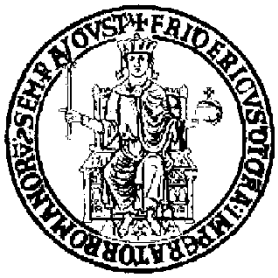
UNIVERSITÀ DEGLI STUDI DI NAPOLI FEDERICO II



FACOLTÀ DI SCIENZE POLITICHE

DIPARTIMENTO DI TEORIE E METODI DELLE SCIENZE UMANE E SOCIALI

SCUOLA DI DOTTORATO IN

SCIENZE PSICOLOGICHE, PEDAGOGICHE E LINGUISTICHE

DOTTORATO DI RICERCA

IN

LINGUA INGLESE PER SCOPI SPECIALI

XXIV CICLO

TESI DI DOTTORATO

Illness narratives: a linguistic study of gender and identity in patients' accounts

CANDIDATO

dott. MARCO DE MARTINO

RELATORE
Prof.ssa Cristina Pennarola

COORDINATORE
Prof.ssa Gabriella Di Martino

TUTOR

Prof.ssa Stefania Maria Maci

NAPOLI 2011

Acknowledgments

I would like to thank Sue Ziebland, research director of the DIPEx research group for the multimedia website www.healthtalkonline.org, for giving me permission to use the material contained in the website.

I am deeply indebted to Silvia Bernardini for her valuable help throughout my PhD course, to my supervisor Cristina Pennarola and to my tutor Stefania Maci for their stimulating suggestions.

Most thanks also go to Giovanni Miniero for providing computer technology support in the corpus building stage.

I am also grateful to Suzanne Romaine, Jenny Cheshire, Gabriella Di Martino, Vanda Polese and Marco Venuti for their precious comments and observations.

1. Introduction

Illness narratives are generally conceived as patients' written and/or oral accounts about their illnesses and the effect on their lives. They can also include the perspective of relatives about the effects the illnesses have had on their relationships with the sick people and on their own lives. Both oral and written illness narratives help to configure and articulate experiences and events that change one's life and its "prerequisites" as a result of illness.

Research on the forms and functions of illness narratives burgeoned in the past twenty years. The medical sociologist Arthur Frank (1995) suggests that this interest has to do with ill persons in late modernity wanting to have their own suffering recognized in its individual particularity. Langellier (2001:699) identifies four reasons underlying this interest:

- The "narrative turn" in the human sciences away from positivist modes of inquiry;
- The "memoir boom" in literature and popular culture;
- The new "identity movements" — emancipation efforts of people of colour, women, gays and lesbians, and other marginalized groups;
- The burgeoning therapeutic culture—exploration of personal life in therapies of various kinds.

As Hydén (1997:49) states, "patients' narratives give voice to suffering in a way that lies outside the domain of the biomedical voice." In other words, patients' illness narratives capture the individual's suffering in an everyday context, in contrast to the medical narratives that reflect the needs of the medical professions and institutions.

Illness (like other life events, such as divorce or infertility), interrupts lives that many individuals assume will be continuous, ordered, sequential, and also raise questions about the sense and purpose of life in the world. Such interruption undermines established social roles and requires a complete re-evaluation and re-negotiation of the "self", and it is likely that in such a reconstruction language plays a fundamental role (cf. also Frank 1995 and next chapter).

The aim of this doctoral thesis is to elaborate on the relation between gender, language and illness, to answer the following questions:

- Do men and women "do" illness differently as they "do" gender (in the sense of *performing* it, cf. Butler 1990) in many different ways?
- If so, why do men and women "do" gender and illness differently?

However, it should be stressed that the purpose is not to generalise results to all men and women, but rather to relativize their behaviour to the specific corpus analysed in this doctoral thesis. Indeed, as gender theorists now argue, we need to speak about *masculinities* and *femininities*, rather than assuming singular notions about gender (Connell, 1995). As Tannen (1990:16-17) says, "there *are* (her emphasis) gender differences in ways of speaking, and we need to identify and understand them", because "only by understanding each other's styles and our own options can we begin to realise our opportunities and escape the prison of a monolithic conversational style".

However, as Bing & Bergvall (1998) suggest, the problem is not difference, but oversimplification and stereotyping. One obvious oversimplification is that of using statistical differences between two groups as proof that all members of one group have certain characteristics shared by no members of the other group (and vice versa).

This oversimplification (e.g. "boys are better at maths than girls", etc.)- which has traditionally limited choices and opportunities for girls and women- is also reflected in research, with the so-called phenomenon of the "hall of mirrors" (Eckert and McConnell-Ginet 2003:81): even when each individual researcher has made only modest claims on the basis of individual studies, the combination of the sheer volume of studies has led to a general impression of robust findings, whereby in the end these stereotypes are given a scientific endorsement and become part of the background of general truth about language and gender.

As has been suggested, the issue should not be difference, but *gender polarisation*, "the ubiquitous organisation of social life around the distinction between male and female" (Bem1993: 2). As Bem shows, the problem with gender polarisation is not that there are differences, but that these differences define mutually exclusive scripts for being male and female.

If linguists are to undermine rather than strengthen gender polarisation, they need to create new metaphors to help to think about sex, gender and language. Nicholson (1994: 100) for instance, proposes a metaphor of women compared to a tapestry, unified by overlapping threads of colour, and suggesting a "complicated network of criss-crossing intersecting similarities and differences". However, for the sake of equal "metaphor opportunities", this should apply to men too.

The present doctoral thesis is structured as follows: Chapter 2 contains a literature review on the theoretical framework of the thesis, where I try to summarise some of the main trends in *narrative-based medicine* and to highlight the theoretical approaches that underpin the analysis: *corpus linguistics*, *discourse analysis* and *gender studies*.

In Chapter 3 I describe the corpus and give an overview of the *Healthtalkonline* website; I also expand on the processes of data collection, transcription, mark-up and post-editing. I also explain that the corpus was divided into two sub-corpora: the first (named “gender corpus”) deals with cancers affecting primary and secondary sexual organs, whereas the reference subcorpus relates all the other conditions. The corpora were then compared in order to obtain a “gender” KW list. Afterwards, the “gender” subcorpus was split into two further subcorpora (*men* and *women cancer*) which were compared together, resulting in separate keyword lists for each.

Chapter 4 deals with the analysis of the corpus: here I examine a number of keywords in detail, in order to identify different discourses of gender and identity in the patients’ accounts. Moreover, I explore key clusters and key semantic categories and also compare some results to a reference corpus of general British English.

Finally, Chapter 5 provides conclusions and suggestions for future research.

2. Literature review

2.1 Narrative medicine

Narrative medicine is the practice of medicine with narrative skills, that is, with the narrative competence allowing health practitioners to recognize, elaborate and act upon the patients' stories of illness (Charon 2006). A *melting pot* of heterogeneous sources (humanities and medicine, primary care medicine, contemporary narratology, the study of doctor/patient relationship) narrative-based medicine (henceforth NBM) has gradually developed from the 1960s to date to acquire its own status in medical care. But why narrative medicine? What kind of need does it try to satisfy?

Medical research has undoubtedly made enormous progress in the past decades: this implies that a lot of lives are saved every day thanks to many factors; for example, earlier cancer detection through medical imaging, better management of chronic diseases thanks to new drugs available, improved surgical techniques allowing organ transplants; suffice it to mention the sensation caused by partial and total face transplants, which gained wide media coverage.

On the one hand, medical advances have improved life expectancy and quality of life for the diseased, at least in Western countries. On the other hand, however, the path to progress is not without stumbling rocks: much medical progress was made possible at the expense of the inherent dignity of the human person. Several scholars (Foucault 1963, 1976; Galimberti 1983; Kleinman 1988; Good 1994; Frank 1995; Greenhalg & Hurwitz 1998, 2004; Charon 2006) have criticised the reductionist pattern that medicine uses in relation to patients, which are often regarded more as embodied diseases rather than sentient human beings; the patient is seen as the carrier of symptoms which have to be deciphered by medical expertise and translated into a taxonomy of diseases fitting into detailed nosological schemes; this ability is a prerequisite of the medical profession but the terminology used is usually obscure to patients themselves.

The biomedical model of modern medicine is deep-rooted in the Cartesian dualism *res cogitans/res extensa* (Galimberti 1983, Giarelli&Venneri 2009): the mind, *res cogitans*, is thought as perfectly rational while the body, *res extensa*, is conceived mechanically and atomistically as a machine. This mechanistic view is not a novelty of the 17th century, but is rather an underlying concept of the Western culture, dating back to Plato with his

anthropologic duality *body/soul* (*soma/psyche*) and his doctrine of knowledge (Galimberti 1983, 1992).

The Cartesian duality is at the very base of the cultural dichotomy between humanistic and scientific culture; the humanistic culture is rationally oriented to the problem of truth through introspection, whilst the scientific culture is empirically oriented through the experimental method developed by Galileo, Bacon and Newton. According to Descartes (cit. in Galimberti 2009: 72) only the *res cogitans* is endowed with the faculty of thought; therefore, the body can only be conceived by the mind: it is an idealized body rather than a body in flesh and bone, the body of anatomy which is inspected through anatomical dissections of corpses (*soma* in ancient Greek). This tradition was carried on by English empiricism (Locke, Hume, and Berkeley) at the very eve of the Enlightenment and the following scientific and industrial revolutions.

