14.17

Class in the BNC

	Texts	Word-units	%	Sentence-units	%
Unknown	7	37,622	0.88	5,340	0.87
AB respondent	59	1,372,933	32.42	197,795	32.39
C1 respondent	36	1,104,279	26.08	169,387	27.74
C2 respondent	31	1,087,808	25.69	144,876	23.72
DE respondent	20	631,313	14.91	93,159	15.25

Continued

Gender in the BNC

	Texts	Word-units	%	Sentence-units	%
Unknown	5	16,245	0.38	2,407	0.39
Male respondent	73	1,742,222	41.14	248,241	40.65
Female respondent	75	2,475,488	58.46	359,909	58.94

References

Addis, M. E. and Mahalik, J. R. (2003) 'Men, masculinity, and the contexts of help-seeking', *American Psychologist*, 58, 5–14.

Alexander, M. G. and Wood, W. (2000) 'Women, men and positive emotions: A social role interpretation', in *Gender and Emotion: Social Psychological Perspectives* (Cambridge: Cambridge University Press), pp. 189–209.

Allan, G. (2005) *Family Life* (Oxford, Blackwell).

Allender, S., Peto, V., Scarborough, P., Boxer, A. and Rayner, M. (2006) *Coronary Heart Disease Statistics* (London: British Heart Foundation).

Applegate, J. S. (1997) 'Theorizing older men', in J. I. Kosberg and L. W. Kaye (eds), *Elderly Men: Social Problems and Professional Challenges* (New York: Springer), pp. 1–15.

Arber, S. (2004) 'Gender, marital status, and ageing: Linking material, health, and social resources', *Journal of Ageing Studies*, 18, 91–108.

Arber, S. and Ginn, J. (1991) *Gender and Later Life: A Sociological Analysis of Resources and Constraints* (London: Sage).

Arber, S. and Ginn, J. (2005) 'Gender dimensions of the age shift', in M. L. Johnson (ed.), *The Cambridge Handbook of Age and Ageing* (Cambridge: Cambridge University Press), pp. 527–537.

Arber, S., Andersson, L. and Hoff, A. (2007) 'Changing approaches to gender and ageing', *Current Sociology*, 55(2), 147–153.

Baker, P. (2005) *Public Discourses of Gay Men* (London: Routledge).

Bakhtin, M. (1981) *The Dialogic Imagination*, ed. M. Hoquist (Austin: University of Texas Press).

Barnes, H. and Parry, J. (2004) 'Renegotiating identity and relationships: Men and women's adjustments to retirement', *Ageing and Society*, 24, 213–233.

Benwell, B. and Stokoe, E. (2006) *Discourse and Identity* (Edinburgh: Edinburgh University Press).

Bergvall, V. L. (1999) 'Toward a comprehensive theory of language and gender', *Language in Society*, 28, 273–293.

Berstein, B. (1971) *Class, Codes and Control* Vol. 1 (London: Routledge and Kegan Paul).

Biber, D., Conrad, S. and Reppen, R. (1998) *Corpus Linguistics* (Cambridge: Cambridge University Press).

Bourdieu, P. (1986) 'The forms of capital', in J. G. Richardson (ed.), *The Handbook of Theory: Research for the Sociology of Education* (New York: Greenwood Press), pp. 241–258.

Brody, L. (1999) *Gender, Emotion, and the Family* (Cambridge, MA and London: Harvard University Press).

Bryman, A. (1988) *Quantity and Quality in Social Research* (London: Unwin Hyman).

Bury, M. (1982) 'Chronic illness as biographical disruption', *Sociology of Health and Illness*, 4, 167–182.