According to Berkeley (cit. in Luce 1966), *esse est percipi* (to be is to be perceived): this means that all the things surrounding us are nothing but our ideas. Sensible things have no other existence distinct from their being perceived by us. This also applies to human bodies. When we see our bodies or move our limbs, we perceive only certain sensations in our consciousness. Similarly, Hume (*A treatise of human nature*, 1739, cit. in Galimberti 2009: 74) states that nothing is really present to the mind except its perceptions or ideas; this implies that the body too is reduced to a mere subjective representation.

Much in line with this argument, the biomedical model of contemporary science reduces the body into a *biological simulacrum* (Galimberti 1983). Our body is no longer our perspective on the world; it is rather an object of this world, reduced by science into a sum of molecules, cells, tissues, organs. If science represents the real and the only worthwhile point of view, then the body is not to be interpreted as we live and perceive it, but rather according to anatomical and physiological categories which imply that personal experiences be transcended in favour of a general description of the world.

Scientific knowledge, in its biomedical declination, makes the same abstraction from the particular to the general which is a characteristic of the experimental method of physics, used by scientists like Galileo, Bacon, Newton: it is noteworthy that physiology, the study of the function of the living systems, relies heavily on the mechanistic model of the body-machine and on the experimental method of physics. Not surprisingly, physiology acquired scientific status in the 17th century with William Harvey's description of the cardiovascular system (*De motu cordis*, 1628).

However, this mechanistic vision was to be questioned in the centuries to come; against empiricism, Wittgenstein (2006) considers that the human being is a psycho-physical unity, not an embodied *anima*, but a living creature in 'a stream of life', because it is human beings, not minds, who perceive and think, have desires and act, feel joy and sorrow. *Hic est locus ubi mors gaudet sucurrere vitae* ("This is the place where death delights in helping life") is an inscription which can be read on entering the *Anatomical Theatre* in Padua and the Anatomical Hall of the *Ospedale degli Incurabili* in Naples; however, in line with Galimberti (2009) one could highlight the paradox of biomedicine which claims to provide a thorough explanation of life resting upon the study of cadavers. The dissected cadaver is not the body, but instead a simulation model which cannot fully account for the complexity of a living body; now, science absolutizes this fictional model and does not acknowledge its conventional nature; in so doing, it builds up a reality where objectivity is a homologating postulate (Monod 2001) which not only avoids conflict, but also conceals political strategies underpinning scientific discourse (Galimberti 2009).

With such epistemological grounds, disease becomes a gnoseological category for physicians whose eyes never meet the ill person's embodied biography, but her pathology. The biomedical gaze interprets the ill person's individual symptoms and translates them into another code made of objective signs, according to the aforesaid abstraction pattern typical of the scientific method; the patient's ailments are recast as a pathology name (pneumonia, liver cancer, Asperger's syndrome etc.). It is also noteworthy that the objectivation process is radicalized in medical jargon, where it is not rare to refer metonymically to patients with the organ affected or the pathology label (the *liver* in room 4, the *lung* in ward 3, the *Asperger* boy etc.; cf. also Couser 1997).

Against this background, narrative medicine tries to give new dignity to patients' accounts of illness. Frank (1995) explains the growing attention on illness experiences with the shift from modernity to postmodernity. In his words, postmodernity occurs when the same ideas and actions acquire different meanings. Likewise, the modern experience of illness begins when popular experience is overtaken by the technical expertise of professionals who interpret pains as symptoms and also use a specialized jargon that is unfamiliar and overwhelming; the chart becomes the official story of illness, the medical narrative *par excellence*. At the same time, the prestige of medical language colonizes the ill persons' accounts, so that ill people tell family and friends versions of what the doctors said. The central moments in modernist illness experience is therefore a narrative surrender, whereby the ill person not only agrees to follow prescriptions but also tacitly agrees to tell her story in medical terms.

This position is very much in line with sociologist Parsons' theory of the *sick role* (Parsons 1950, cit. in Frank 1995:5, Giarelli & Venneri 2009:201-204), according to whom a main social expectation of being sick is surrendering oneself to the care of a physician. 'Being Sick', according to Parsons, is not simply a 'state of fact' or 'condition', it contains within itself customary rights and obligations based on social norms. Being sick means that the sufferer enters a role of 'sanctioned deviance'. This is because, from a functionalist perspective, a sick individual is not a productive member of society. Therefore this deviance needs to be policed, which is the role of the medical profession. The general idea is that the individual who has fallen ill is not only physically sick, but now adheres to the specifically patterned social role of being sick. As a consequence, medicine is conceived as a tool of social control, aimed at enhancing the sense of duty and social responsibility.

Another milestone in sociological studies on medicine is the therapeutic triangle composed of the terms *illness, disease and sickness* (Kleinman 1980, 1988, 2006; Good 1999).

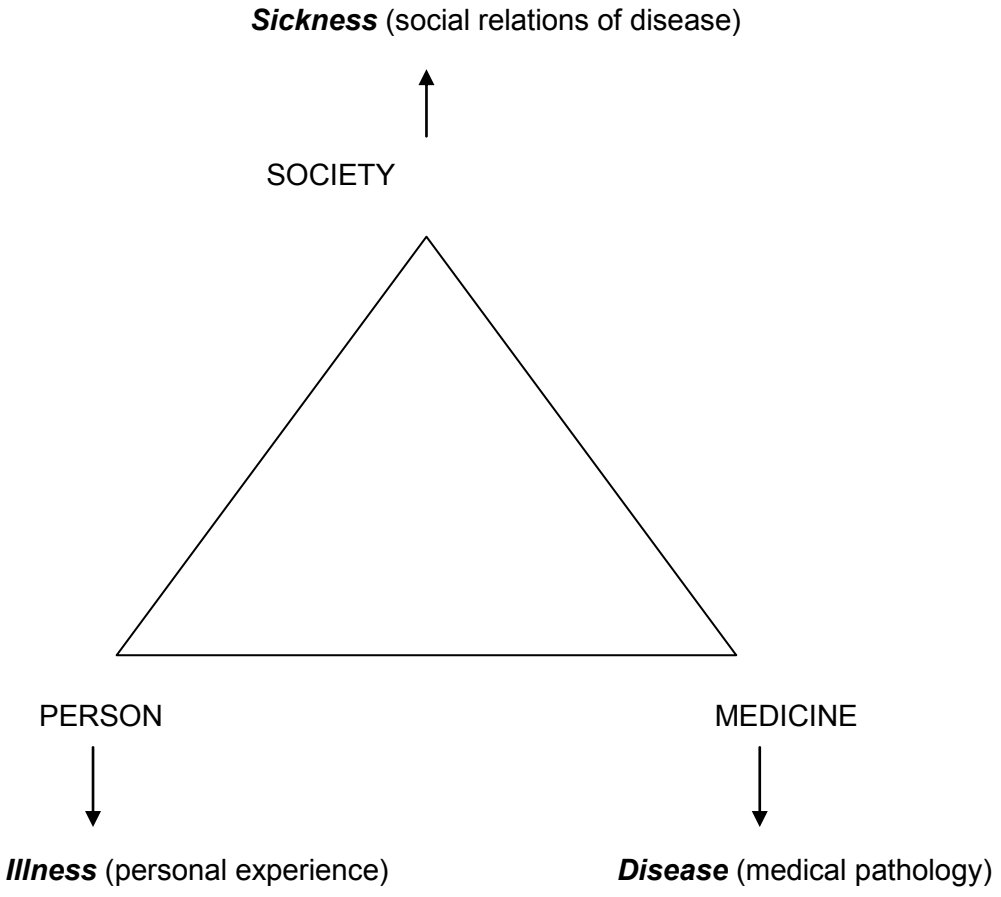


Fig. 1 The therapeutic triangle*: illness/disease/sickness* (adapted from Giarelli & Veneri 2009)

Illness is indeed both an individual and a social phenomenon, with at least three subjects at stake: the ill person/patient, the medical profession/staff, and society on the whole, which form a triadic system of social interaction. According to health sociology, each bears a different perspective on the phenomenon, thus justifying the use of the labels *illness, disease and sickness*.

- **Illness** is the personal experience of symptoms and suffering, along with the perception, emotional response, cognition and evaluation of symptoms and disability (Kleinman 1998, Giarelli & Venneri 2006). Illness has a special (but not exclusive) focus on the psychological and cultural dimensions of the subjective malaise, as conceived by the ill person and the inner circle of family and friends;

- **Disease** is the health problem from the practitioner's perspective: the practitioner interprets the patient and the family's illness problem according to his/her biomedical model, in terms of alteration in biological structure or function. In Western societies it is expressed through the nosological taxonomies of the biomedical knowledge (Kleinman 1980, 1988);

- **Sickness** is the health problem from the social point of view whereby certain biological or behavioural signs are loaded with recognizable features and recast into socially meaningful symptoms. For instance, the relationship between tuberculosis (TBC) and malnutrition in some areas of the world is a way of investigating TBC from a *sickness* perspective (Kleinman 2006).