Butler, J. (1990) *Gender Trouble Feminism and the Subversion of Identity* (London: Routledge).
Cameron, D. (2003) 'Gender and language ideologies', in J. Holmes and M. Meyerhoff (eds), *The Handbook of Language and Gender* (Oxford: Blackwell), pp. 447–467.
Cameron, D. (2005) 'Language, gender and sexuality: Current issues and new directions', *Applied Linguistics*, 26, 482–502.
Campbell, D. T. and Stanley, J. C. (1966) *Experimental and Quasi-experimental Designs for Research* (London: Wadsworth).
Cella, D. F. and Yellen, S. B. (1993) 'Cancer support groups: The state of the art', *Cancer Practice*, 1, 56–61.
Channell, J. (2000) 'Corpus-based analysis of evaluative lexis', in S. Hunston and G. Thompson (eds), *Evaluation in Text* (Oxford: Oxford University Press), pp. 38–55.
Chappell, N. (1989) 'Health and helping among the elderly: Gender differences', *Journal of Aging and Health*, 1(1), 102–120.
Charteris-Black, J. (2004) *Corpus Approaches to Critical Metaphor Analysis* (Basingstoke: Palgrave-Macmillan).
Charteris-Black, J. and Seale, C. (2009) 'Men and emotion talk: Evidence from the experience of illness', *Gender and Language*, 3(1), 81–113.
CIA World Factbook, https://www.cia.gov/library/publications/the-world-factbook/ (accessed 5/11/2009)
Coates, J. (2004) *Women, Men and Language* (London and New York: Pearson/Longman).
Connell, R. W. (1995) *Masculinities* (Berkeley: University of California Press).
Coupland, N. (1991) 'Preface: Sociolinguistic issues in ageing', *Ageing and Society*, 11, 99–102.
Coupland, N. (1997) 'Language, ageing and ageism: A project for applied linguistics?' *International Journal of Applied Linguistics*, 7(1), 26–48.
Courtenay, W. H. (2000) 'Constructions of masculinity and their influence on men's well-being: A theory of gender and health', *Social Science and Medicine*, 50, 1385–1401.
Coyne, I. T. (1997) 'Sampling in qualitative research: Purposeful and theoretical sampling; merging or clear boundaries', *Journal of Advanced Nursing*, 26, 623–630.
Davison, K. P., Pennebaker, J. W. and Dickerson, S. S. (2000) 'Who talks? The social psychology of illness support groups', *American Psychologist*, 55, 205–217.
DeFrancisco, V. L. (1998) 'The sounds of silence: How men silence women in marital relations' in J. Coates (ed.) *Language and Gender: A Reader* (Oxford: Blackwell), pp. 176–184.
Denzin, N. K. and Lincoln, Y. S. (2005) *The Sage Handbook of Qualitative Research*, 3rd ed. (Thousand Oaks, CA: Sage).
Dimatteo, M. R., Hays, R. D. and Prince, L. M. (1986) 'Relationship of physicians nonverbal communication skill to patient satisfaction, appointment noncompliance and physician workload', *Health Psychology*, 6, 581–594.
Docherty, A. (2004) 'Experience, functions and benefits of a cancer support group', *Patient Education and Counseling*, 55, 87–93
Dreger, A. D. (1998) 'Ambiguous sex – or ambivalent medicine?', *The Hastings Center Report*, 28, 24–35.