The postmodern experience of illness begins when ill people acknowledge that their experience cannot be reduced to a medical chart and reclaim the importance and dignity of their voice. People challenge the reductionist and reifying view of medicine which de-humanizes patients into organs and pathologies, demanding to speak, rather than to be spoken for (Frank 1995). The modernist thought is "either/or": you are either well or sick; either wellness is in the foreground and sickness is in the background or vice versa, they are conflicting aspects of human life. By contrast, the postmodernist thought is much more "both/and", in the sense that the foreground and background of sickness and health represent a more shaded picture, deeply affecting one's own sense of identity.

Moreover, illnesses themselves have changed in the past thirty years, shifting from acute to chronic; as a consequence, the postmodern chronically ill person wants his/her suffering acknowledged in its individual character. From a certain viewpoint, this phenomenon might also be explained as an ambivalent side effect of the individualistic wave (Lasch 1979, Giddens 1991, Elliot & Lemert 2006, Elliot 2007) involving the political,

social and private dimensions which started in the 1970s - moving from the USA and the UK to the Western world and to date globally widespread.

Behind the epistemological shift from objective to subjective, or -in Frank's words- from modernity to postmodernity/post-colonialism, it is possible to note the influence of phenomenology (especially Husserl and Merleau-Ponty) and existentialism (especially Heidegger). According to Husserl (cit. in Good 1999:186), the "world of life" (*Lebenswelt*) is the world of our common lived experiences; this is usually at odds with the objective world of science, which many people conceive as reality *par excellence*. Conversely, Husserl states that it is science which is based on the world of life, the scientific world being only one of the possible worlds we live in: the world of dreams, of religion, art and music, and of common sense which dominates our lives. In the *Phénoménologie de la perception* (1945) Merleau-Ponty interprets the body as the main tool of experience and of our comprehension of the phenomenal world; his phenomenological analysis was the cause of the later discussion on the concept of *embodiment* in philosophy and medical anthropology (Good 1999).

According to this view, the experiential world of chronic pain and illness can only be understood by individuals' experience. The ill person's pain may become a "whole", a totalizing experience, a dimension absorbing the self's whole perception, thus also influencing the workplace and daily activities. The self is then built in relation to a peculiar *Lebenswelt* which is made of pain. Chronically ill people or those who are diagnosed with "incurable" diseases often report the sensation that the world has changed; the scale of values is no longer what it was before the diagnosis. This involves the risk of a definite collapse of the patients' *Lebenswelt* ("world of life"), which may be contrasted through narrative tools. The problem of illness as suffering raises two fundamental questions for the ill person and the social group: *Why me?* (the question of bafflement) and *What can be done?* (the question of order and control). To date, the societal response to such questions raised by suffering is still given prevalently in the rational-technical "biomedical language", with limited attention to their deeper significance.

By contrast, illness narratives (Good 1999, Kleinman 1988) allow ill people to historically collocate suffering in their stories, so giving a restitution story (Frank 1995) which recasts the events in a temporal and meaningful order.

Indeed, one of the aims of this doctoral thesis is to provide insights into the linguistic features used by men and women in their accounts of illness.

2.2 Corpus linguistics and discourse analysis

In modern linguistics, a corpus can be defined as a collection of machine-readable authentic texts (including transcripts of spoken data) which is sampled to be representative of a particular language or language variety (McEnery & Xiao 2006:5) and is suitable for linguistic analysis (Tognini-Bonelli 2001:2).

Broadly speaking, corpus linguistics is "the study of language based on examples of real life language use" (McEnery & Wilson 1996:1). It is an empirical approach since the enquiry starts from authentic data and aims at analysing and describing language use as realised in texts (Tognini-Bonelli 2001:2).

Corpus linguistics is a relatively recent branch of linguistics and many scholars do not seem to agree with its status, halfway between a methodology and a theory of language; according to McEnery and Wilson (1996:1), corpus linguistics is "nothing but a methodology", created from a set of theoretical principles about language. Leech (1992, cit. in Baker 2010:6) and Tognini-Bonelli (2001) state that it is a new philosophical approach to linguistic enquiry. McEnery (2006:7-8) agrees that corpus linguistics should be considered a methodology within linguistic analysis, but not an independent branch of linguistics in the same way as phonetics, syntax, semantics or pragmatics.

Tognini-Bonelli (2001) draws a distinction between *corpus-based* and *corpus-driven* research:

- A *corpus-based* approach uses a corpus as a source of examples, to check the researcher's intuition or to exemplify theories and descriptions that were formulated before large corpora became available (Tognini-Bonelli 2001:65);
- A *corpus-driven* analysis is more inductive, in that the corpus is used to support linguistic argument or to validate theoretical statements, which are "fully consistent with, and reflect directly, the evidence provided by the corpus" (Tognini-Bonelli 2001:84).

The present study may qualify for a corpus-based approach, in that it relies on both quantitative and qualitative techniques (Biber et al. 1998:4). Corpus software provides quantitative patterns which in turn need a functional (qualitative) interpretation. This is an essential step in any corpus-based analysis, because the software can present or sort concordance data in various ways, but it cannot make sense of it (Biber et al. 1998, Baker 2010).

McEnery (2006) suggests that the distinction between corpus-based and corpus-driven approach is overrated and it would be probably better to consider them as the opposite poles of a continuum. In this sense, Partington (2006) prefers the expression *corpus-assisted analysis*, which can involve using a corpus as data to carry out linguistic analysis, but can also imply other forms of data or analysis occurring simultaneously (e.g. interviews, historical research etc.).

Teubert (2005:8) and Hoey et al. (2007) underline that corpus linguistics focuses on language as a social phenomenon and makes visible the attitudes and beliefs expressed by the members of a discourse community (Swales 1990). Again in Teubert's (2007: 67) view, the prime object of corpus linguistics is discourse, in the sense of language as a concrete object which can be empirically analysed, whereas the language system (Saussure's *langue*) remains by its very nature an object of speculation. Discourse is where language and social studies meet (Hoey 2007) since it has historical, social, functional and regional dimensions. This position represents a shift from mainstream linguistics (from Saussure to Chomsky) which has defined itself with reference to the dualism *langue/competence* versus *parole/performance* (with a special focus on the former).

Actually, Labov (1972, cit. in Stubbs 2001) underlined the "Saussurean" paradox: *langue/competence* is seen as systematic and as the only true object of study; but, being abstract ("a social fact" or an aspect of individual psychology), it is unobservable. *Parole/performance* is seen as unsystematic and idiosyncratic; but, although concrete, it is observable only in passing fragments, thus equally unobservable as a whole. As Stubbs (2001: 317) states, corpus linguistics provides a way out of this paradox; a corpus is a sample of actual utterances, which are not records of one individual's performance, but of the language use of many speakers. The analysis of large corpora allows for the study of patterns which are stable across the language performance of many speakers, although not directly visible to a human observer.

As regards discourse analysis, it is a fast growing and evolving field, which borrows from many and heterogeneous academic disciplines: linguistics, anthropology, philosophy, communication, cognitive psychology, social psychology and artificial intelligence.

Work in discourse analysis is so diverse that *discourse* is almost a synonym for *language* (Schriffin et al. 2001:3). Against such a diverse background, the terms *discourse* and *discourse analysis* may acquire different meanings. A thorough and exhaustive explanation of all these meanings is beyond the remit of the present work; however, Schriffin et al. (2001) state that all the definitions of discourse share three main features:

- Anything beyond the sentence;
- Language use;
- A broader range of social practice that includes non-linguistic and non-specific instances of language.

In line with Gee (2004: 8), who states that language has meaning only in and through social practices, it is possible to say that discourse analysis aims at providing the "thinking devices" (Gee 2004) for studying how language is used to enact specific social activities and social identities and how meanings are shaped in texts and/or situations of use. Meanings are situated in actual contexts of use, because of the "reflexivity" (Duranti & Goodwin 1992, Gee 2004) of language, whereby it always simultaneously reflects and constructs the situation or context in which it is used; in this sense, language and context are like two mirrors facing each other and constantly reflecting their own images back and forth. Accordingly, discourse analysis implies a movement from context to language and vice versa: we gain information about a context of language use and employ this information to form hypotheses about the meaning and function of that instantiation of language. This process may prove useful to fine-tune the findings of the present corpus-based study.

2.3 Gender studies

The corpus investigated in this doctoral thesis presents many features that can be properly analysed only taking into account gender studies.

Gender studies is an interdisciplinary field (involving subjects such as literary theory, drama studies, film theory, performance theory, contemporary art history, anthropology, sociology, psychology and psychoanalysis) which has as many different views as the disciplines considered. French philosopher Simone de Beauvoir said "On ne naît pas femme: on le devient" (1949: 285); by elaborating on this aphorism, in gender studies the term "gender" is used to refer to the social and cultural constructions of masculinities and femininities, not to the biological state of being male or female. Indeed, while *sex* refers to a biological *male/female* distinction, *gender* operates as a *masculine/feminine* dichotomy, since it refers more to cultural and societal expectations (cf. Cameron & Kulick 2003, Baker 2008). *Sexuality*, instead, is related to both sex and gender and refers to the ways that people conduct themselves as sexual beings (in terms of sexual behaviour, desire, identity, orientation; cf. Baker 2008: 6, Cameron & Kulick 2003: ix-xi).