Eckert, P. (1990) 'The whole women: Sex and gender differences in variation', *Language Variation and Change*, 1, 245–267.
Eckert, P. (1997) 'Age as a sociolinguistic variable', in F. Coulmas, (ed.), *The Handbook of Sociolinguistics* (Oxford: Blackwell), pp. 151–167.
Eckert, P. (2000) *Linguistic Variation as Social Practice: The Linguistic Construction of Social Meaning in Belten High* (Oxford: Blackwell).
Eckert, P. and McConnell-Ginet, S. (1992) 'Think practically and look locally: Language and gender as community-based practice', *Annual Review of Anthropology*, 21: 461–490.
Eckert, P. and McConnell-Ginet, S. (2003) *Language and Gender* (Cambridge: Cambridge University Press).
Edelson, P. (1991) 'Sports during wartime', *Z Magazine*, pp. 85–87.
Emslie, C. and Hunt, K. (2009) 'Men, masculinities and heart disease: A systematic review of the qualitative literature', *Current Sociology*, 57, 155–191.
Emslie, C., Ridge, D., Ziebland, S. and Hunt, K. (2006) 'Men's accounts of depression: Reconstructing or resisting hegemonic masculinity?' *Social Science and Medicine*, 62, 2246–2257.
Erman, B. (2001) 'Pragmatic markers revisited with a focus on you know in adult and adolescent talk', *Journal of Pragmatics*, 33, 1337–1359.
Evangelista, L. S., Kagawa-Singer, M. and Dracup, K. (2001) 'Gender differences in health perceptions and meaning in persons living with heart failure', *Heart and Lung*, 30: 167–176.
Firth, J. R. (1935) 'The technique of semantics', *Transactions of the Philological Society*, 36–72.
Fishman, P. A. (1978) 'Interaction: The work women do', *Social Problems*, 25: 397–406.
Fishman, P. A. (1980) 'Conversational insecurity', in H. Giles, W. P. Robonson and P. M. Smith (eds) *Language and Social Psychological Perspectives* (Oxford: Pergamon), pp. 127–131.
Fodor, J. G. and Tzerovska, R. (2004) 'Coronary heart disease: Is gender important?' *Journal of Men's Health and Gender*, 1, 32–37.
Foucault, M. (1976) *The History of Sexuality: An Introduction* (Harmondsworth: Penguin).
Frank, A. W. (1995) *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago and London: University of Chicago Press).
Freed, A. (1992) 'We understand perfectly: A critique of Tannen's view of miscommunication', in K. Hall, M. Bucholz and B. Moonwomon (eds), *Locating Power: Proceedings of the Second Berkeley Women and Language Conference* (Los Angeles: University of California), pp. 144–152.
Galasiński, D. (2004) *Men and the Language of Emotions* (London and New York: Palgrave).
Giddens, A. (1986) *The Constitution of Society: Outline of the Theory of Structuration* (Berkeley: University of California Press).
Giddens, A. (1991) *Modernity and Self-Identity. Self and Society in the Late Modern Age* (Cambridge: Polity).
Giddens, A. (1994) *Beyond Left and Right – the Future of Radical Politics* (Cambridge: Polity).
Goatly, A. (2007) *Washing the Brain – Metaphor and Hidden Ideology* (Amsterdam/Philadelphia, PN: Benjamins).