As Baker (2008: 5) states, not all men and women act an think in traditionally gendered (masculine and feminine) ways, which makes the idea of always linking sex to gender (e.g. male=masculine, female=feminine) erroneous. Moreover, sex is a binary, biological concept, while gender is a more fluid concept, which can be characterised on a linear scale and is subject to change across societies and individuals. According to Ochs (1992: 339), the notion of gender centres on the premise that the notions of *men and women/male and female* are sociocultural transformations of biological categories and processes. That is, social groups organise and conceptualise men and women in culturally specific and meaningful ways.

One of the most famous early linguistic studies on gender is Robin Lakoff's *Language and Woman's Place* (1975), where she suggested the presence of a distinctive feminine register, which she called *women's language* (WL). The reported features of WL included polite forms, hedges, avoidance of strong expletives (*fudge* rather than *damn* or *shit*), rising intonation on declarative sentences, question tags, and lexical items such as *lovely, divine* and elaborate colour shades (e.g. *mauve* rather than just *purple*). The common denominator of all these characteristics is to reduce the force of the utterances, making the speaker feel less confident, less certain and less powerful.

Another germinal book was Tannen's *You Just Don't Understand* (1990), on the subject of male-female misunderstandings and "talking at cross-purposes" within heterosexual couples.

However, later research (cf. McElhinny 2003: 24) pointed out that these studies might be flawed in taking heterosexuality as the norm and studying gender only in heterosexual interactions, which may be quite misleading, since gender differences may be exaggerated in such interactions.

The post-structuralist feminist approach, much influenced by philosophers such as Jacques Lacan and Judith Butler (namely by her book *Gender Trouble*, 1990) poses the question in another way: instead of asking "what are the gender differences?", this approach leads one to ask "what difference does gender make?" and "how did gender come to make a difference?" This approach, then, aims to investigate how categories such as "woman" are created and which political interests the creation and perpetuation of certain identities and distinctions serves. Where people's behaviour does not conform to dominant norms of masculinity or femininity, it is rendered unintelligible or incoherent: certain people or certain behaviours may not be recognized as legitimately human. Because they deviate from normative conceptions of how sex, gender, and sexuality

should be aligned they are subject to repercussions and sanctions which vary according to local context.

In her seminal *Indexing gender* (in Duranti & Goodwin,1992), Ochs critiques earlier feminist work on language (e.g. Lakoff 1975) which assumes that language is a referential index of gender. Ochs argues that in any given community there is only a small set of linguistic forms that referentially, or directly and exclusively, index gender. Examples in English include third person pronouns - *he, she, him, her* - and some address forms like *Mr, Mrs, and Ms*. Instead, she states that gender and other aspects of social identity are much more frequently non-referentially, or indirectly, indexed with language. With this view the relationship of language and social identity moves, for example, from a claim that the use of tag questions is an attribute of female speakers, to a claim that the use of a tag question is sometimes a way of softening a harsh utterance, or indicating tentativeness, or eliciting contributions from a silent or isolated person.

Therefore, this indexical model of the relationship between linguistic forms and the construction of social identity accounts for different interpretations that different hearers may assign to a single speaker's utterance: someone with an ideology about women that suggests that they are hesitant and tentative may interpret a tag question in one way, while another hearer interprets the same tag question as that speaker's attempt to mitigate an otherwise harsh statement. From this point of view, the assignment of situational meaning is interactionally governed.

3. Data and method

3.1 Corpus material: the *Healthtalkonline* website

The corpus is based on authentic material collected from the website www.healthtalkonline.org (henceforth HT) of the DIPEx charity. The website is led by experts in the University of Oxford's Department of Primary Health Care and gathers more than 2000 interviews on health and illness. The interviews were held in the UK, mainly in people's homes. Depending on the condition analysed, the interviewees were either the patients themselves or relatives/friends. The respondents were generally interviewed on their own, but in some cases a relative, partner or friend was also present. All the interviews were audio recorded; a digital video recording was added if agreed by the interviewees.

The research group is composed of social scientists with backgrounds in sociology, anthropology, health policy, psychology, discourse analysis and history. The participants were recruited in numerous ways, ranging from GPs' and hospital personnel's invitations to newspaper advertisements, newsletters and word of mouth.

The DIPEx interviews consist of two sections. The first is unstructured: the participant is asked to start from the moment when the first problems arose. The researcher/interviewer tries not to interrupt, except for clarification. In some cases s/he allows the narration to flow smoothly through phatic cues (Jakobson, 1963) or backchannel devices (*uh huh, yeah, ok, right*...). When narration comes to a standstill the researcher/interviewer may ask further questions, prompted by issues in the respondent's story or in previous interviews or from literature reviews. In any case, the content of the interview is always intended to be driven by the patients' account, with limited use of structured questions (Ziebland, personal communication).

The second section of the DIPEx interview is semi-structured and the respondent is asked about particular issues that s/he might not have dealt with in the narrative, such as sources of information, treatment choices, reasons for attending (or not) a support group. The whole interviews are transcribed via special software and then sent to respondents, in case they prefer some specific part not to be published on the website. Afterwards, respondents are asked to sign a copyright agreement with the University of Oxford to make the interviews available for research, teaching and the HT website.

The interviews are divided into groups according to the condition dealt with. As of September 2010, the topics covered are:

- Cancer
- Nerves & brain
- Mental health
- Dying and bereavement
- Chronic health issues
- Intensive care
- Heart disease
- Bones & joints
- Pregnancy & children
- Carers
- Living with disability
- Medical research
- Later life

Each group is subdivided into condition-specific modules. For instance, the “Cancer” section encompasses the following areas:

- Bowel screening
- Breast cancer
- Breast screening
- Cervical abnormalities
- Cervical cancer
- Cervical screening
- Colorectal cancer
- Ductal carcinoma in situ (DCIS)
- Leukaemia
- Lung cancer
- Lymphoma
- Ovarian cancer
- Prostate cancer
- Testicular cancer
- The PSA (prostate-specific antigen) for Prostate cancer

In every subgroup the material is arranged both according to “topic” and “people’s stories” section, the former containing a list of topics elicited by HT researchers, the latter

composed of single interviews which are grouped into disease/condition subtypes, in age brackets, or, more rarely, in number of years from disease onset. As for the “topic” section, a topic summary is provided which represents all the perspectives collected during the interviews, not just a majority view or a few selective opinions. (http://www.healthtalkonline.org/Overview/Research) For instance, the “Bowel screening” list of topics is structured as follows:

- What is the NHS bowel cancer screening programme?
- Getting an “unclear” or “abnormal” result by post
- The colonoscopy: procedure and treatment
- Getting colonoscopy results
- Why people decide to take part in screening
- Preparing for colonoscopy
- Side effects of colonoscopy

Sections of the text from the interviews are collected under different headings, either practical such as "symptoms", "seeking help", "getting the diagnosis", "telling others", "information sources", "medical communication", "medications", "financial issues", "support groups", etc., or more abstract ideas such as "coping", "humour", "body image", "ideas about causes", "decision making", "distancing" or "identity work". The aim of coding is to make sure that all the interview sections that are related under the same heading can be retrieved with ease. (Ziebland & Mc Pherson 2006)

Each condition-specific module on the site has around 25 topic summaries (each illustrated with 10–12 video and audio clips) to illustrate the respondents’ range of perspectives.

The “People’s stories” section, contains single respondents’ interviews organized into a list of clips which are variable in length (from 1 to 5-6 minutes each) and in number, since every interview may consist from 1 up to 10 or more clips.

The interviews are not fully available on the HT website, in that they are edited and only a few clips are retained for each interview. Furthermore, apart from being edited, the clips are not always arranged chronologically, so that their order on the webpage may not reflect the actual sequence of the integral interview. These aspects have influenced the methodology applied for this study, since for instance, the data did not qualify for a narratological analysis as conceived by Labov (2001[1972]).

The interviews may be either audio-video (the interviewee gave his/her consent to the video being displayed online), or audio only (the interviewee preferred not to be

videotaped or to appear on the website); in some cases neither the video nor the audio track are present. For every interview a transcript is provided alongside the video window. The transcripts are available both for "audio-only" and for "no video-no audio" interviews; in the first case, the video window is simply black, in the second case the opening window only displays a chunk of text.

The average number of interviews for every condition-related module ranges from 40 to 50. The website is updated on a regular basis, so it is possible that further interviews are added to each section. At the time the corpus was created for this study (March 2009-July 2010), the publication year of each section varied from 2001 to 2009.

3.2 Copyright and permissions

All the interviews and transcripts on the HT website are copyright protected (http://www.healthtalkonline.org/TermsOfUse). The material broadcast does not correspond to the integral interviews conducted by the DIPEx research group. Since it is stated that "[...] researchers in other higher education institutions may, under agreement with the University of Oxford, access the full interview collections for secondary analysis" (http://www.healthtalkonline.org/Overview/Research, September 2010), I contacted Sue Ziebland, Research Director of the Health Experiences Research Group responsible for the DIPEx research, later to discover that the material was not free; the price charged for the full interviews (£10,000 per collection) was far too expensive for me to afford. However, the online interviews, edited as they were, could still be interesting and worth linguistic analysis, so I asked for (and was given) written permission to use the online material.

3.3 Corpus description

3.3.1 Data collection and transcription

The actual data collection took place between November 2009 and June 2010. In order to make a full use of the HT website, I decided to use the highest number of interviews available from the "people's stories" section of every condition-related module. Since one of the aims of the research is to analyse identity and gender-related issues in discourse, I decided to create folders relating to "gender-oriented" diseases, namely a "female cancer" and a "male cancer" folder. The former was further subdivided into subfolders: breast, ovary, cervix, containing condition-related files (e.g. for breast: breast cancer, breast screening, ductal carcinoma in situ). Moreover, every condition-related file

was subdivided in age brackets (or more rarely, in years from diagnosis), thus mirroring at best the HT website structure (e.g. for breast cancer: age 30 and under, 30-49, 50-69, 70 and over). The interview transcripts were copied and pasted in .txt format files, to use them for quantitative analysis, and given a code for unambiguous retrieval. All the preliminary information (name, age, profession, nationality) was also saved in .txt format and stored into an “info” folder.

The parts of the code are separated by underscores: the first stands for the 1st level subfolder (w= female cancer, m= male cancer, cc= control corpus), then an acronym identifies the condition related module, the age bracket and the progressive number of the interview, reflecting the HT website classification (people’s stories section)

For instance, the label “w_bc_30-49_01.txt” refers to the first interview of the 30-49 age bracket (3rd level folder) within the condition-related module “breast cancer” (bc, 2nd level folder), contained in the (1st level) folder “female cancer” (w). Similarly, the file “w_bc_30-49_01_info.txt” contains the data relating to the interviewee.

After collecting the material, a further step was the corpus mark-up, which means adding a system of standard codes into an electronic document to provide information about the text. Since corpora are generally made up of de-contextualised samples of language in use, contextual information (e.g. metadata, “data about data”) should be added whenever possible to help relate the specimen to its original context (McEnery et al. 2006). This is all the more true for a spoken corpus, where you also need to mark up pausing and paralinguistic features such as laughter (McEnery et al. 2006).

The main task was to distinguish speech turns between researcher/interviewer and responder/interviewee and to detach editorial comments from speech.

The headers used for tagging are based on the Text Encoding Initiative (TEI) standards, which serve as guidelines for text encoding and were developed from Standard Generalised Markup Language (SGML, cf. Baker 2010: 15):

<c> start comment

</c> end comment

 interviewee, start of speech turn

 interviewee, end of speech turn

<q> interviewer, start of speech turn

</q> interviewer, end of speech turn

I also decided to add notations for silent pauses (...) and for filled pauses (*ehm*) according to the EPIC transcription conventions (Monti et al. 2005), although other transcriptions were found in the corpus (*uhm, er*); in order not to modify too much the original corpus, it was decided not to change them into a single form (*ehm*). The transcripts provided by the HT website generally include filled pauses and laughter. Revision was carried out in order to make them suitable for quantitative analysis.

All the *.txt* files previously copied and pasted from the website transcripts were opened with TextPad, a text editor software, which proved very helpful in tidying up the transcripts. Indeed, after copy-pasting the .txt file on Text pad, the text contained too many spaces, and also lacked clear speech turn boundaries. In order to obtain a readable text, I used a semiautomatic process:

- With an aim to speed up the mark-up/tagging process (which would otherwise have been extremely time-consuming) an expert programmer developed a data processing utility in Visual Basic environment;
- The incoming data were processed through this tool to eliminate irrelevant spaces and to add speech turn headers (see above);
- The output file was “post-edited” (McEnery et al. 2006), that is, manually revised against the audio/video track (when available) to add silent/filled pauses, repetitions, false starts and paralinguistic features (laughs, coughs, sighs).

This is a small excerpt from the corpus to show the tagging procedure:

Sample of raw corpus	Sample of tagged and post-edited corpus
Explains why she believes that stress might be involved in causing breast cancer. Stress plays a part, I'm sure in my case that's played a part, because I've been a single parent for 12 years and everyone's lives are stressful, we've all got a certain amount, but it's quite a lot to bring up a family as a single parent. I've been very much more fortunate than many in that, but it's just tiring and other stresses of life probably all combine, and maybe I had more factors than I realised. And at the moment we don't really know what they all	<c> Explains why she believes that stress might be involved in causing breast cancer.</c> <i> Stress plays a part, I'm sure in my case that's played a part...because...I've been a single parent for 12 years and... everyone's lives are stressful, we've all got a certain amount...but it's quite a lot to bring up a family ehm...as a single parent. I've been very much more fortunate than many...in that, but it's just tiring and...ehm other stresses of life probably all combine, and...maybe I had more factors than I realised. And...and at the moment we don't really know what they

are. I think it can only be beneficial to cut down on the stresses that you can really. Don't take on things you can't deal with. I do know quite a lot of women who, in fact I would say nearly all the women I met in hospital, had had some sort of trauma or difficulty. I mean most people have had traumas in their life by the time they get to their mid-life, but there was a surprising number who'd had difficulties of one sort and another and they'd ended up with breast cancer. Or they'd had a very unhappy time in one way and another. And I just personally think that that must all be relevant but it's probably difficult to say why.	all are. Ehm I think it can only be beneficial to...cut down on...on the.. the stresses that you can really. Don't take on things you can't deal with. I-I do know quite a lot of women who, in fact I would say nearly all the women I met in hospital...had had some sort of trauma or difficulty. I mean, most people have had traumas in their life by the time they get to their mid-life, but there was a surprising number who'd had ehm... difficulties of one sort and another ehm and they'd ended up with breast cancer. Or they'd had a very unhappy time ehm...in one way and another. And I just personally think that that must all be relevant but it's probably difficult to...say why.</i>

It should be noted that the end product is not a close transcription, since this was beyond the scope of my research. For this reason, no pause duration was added. In most cases overlapping speech was marked with the notation **<[speech]>** according to Hasan (2000).

Provided that a close transcription is not required for the purpose of this research, it was decided not to erase punctuation marks in the HT interviews, so that the (output) transcripts might achieve a good balance between readability and corpus mark-up added features. Moreover, should one wish to edit the corpus morpho-syntactically, punctuation would be indispensable.

The corpus is composed of 1859 interviews and corresponding transcripts, for an overall number of 4031863 word tokens. The average file length is 2168.83 words

The whole corpus collected on the HT website was subdivided into a “gender” subcorpus (also abbreviated with “gender corpus”) and a corresponding reference subcorpus, in order to obtain relevant keyword lists by means of corpus software (*Wordsmith 5* and *AntConc*). The reference subcorpus is at least 3 times larger than the “gender” subcorpus (cf. Table 2).

Table 1. **Subcorpora comparison (1)**

Gender subcorpus	Control subcorpus
• Women's cancer: breast, cervical, ovarian cancer • Men's cancer: prostate cancer, testicular cancer	• Bones and joints • Other cancers: leukemia, lymphoma, lung cancer, colorectal cancer, bowel screening • Chronic health problems • Disability • Living with dying • Heart conditions • Intensive care • Later life • Medical trials • Mental health problems • Nerves and brain • Pregnancy

Table 2. Subcorpora comparison (2)

Gender	Reference
416 files	1443 files
Tokens 535,527	Tokens 3,361,033
Types 9997	Types 25349
Type/Token Ratio 1.87	Type/Token Ratio 0.75
Standardised TTR 31.94	Standardised TTR 32.37

I have omitted translated interviews, when audio track was recorded in a respondent's mother tongue other than English (e.g. Guajarati, Hindi, Urdu, Mandarin, Cantonese). Other interviews relating to highly stigmatising diseases (HIV-AIDS, mental diseases) were played by actors, although they were based on the actual interview script. Since they closely reflect what the respondent said (in English) in the original conversation, I decided to include them in the corpus.

3.3.2. Keyword list extraction and comparative keyword analysis

As stated by Charteris-Black and Seale (2010: 32), the notion of keywords was first introduced by Firth (1935, cit. in Charteris-Black & Seale 2010), who referred to these as "sociologically important words". With the development of corpus linguistics software, the identification of keywords became an empirical process carried out through statistical tests. According to Scott (2005), keywords are words that occur significantly more frequently in the vocabulary choices of one group as compared with the other.

For the present study, the software Wordsmith 5 was used to generate a first wordlist from the gender subcorpus, and the same process was repeated with the reference subcorpus: afterwards, the WS5 Keywords tool was employed to generate a keyword list from the previously obtained wordlists. The results were also compared to the spoken section of the *British National Corpus* (henceforth *BNC spoken*) -which is a larger reference corpus representative of general language use- by means of the *BYU-BNC* interface (URL: http://corpus.byu.edu/bnc/).