Goffman, E. (1967) *Interaction Ritual: Essays on Face to Face Behaviour* (New York: Garden City).
Halliday, M. A. K. (1985) *An Introduction to Functional Grammar* (London: Edward Arnold).
Harrington, K. (2008) 'Perpetuating difference? Corpus linguistics and the gendering of reported dialogue', in K. Harrington, L. Litosselitt, H. Saunston and J. Sunderland (eds), *Gender and Language Research Methodologies* (Basingstoke: Palgrave Macmillan).
Harrison, J., Maguire, P. and Pitceathly, C. (1995) 'Confiding in crisis: Gender differences in pattern of confiding among cancer patients', *Social Science and Medicine*, 41(9), 1255–1260.
Hine, C. (2000) *Virtual Ethnography* (London: Sage).
Hoey, M. (2005) *Lexical Priming* (London: Routledge).
Holmes, J. (1986) 'Women's role in language change: A place for quantification', in N. Warner, J. Ahlers, L. Bilmes, M. Oliver, S. Wertheim and M. Chen (eds), *Gender and Belief Systems: Proceedings of the Fourth Berkeley Women and Language Conference, April 19–21* (Berkeley, CA: Berkeley Women and Language Group).
Holmes, J. and Meyerhoff, M. (2003) *The Handbook of Language and Gender* (Oxford: Blackwell).
Hunston, S. and Thompson, G. (eds) (2001) *Evaluation in Text* (Oxford: Oxford University Press).
Hunt, K., Lewars, H., Emslie, C. and Batty, G. D. (2007) 'Decreased risk of death from coronary heart disease amongst men with higher "femininity" scores: A general population cohort study', *International Journal of Epidemiology*, 36(3), 612–620.
Hutchby, I. and Wooffitt, R. (2008) *Conversation Analysis* (Cambridge: Polity Press).
Irvine, J. (2001) 'Style as distinctiveness: The culture and ideology of linguistic differentiation', in P. Eckert and J. R. Rickford (eds), *Style and Sociolinguistic Variation* (Cambridge: Cambridge University Press), pp. 21–43.
Jansen, S. C. and Sabo, D. (1994) 'The sport/war metaphor: Hegemonic masculinity, the Persian Gulf War, and the New World Order', *Sociology of Sport Journal*, 11, 1–17.
Jansz, J. (2000) 'Masculine identity and restrictive emotionality', in A. Fischer (ed.) *Gender and Emotion: Social Psychological Perspectives* (Cambridge: Cambridge University Press), pp. 166–186.
Jerrome, D. (1993) 'Intimate relationships', in J. Bond, P. Coleman and S. Peace (eds), *Ageing in Society: An Introduction to Social Gerontology* (London: Sage), pp. 226–254.
Johnson, S. and Finlay, F. (1997) 'Do men gossip? An analysis of football talk on television', in S. Johnson and U. H. Meinhof (eds), *Language and Masculinity* (Oxford: Blackwell), pp. 130–143.
Johnson, Sally and Meinhof, Ulrika H. (eds) (1997) *Language and Masculinity* (Oxford: Blackwell).
Johnstone, B. (1990) *Stories, Community and Place: Narratives from Middle America* (Bloomington: Indiana University Press).
Johnstone, B. (1993) 'Community and contest: Midwestern men and women creating their worlds in conversational storytelling', in D. Tannen (ed.),

Gender and Conversational Interaction (New York: Oxford University Press), pp. 62–80.
Kiesling, S. F. (2005) 'Homosocial desire in men's talk: Balancing and re-creating cultural discourses of masculinity', *Language in Society*, 34, 695–726.
Kiss, A. and Meryn, S. (2001) 'Effect of sex and gender on psychosocial aspects of prostate and breast cancer', *British Medical Journal*, 323, 1055–1058.
de Klerk, V. (1997) 'The role of expletives in the construction of masculinity', in S. Johnson and U. H. Meinhof (eds), *Language and Masculinity* (Oxford: Blackwell), pp. 144–158.
Labov, W. (1966) *The Social Stratification of English in New York City* (Washington, DC: Center for Applied Linguistics).
Lakoff, G. (1991) 'The metaphor system used to justify war in the Gulf', *Journal of Urban and Cultural Studies*, 2, 59–72.
Lakoff, R. (1975) *Language and Women's Place* (New York: Harper and Row).
Lukkarinen, H. (1999) 'Life course of people with coronary artery disease', *Journal of Clinical Nursing*, 8, 701–711.
Macaulay, R. K. S. (1977) *Language, Social Class and Education: A Glasgow Study* (Edinburgh: Edinburgh University Press).
Macaulay, R. K. S. (2005) *Talk That Counts: Age, Gender, and Social Class Differences in Discourse* (Oxford: Oxford University Press).
Mackay, J. and Mensah, G. (2004) *Atlas of Heart Disease and Stroke* (Geneva: WHO).
McElhinny, B. (2003) 'Theorizing gender in sociolinguistics and linguistic anthropology', in Janet Holmes and Miriam Meyerhoff (eds), *The Language and Gender Handbook* (Oxford: Basil Blackwell), pp. 21–42.
McEnery, A. and Xiao, Z. (2004) 'Swearing in modern British English: The case of *fuck* in the BNC', *Language and Literature*, 13, 235–268.
Milroy, L. (1980) *Language and Social Networks* (Oxford: Blackwell).
Norcross, W. A., Ramirez, C. and Palinkas, L. A. (1996) 'The influence of women on the health care-seeking behavior of men', *Journal of Family Practice*, 43, 475–480.
O'Brien, Rosaleen, Hunt, Kate and Hart, Graham (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 and Medicine*, 61, 503–516.
Ochs, E. (1992) 'Indexing Gender', in A. Duranti and C. Goodwin (eds) *Rethinking Context: Language as an Interactive Phenomenon* (Cambridge: Cambridge University Press), pp. 335–358.
Perren, K., Arber, S. and Davidson, K. (2003) 'Men's organisational affiliations in later life: The influence of social class and marital status on informal group membership', *Ageing and Society*, 23, 69–82.
Rayson, P. (2009) 'Wmatrix: A web-based corpus processing environment', Computing Department, Lancaster University, http://ucrel.lancs.ac.uk/wmatrix/
Rayson, P., Leech, G. and Hodges, M. (1997) 'Social differentiation in the use of English vocabulary: Some analyses of the conversational component of the British National Corpus', *International Journal of Corpus Linguistics*, 2, 133–152.
Riessman, Catherine K. (1990) 'Strategic uses of narrative in the presentation of self and illness: A research note', *Social Science and Medicine*, 30, 1195–1200.