A further step was a comparative keyword analysis (Charteris-Black & Seale 2010: 32-33), a procedure whereby it is possible to compare two corpora and search for "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*). This method was applied with an aim to compare men's with women's keywords. The two corpora were isolated from the gender subcorpus and the keywords extracted via WS5. The following table shows the two subcorpora in comparison:

Table 3. Subcorpora comparison (3)

Male cancer	**Women cancer**
141 files	275 files
Tokens 163,004	Tokens 372,563
Types 6320	Types 7963
Type/Token Ratio 3.90	Type/Token Ratio 2.14
Standardised TTR 33.58	Standardised TTR 31.27

Since keywords can only be extracted through comparison, it could be objected that this method implies a predetermined dualism; nevertheless, only through comparison can social variables (such as gender, age, social class) be indexed in the first place

(Charteris-Black and Seale 2010). As Charteris-Black and Seale (2010: 33) suggest, the analysis should go beyond software results and the analyst should aim at investigating the semiotic significance of particular keywords, which may be considered the starting point for an exploration of the discourses whereby people (more specifically, the HT interviewees) construct their identity in relation to their illness experience. The selection of keywords or language patterns to report does not rely on statistical grounds, but on the analyst's qualitative judgement. For the purposes of the present study, the keywords proved fundamental to help elicit concepts and ways whereby identity is performed within discourse, with the explanation of patterns of language use through detailed analysis of language samples in context (keyword in context/KWIC), as shown by corpus linguistics software (cf. also Baker, 2005: 27).

4. Corpus analysis

4.1 Keyword selection

As highlighted in the methodology chapter, I have used a corpus-based approach (Tognini-Bonelli 2001) for my study; I first created a folder containing all the interviews of people suffering from "gender-threatening" diseases, i.e. diseases that patients may perceive as harming their own sense of masculinity/femininity. In order to obtain a keyword list, this subfolder was compared -by means of corpus linguistics software (*AntConc, Wordsmith tools 5*) - to a reference corpus with the other interviews listed in the website. As Scott (2008) states, keywords (KW) are words that occur significantly more frequently in the vocabulary choices of one group as compared with the other, thus implying an inherent comparative dimension.

Keyword selection is a starting point for an exploration of discourse(s) – how groups of people construct their identity in relation to their experience of illness (Charteris-Black & Seale 2010); however this is a qualitative choice relying on the purpose of the analysis (Charteris-Black & Seale 2010: 42). For keyword selection, I decided to examine the first 25 KWs ranked by keyness, discarding strictly technical words due to the content of the corpus (e.g. *PSA, mammogram, colposcopy*, *breast, prostate, smear*, etc.). The KWs selected are as follows:

1. Cancer
2. Treatment
3. Screening
4. Remove(d)
5. Result(s)
6. Women
7. Surgeon
8. Painful
9. Procedure
10. Sex
11. Radical
12. Worry
13. Nurse
14. Wait
15. Masculinity

The keywords are then grouped according to parts of speech and semantic areas as follows:

- Nouns (further grouped into semantic fields):
  - Medical terminology: *cancer, treatment, screening, results, procedure*;
  - Health care staff: *surgeon, nurse;*
  - Potentially identity-related words: *masculinity, women, sex, age*;
- Verbs
  - Worry
  - Remove
  - Wait
- Adjectives
  - Painful
  - Radical

4.2 Part-of-speech KW analysis

4.2.1. Nouns

4.2.1.1. Semantic field: medical terminology

The keywords examined in this section are: *cancer, treatment, screening, result(s), procedure*.

Table 4. Noun KWs: rank and frequency (source AntConc)

Keyword	Standardised frequency (per million words)	Rank (ordered by keyness)	Frequency in the corpus
1. Cancer	3456.40	2	1851
2. Treatment	1497.59	14	802
3. Screening	752.53	18	403
4. Results	733.86	30	393
5. Procedure	347.32	53	186

1. Cancer

The word *cancer* is the 2nd keyword in the list, with a standardised frequency of 3456.40 instances per million words (henceforth PMW). Since the corpus deals with people suffering from conditions affecting primary and secondary sexual organs, it may be worthwhile enquiring if men and women express differently the consequences that these predicaments may have on the self and, more specifically, on their personal beliefs on gender and identity.

> (1) And I think at the moment so many of those are stacked on the uncertain unpleasant or unsure, unsure side of things as far as prostate cancer is concerned that doesn't persuade me to take a test routinely unless I had quite serious symptoms. I think you know personality and what, the way you think about life philosophically probably plays a part in this. I mean you know I'm not going to be somebody who's going to cling onto life desperately at all costs. (man, PSA test, age 51-60, interview 3)

> (2) And then last Autumn when they were doing the annual check-up and so on and took a bit of blood I noticed that they hadn't put PSA on it. She said, "Oh no we don't, we don't like to frighten people because it gives false positives sometimes." Well nowadays most of my pals have had prostate problems of one kind or another and the Big C, cancer, is not as petrifying as it used to be by any means, people talk about it so I asked her to put it on and she put it on in biro on the thing and it came back 7.3. So I thought well the doctor is going to ask for another PSA test and to my surprise he didn't, he put me in for the full biopsy which is not a very pleasant experience having a camera crew stuffed up your backside and so on.[...] And he [the doctor] was absolutely right it was a Gleason score of I think 7 and they reckoned something like 40% of the, maybe it's more than that, of the prostate was cancerous. (man, PSA test, age 61-70, interview 20)

> (3) [...] with a Gleason score of 7 and 9 the cancer was too aggressive something had to be done and had to be done fairly rapidly. (man, PSA test, age 51-60, interview 09)

As already noted by Charteris-Black and Seale (2010: 71), men following traditional masculine style show a discursive orientation to measuring and counting entities and processes: this seems particularly evident from these excerpts, where different male patients use technical measurements and jargon to speak of their condition. In a similar study carried out by Charteris-Black and Seale (2010), men are also reported to use more technical jargon than women; this seems to be in line with the observation (Eckert &

McConnell-Ginet 2003, Cameron & Kulick 2003) that men display technical competence as a prestige “enhancer”.

Collocation: *my cancer*

The collocation *my cancer* (ranked 34th by WS5) was found more among men than women (58% men, 42% women); however, this finding is to be interpreted also in the light of the idiosyncratic style of two male respondents, who use the collocates several times in their interviews.

> (4) Ehm I'm-I'm a very down to earth, practical...person ehm and that's-that's how I've treated my cancer. You know, just straight down the line, and none of this nonsense. (woman, breast cancer, age 50-69, interview 20)
>
> (5) I feel, you know, so privileged that I am able to have access to this information and be reassured that-that my cancer is not there anymore. w_bs_50-59_18.txt
>
> (6) I said 'Do you know what caused my cancer? Now, you know, you've seen it and now I've been operated on, could you tell the cause?' (woman, cervical cancer, age 39-44, interview 05)
>
> (7) It [divorce] was an enormous shock and I took it very badly, and I do think that, while it didn't cause my cancer, the cancer was waiting for something like that to happen, and it happened and it's just said "whoopee chaps, we've got her, another one". (woman, ovarian cancer, 2 years from diagnosis, interview 12)
>
> (8) In the first year I believe it's going to be every 3 months and then it will go to 6 months. I have, I'm a firm believer in the PSA test for obvious reasons. I might well go and have a private PSA test every 3 months just to make sure because it did screen me, it did discover my cancer and I can't understand why after I've had my cancer it's sufficiently good to screen me for the future, why couldn't I have been screened beforehand and logic just tells me, I'm a very logical person, medical opinions may say one thing but logic tells me everything I've gone through that the PSA test is a good way to screen for prostate cancer. [...] If my cancer had not been so advanced I'd have tried to have had brachytherapy [...] In addition how advanced my, my cancer was quite advanced so I really didn't have much option. (man, PSA test, 51-60, interview 09)
>
> (9) So try and survive for as long as possible. There is nothing which has happened to me, since I've had treatment for my cancer, which has in any way upset me. It's been a nuisance and tiresome but I've lived a very enjoyable and

very full life and I'm extraordinarily pleased that I had the surgery. (man, prostate cancer, 71-74, interview 12)

(10) Well what I'd like to say is that the injections, the testosterone injections have worked really, really well.[...] I've just been really impressed, because my testosterone levels were depleting quite rapidly, because I didn't deal with my cancer and I only had one testicle. I mean the freakiest thing was that I lost my sex drive, well not completely, but I lost a lot, and yeah, I've just been really impressed with the testosterone replacement, it's really worked well. (man, testicular cancer, 20-30, interview 06)

One could infer that men respondents were more at ease in considering cancer as part of their sense of self, or at least as an event which served the purpose of redefining the self, not necessarily as the exogenous, monstrous enemy which has to be fought at any cost - however, the war metaphor recalled by Lakoff & Johnson (1980) and Sontag (1991) is widely represented in the corpus. This seems at least to indicate that men, notwithstanding their alleged difficulty in dealing with their emotions (Charteris-Black & Seale 2010), are able to refer to themselves as embodied selves (cf. Merleau-Ponty 2005[1962], Eckert & McConnell-Ginet 2003, Cameron & Kulick 2003, Moore & Kosut 2010).