Romaine, S. (2003) 'Variation in Language and Gender', in Janet Holmes and Miriam Meyerhoff (eds), *The Language and Gender Handbook* (Oxford: Basil Blackwell), pp. 98–118.

Rose, D. and Pevalin, D. J. with O'Reilly, K. (2005) *The NS-SEC: Origins, Development and Use* (London: Palgrave Macmillan).

Russell, C. (2007) 'What do older women and men want? Gender differences in the "lived experience" of ageing', *Current Sociology*, 55, 173–192.

Savage, M. (2000) *Class Analysis and Social Transformation* (Buckingham: Open University Press).

Sax, L. (2002) 'How common is intersex? A response to Anne Fausto-Sterling', *Journal of Sex Research*, 39(3), 174–178.

Schmid, H-J. and Fauth, J. (2003) 'Women's and men's style: Fact of fiction? New grammatical evidence', paper delivered at Corpus Linguistics Conference, Lancaster University, UK.

Scott, Michael (2005) Wordsmith tools 4.0 Oxford: Oxford University Press, http://www.lexically.net/wordsmith/version4/.

Seale, C. (1999) *The Quality of Qualitative Research* (London: Sage).

Seale, C. (2002) 'Cancer heroics: A study of news reports with particular reference to gender', *Sociology*, 36 (1), 107–126.

Seale, C. (2005a) 'Portrayals of treatment decision-making on popular breast and prostate cancer web sites', *European Journal of Cancer Care*, 14(2), 171–174.

Seale, C. (2005b) 'New directions for critical internet health studies: Representing cancer experience on the web', *Sociology of Health and Illness*, 27(4), 515–540.

Seale, C. (2006) 'Gender accommodation in online cancer support groups', *Health*, 10(3), 345–360.

Seale, C. (2008) 'Mapping the field of medical sociology: A comparative analysis of journals', *Sociology of Health and Illness*, 30(5), 677–695.

Seale, C. and Charteris-Black, J. (2008a) 'The interaction of class and gender in illness narratives', *Sociology*, 42, 453–469.

Seale, C. and Charteris-Black, J. (2008b) 'The interaction of age and gender in illness narratives', *Ageing and Society*, 28, 1025–1045.

Seale, C. and Charteris-Black, J. (2010) 'Keyword analysis: A new tool for qualitative research', in I. L. Bourgeault, R. DeVries and R. Dingwall (eds), *Handbook of Qualitative Health Research* (London: Sage).

Seale, C., Charteris-Black, J. and Ziebland, S. (2006) 'Gender, cancer experience and internet use: A comparative keyword analysis of interviews and online cancer support groups', *Social Science and Medicine*, 62(10), 2577–2590.

Seale, C., Boden, S., Lowe, P., Steinberg, D. and Williams, S. (2007) 'Media constructions of sleep and sleep disorders: A study of UK national newspapers', *Social Science and Medicine*, 65(3), 418–430.