Merleau-Ponty (1962) challenged the dualistic legacy of the Cartesian thought. His phenomenological analysis of perception -how we become aware of the sensory world around us- rejects the subject/object division between mind and body and the notion that the mind is the locus of subjectivity. Merleau-Ponty asserts that perception is inherently carnal and stems from openness to the world. In other words, when our mind perceives (observes, identifies), it does so through a practical and sensual embodied location within the social realm. A practical understanding of the body accounts for a fuller understanding of the way culture, customs, norms and routines materialize through lived experience. Merleau-Ponty's phenomenological body helps to understand the difference between studying the body as an object and the idea of *embodiment,* which refers to a perceptive way of knowing and experiencing the world through our own bodies.

However, coming back to the analysis, the use of personal adjective *my+cancer*, which is all the more frequent in the corpus in expressions involving medical staff such as *my doctor/my oncologist/my nurse*, may also be explained from a completely different point of view, adopting Elliott's concept of *syntax of possession*:

> […] in a society awash with flashy commodities [...] our language for representing and elaborating our image of self-identity is more and more fixed into a syntax of possession,

> ownership, control and market value. What we are suggesting is that people today increasingly suffer from an emotionally pathologizing sense of neoliberalism. More and more, individuals translate-in the sense of projecting desires, reimagining Self with a capital S-experience in society, in business, and also in private life as reducible to self-regulation, self-management and self-sufficiency. (Elliott & Lemert 2006:36)

In the BNC spoken no occurrence of the collocation *my cancer* was found. However, one should qualify these result by adding that the BNC spoken does not deal specifically with personal accounts of illness, this is why the word *cancer* might not collocate with first person pronouns or adjectives (*I/my, we/our*).

Collocation: *had cancer/got cancer*

The simple past/past participle form *had* ranks 6th among the *cancer* collocates; the frequency is 160.58 instances PMW), 69.7% used by women respondents, 30.3% by men. It should also be noted that women make a wider use of the 1st personal pronoun *I* (e.g. *that I had cancer*), while men tend to rely more on impersonal forms.

> (11) I left the meeting not quite sure whether I had cancer or pre-cancerous cells. (woman, cervical abnormalities, 25-30, interview 03)

> (12) <c>A. F. recalls that losing his hair was one of the most traumatic moments of his illness.</c>

> <i>A.F.: Losing hair is weird and in some ways losing hair was almost more powerful than losing the testicle, even though I took it by then that losing hair was temporary. [...] And I remember being, visiting my older daughter and as soon as chemotherapy was over I didn't feel any need to wear hats or anything and some people were kind of, this child I think was asking his mother you know why this guy was virtually bald er and I remember thinking actually I didn't care. To me the problem with hair loss was that it marked me as someone who had cancer and as soon as it no longer was associated with cancer for a man at least it wasn't that much of a problem. (man, testicular cancer, 51-55, interview 03)

The collocation *got cancer* presents many similarities with the previous one: as for frequency, it has a standardised frequency of 126.98 occurrences PMW (3.67% of the instances of *cancer*), 85% used by women, 15% by men. The context of use seems to be overlapping with *had cancer* as shown in the following examples:

> (13)<q>And what did the letter say?</q>

It just said that your smear test was, there were abnormalities found and that they, I was being referred to colposcopy and then they just put the leaflet in with like all the details and it just made it look like I'd got cancer. It frightened me. (woman, cervical screening, 31-44, interview 07)

(14) my neighbour would know I panicked and I thought I've got cancer (woman, cervical cancer, 31-38, interview 03)

(15) <c>Describes the extremely negative and uneducated reactions he has had from some people.</c>

I think it's the lack of education because if somebody has got cancer people are led to believe that you can turn round, if you touch somebody you're going to catch it. So if they are over the other side of the road and they're shouting to you there's no possibility of them catching you. (man, prostate cancer, 61-65, interview 06)

(16) <c>Stresses the importance of a positive attitude.</c>

I think a positive attitude to the disease is essential, it's so easy just to sit back and give up and think well I've got cancer, I'm going to die and that's it. If you think I've got cancer and I'm not going to die I'm going to fight it I think that's the way that you can beat it, so I think as I say a positive attitude and do everything you possibly can to help yourself, inform yourself as much as you possibly can so that you know what the best options are for you and do it that way. (man, prostate cancer, 61-65, interview 08)

The excerpts above can be considered a good example of the way that disease elicits a discourse loaded with war metaphors (Lakoff & Johnson 1980, Sontag 1991). The positive and assertive standing towards cancer is often coupled with such metaphors; moreover, this discoursal practice seems not to be confined to male respondents (who are stereotypically considered more aggressive and therefore more likely to use belligerent lexis), since also women are reported to make use of it, as in the following example:

(17) Well the thing is, if you find out you've got cancer you've got to be positive...You've got to try and beat it because I think you are bigger than the cancer, so you've got to beat it. And you've got to be determined to make sure it doesn't get the better of you. So you get up every day, thank God you are living, and try to do what you have to do. You do not sit down and think: "Well, I'm going to get better," because...you will get better, but if you sit down you're going to feel lazy, and you're going to start getting, you know, careless. But if you are up, you're about, at least you are active...You know, you are positive. Very positive you've got

to be. And you've got to do what you know you're supposed to do: eat the right food, do the right things, get your exercises...You can't go to the gym but you can still go for a walk, walk round the block and come back. But you've got to be very positive about it. (woman, breast cancer, 50-69, interview 13)

Another feature which seems interestingly more attributable to male interviewees is the way they use self-irony ("tumour humour", Chapple & Ziebland 2004: 1136) in their accounts, as in the following examples:

(18) <c>Asserts that a joke 'lightens' the situation for him and reduces his friends" embarrassment.</c>

<q>And what's your, how do you feel about those sort of things, those sort of jokes?</q>

Oh you get used to it you know it's all part of everyday life isn't it. I mean everyone always makes jokes about something some time or other, er you just get used to it. It doesn't worry me at all.

<q>What's a typical joke can you remember any of them?</q>

Well ping pong balls got mentioned. As I play a lot of tennis everyone kept yelling, "New balls please," as I walked into the office.

<q>Oh no. So that doesn't really worry you?</q>

No, no you know, it's, as long as it's, you know, everyone does it in the right sort of way it doesn't worry me. You know, they're being friendly about it and it's a way of lightening it, but I think for them as well as me. It just lightens the whole thing up for them. Because when you tell, first tell people they're all, they get slightly embarrassed, some people when you first tell them you've got cancer of any sort, and they don't quite know how to react, some people. Some people react very well, they're very positive but others kind of yeah they shy away from it and they don't quite know how to speak to you, you know. (man, testicular cancer, 51-55, interview 07)

(19) I think I waited maybe 3 months and I very soon had a bed and he came by and he explained what the procedure was. I asked could I choose the size, he said "No," I had great visions (laughs). He said, "No, no, no we have small, medium and large and we just match you," so that's what it was. And it was a silicone implant that they were going to put in and I asked him how they were going to achieve this. He said "Exactly in the same way that we took the other one out." So I thought

okay fine and that's exactly what they did. And I was in hospital for no more than 2 days and came out happy again.[...]

<q>And are you pleased that you had one [testicle] replaced now?</q>

Absolutely yes because I can flick it and it doesn't hurt (laughs) which to a man is very important. You've probably lost that completely but such is the pain on flicking a real one it's a great delight to sit in the bath and flick a silicone one and not flinch. (man, testicular cancer, 41-50, interview 08)

The use of humour in the context of testicular cancer has been studied by Chapple & Ziebland (2004), who report the importance in the patients' accounts of maintaining an image as someone who can take a joke and see the funny side of a difficult situation. While it seems clear that irony, together with boastful talk and bantering is a way whereby men are socialised (Eckert & McConnell-Ginet 2003, Cameron & Kulick 2003), it is also evident that in this case the use of irony is polyvalent: on the one hand, it serves the purpose of defusing a state of tension between peers, due to the "untellability" and perhaps the stigma attached to cancer; on the other hand it also proves helpful in conforming to the gender norm according to which heterosexual men are not supposed to vent emotional disclosures with male peers, lest their heterosexuality should be jeopardized by the fear of being perceived as indulging in homosexual/feminine behaviour (this issue will be further analysed in the section devoted to gender-related keywords).

A further interpretation of this finding within the field of applied linguistics is provided by Coates (2003) who showed how humour is used in men's talk with an aim to divert attention from sensitive themes and, in this case, as a "diversionary" device used by men to show that they are not fearful about the diagnosis.

As for the comparison with the BNC spoken, the word *cancer* has a standardised frequency of 18.67 instances PMW and the most frequent L1 collocates are *breast* (5.7%), *bladder* (4.66%), *lung* (3.62%). The expression *had/got cancer* is present in 8.8% of the occurrences, none of which relates to the speaker, maybe because the BNC spoken does not deal specifically with interviews about illness experiences.