Seale, C., Charteris-Black, J., Dumelow, C., Locock, J. and Ziebland, S. (2008) 'The effect of joint interviewing on the performance of gender', *Field Methods*, 20: 107–128.

Seale, C., Charteris-Black, J., MacFarlane, A. and McPherson, A. (forthcoming 2010) 'Interviews and internet forums: A comparison of two sources of data for qualitative research', *Qualitative Health Research*.

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(3), 253–267.
Sharp, I. (ed.) (1994) *Coronary Heart Disease: Are Women Special?* (London National Forum for CHD Prevention).
Sinclair, John (1987) 'Collocation: A progress report', in Ross Steele and Terry Threadgold (eds), *Language Topics Essays in Honour of Michael Halliday Vol. 2*, (Amsterdam: John Benjamins), pp. 319–331.
Sinclair, J. (1991) *Corpus, Concordance, Collocatio*n (Oxford: Oxford University Press).
Silverman, D. (2004) *Doing Qualitative Research*, 2nd ed. (London: Sage).
Sontag, S. (1991) *Illness as Metaphor and Aids and Its Metaphors* (London, New York, Victoria, Ontario and Auckland: Penguin).
Speer, S. A. (2005) Ge*nder Talk: Feminism, Discourse and Conversation Analysis* (London: Routledge).
Stokoe, E. H. and Weatherall, A. (eds) (2002) 'Gender, language, conversation analysis and feminism', *Discourse and Society*, 13, 707–864.
Stubbe, M. and Holmes, J. (1995) *'You know, eh* and other "exasperating expressions": An analysis of social and stylisic variation in the use of pragmatic devices in a sample of New Zealand English', *Language and Communication*, 15: 63–88.
Stubbs, M. (1996) *Text and Corpus Analysis: Computer-Assisted Studies of Language and Culture* (Oxford: Blackwell).
Stubbs, M. (2001) *Words and Phrases: Corpus Studies of Lexical Semantics* (London: Blackwell).
Tannen, D. (1989) *Talking Voices: Repetition: Dialogue and Imagery in Conversational Discourse* (Cambridge: Cambridge University Press).
Tannen, D. (1992) *You Just Don't Understand Women and Men in Conversation* (London: Virago).
Trudgill, P. (1974) *The Social Differentiation of English in Norwich* (Cambridge: Cambridge University Press).
Tudiver, F. and Talbot, Y. (1999) 'Why don't men seek help? Family physicians' perspectives on help-seeking behaviour in men', *Journal of Family Practice*, 48, 47–52.
Umberson, D. (1992) 'Gender, marital status and social control of health', *Social Science and Medicine*, 34, 907–917
Walton, J. (2002) 'Discovering meaning and purpose during recovery from an acute myocardial infarcation', *DCCN: Dimensions of Critical Care Nursing*, 1, 69–76.
Warren, Lynda W. (1983) 'Male intolerance of depression: A review with implications for psychotherapy', *Clinical Psychology Review*, 147–156.
Wenger, G. C., Davies, R., Shahtahmasebi, S. and Scott, A. (1996) 'Social isolation and loneliness in old age: Review and model refinement', *Ageing and Society*, 16, 333–358.
White, A. K. and Johnson, M. (2000) 'Men making sense of their chest pain: Niggles, doubts and denials', *Journal of Clinical Nursing*, 9, 534–541.
Whitehead, S. M. (2002) *Men and Masculinities* (Cambridge and Malden, MA: Polity Press).

Williams, G. (1984) 'Genesis of chronic illness: Narrative reconstruction', *Sociology of Health and Illness*, 6, 175–200.
Williams, R. (1976) *Keywords* (Glasgow: Fontana).
Zimmerman, D. and West, C. (1975) 'Sex roles, interruptions and silences in conversations', in B. Thorne and N. Henley (eds), *Language and Sex: Difference and Dominance* (Rowley, MA: Newbury House), pp. 105–129.

Index