2. Treatment

The analysis of the word *treatment* showed that it ranks 14th in the keyword list, with a standardised frequency of 1497.59 instances PMW (822 hits in the *gender corpus*). It is also worth highlighting the pattern *technical noun+and+treatment* as in the following concordance lines:

- women who have had all the original surgery and treatment and then they've had secondary cancer.
- It is important to go for cervical screening and treatment. The more relaxed you can be before treatment
- Waiting for colposcopy and treatment and the emotional side of CIN3 had a huge impact
- Colposcopy and treatment are quick and painless procedures. They are simil
- If you've had children, it's [colposcopy and treatment] not as bad as that. You can, if you can get thro
- But, as long as it detected, it will be treated. And treatment will reduce the risk of it progressing to cancer
- It's not nice going for colposcopies, smears and treatment and stuff like that, but I'd rather do all that e
- <c>Describes the time between her diagnosis and treatment as the most peaceful time in her life.</c> <i>But
- had days when she felt down during investigations and treatment for abnormal cervical cells.</c> <q>What were the
- 's trust was Kim's lifeline during investigations and treatment. She advises other women not to bottle up their f
- and that could lead to further exploratory tests and treatment which could be actually quite sort of I don't know
- Argues that we don't know that earlier diagnosis and treatment of prostate cancer lengthens life but we do know
- last year, 10 years after his original diagnosis and treatment for those years. And it was just coincidence at t
- which describe the state of play of research and treatment into prostate cancer and I sort of now know that

Frequent L1 collocates are: *the treatment* (26.15%), *hormone treatment* (3.16%), *my treatment* (3.03%), *your treatment* (13 hits), *laser treatment* (1.58%), *radiotherapy treatment* (1.1%).

In the BNC *treatment* is reported to be widely used in academic texts. Its very presence in a spoken corpus may imply that the spoken register is hybridized and influenced by academic registers of science and medicine (cf. *watchful waiting*, ex. 184-192). In the spoken subcorpus, *treatment* is used with a standardised frequency of 31.16 instances PMW, mostly collocating with adjectives/nouns semantically related to medicine (*medical/early/emergency/prolonged treatment* etc.), but also (more rarely) with different fields as in *sewage/water/mortgage treatment*.

In the gender subcorpus, the expression *the treatment* presents a tendentially positive semantic prosody (*the treatment is amazing/positive/much more effective/was fine/was successful*), more frequently found in women respondents than in men. However, this prosody is absent when analysing other collocates.

By contrast, the collocation *hormone treatment* (which is only found in men's interviews since it is a specific therapy for prostate cancer) presents a negative semantic prosody, sometimes linked to the fact that the hormones used are oestrogens. Sometimes this raises gender-shaped concerns, especially in elderly patients, as in the following excerpt:

> (20) <c>Comments on his change in attitude after having female hormones.</c>
>
> <q>How did that make you feel as a man having female hormones?</q>
>
> Terrible, that's when your masculinity really goes. Forget about the sex drive when you get them implanted in you, you just get a crazy mixed up kid for want of a better word because you're doing these terrible things, you know it's not you, you know it's not part and parcel of your upbringing because as I said you'll snap, you'll rant and rave, you just, your total outlook on life is different. It changes your attitude and your attitude to the ones that you're living with, your attitude to your family, you just don't want to know them. And I suppose it's the fact that you're having foreign bodies implanted into your body because all your male hormones just disappear and because they say that the prostate cancer feeds on the male hormones so they replace it with the female hormones so as that's the initial start of the treatment that you're starving the cancer and then you go on to the, in my case onto the radiotherapy. (man, prostate cancer, 61-65, interview 06)

This elderly patient voices his discomfort using rigidly gendered set of behavioural attributes (*it's not part and parcel of your upbringing; you'll rant and rave*...) and holds fast to gender stereotypes (women are supposed to snap, rant and rave...); moreover, in his words female hormones cause a psychical regression (*crazy mixed up kid*). The

interviewee uses pronominal distancing (Charteris-Black and Seale 2010) *they say that* as a linguistic strategy to convey his unhappiness with the therapy, also presenting himself as a passive and unwilling recipient/patient (the Latin etymology is from *patior*, to suffer) of the therapy.

This also points to the reported women's willingness to put themselves at the centre of their lived experience through the use of 1st personal pronouns/adjectives (*deictic centring*, Charteris-Black & Seale 2010: 65) as compared with men's higher reliance on impersonal expressions and nominal style (*deictic distancing*, Charteris-Black & Seale 2010: 63). This is evident in the following examples taken from concordances of the semantically related word *diagnosis*:

> (21) I think that anybody who has had that diagnosis should try these therapies for themselves (man, prostate cancer, 66-70, interview 09)
>
> (22) And I was lying in a hospital bed, right by the window, 4 or 5 floors up, and thought well that's fair enough then we'll jump out now and finish it because I must be riddled, I must be dying from that diagnosis (man, testicular cancer, 31-40, interview 02)
>
> (23) I mean it has been interesting talking to other people because obviously at various times I've had to acquaint my colleagues with my diagnosis and friends and others. They often react rather more seriously than I would expect them to, you know in shock and horror, and this is something that doesn't happen to people we know really. As a doctor obviously I've seen a lot of people who've had diagnosis, a diagnosis of serious disease and many of them are friends and colleagues so I think I'd probably react in a slightly less shocked way if somebody gave me a similar piece of information. (man, testicular cancer, 41-50, interview 01)
>
> (24) And...it is now nearly ten years since I was diagnosed, and...and of course the longer away from the diagnosis that you're free then the better.</i> (woman, breast cancer, 30-49, interview 06)
>
> (25) And...[sighs] you have to undress every day to have...to have your radiotherapy. And eventually after the first week you get used to it but I...I found that difficult. I think it was. I was facing my diagnosis every day and perhaps I hadn't before. I was treated very sensitively, ehm very caringly. Ehm I was always covered up on the s-the breast that wasn't having the treatment. (woman, breast cancer, 50-69, interview 02)

(26) What they do is they-they-they give you this aspiration without an anaesthetic in the hope of getting sufficient cells to be able to give you a diagnosis there and then. (woman, breast cancer, 50-69, interview 08)

On average, men use the nominalised expression with *diagnosis* much more frequently than women, who tend to use the verbalised form *I was diagnosed*, thus putting their subjectivity/agency at the forefront. The feature of deictic centring/distancing is intertwined with the question of (human) agency. Central to agency are the questions: What is an action? Whose action is it (including who can be held responsible for it)? Is it meaningful and morally 'good' or 'bad'? (Bamberg & Andrews 2004). According to Bamberg (2011), agency is central to the study of self and identity construction, in that it considers the speaking subject as a bodily agent (i.e., as bodily present in situ and in vivo and interactively involved), in contrast to a disembodied, reflective, and rational mind that, in other approaches, seems to lurk behind what is surfacing in talk (Bamberg 2011:106).

3. Screening

Screening is the 18th keyword, with a standardised frequency of 752.53 instances (81.4% women, 18.6% men); the main L1 collocates are *breast* (24.31%) and *cervica*l (9.92%); as for R1 collocates, the most frequent are *screening programme* (4.47%) and *screening test* (3.47%).

The 3-word cluster *go* for screening* ranks 3rd with 7.69% of the results; it is noteworthy that only women use it, but the finding may be biased due to the higher presence of screening subsections in the female cancer section (breast cancer screening, cervical screening) than in the male one (PSA test).

Moreover, the HT website seems to promote a (politically-driven? See KW *woman*) discourse of cancer prevention, by stressing the need for screening (breast screening, cervical screening, PSA, bowel screening sections); this seems particularly evident in the women's sections, where a discourse of reassurance and solidarity is created and virtually addressed to other women. More in detail, in the HT comments (signalled with the header <c> in the corpus), the word *screenin*g is often found in a semantically positive environment (positive semantic prosody), as in the following examples:

(27) <c> Supports breast screening because any breast problems can be found and treated early. </c> (woman, breast screening, 50-59, interview 04)

28) <c> Was glad that breast screening detected her early form of cancer before it had developed […]</c> (woman, breast screening, 50-59, interview 05)

(29) <c> Feels screening saved her life[…] </c> (woman, breast screening, 50-59, interview 07)

(30) <c> Says that screening saved her life and she recommended it to other women […]</c> (woman, breast screening, 50-59, interview 10)

(31) <c> She went for screening because she felt that every woman was potentially at risk of getting breast cancer. </c> (woman, breast screening, 50-59, interview 16)

In other cases, a more overtly fear-arousing discourse is employed:

(32) <q> Is there anything you would want to say...to people who've never been but maybe they're a bit afraid of going, what-what would you say to them? </q>

 I would say that having seen...women who've-who've had a mammogram and...have-you know, they've found an abnormality, but it's, as I said before, it's been easily treated and I've seen the positive side really to having a mammogram rather than not bothering and...you know, maybe developing...a severe malignancy.

<q> Uh huh. So you would say ehm go because....? </q>

 Absolutely, absolutely, yes. (woman, breast screening, 50-59, interview 04)

(33) <c> She was terrified before her first mammogram and looked for more information. </c>

 The first screening was just after I was 50 so that was 6 years ago and I was absolutely terrified [laughing] and waiting for the results seemed like an eternity. And that was okay, that was clear. It wasn't painful, slightly uncomfortable, and I was surprised because so people had said, "ooh, it hurts." I didn't know what to expect and I'd just lost 2 very good friends to breast cancer within the previous few months. And one of them had said to me "whatever you do, you must always go for a screening when you're called." And the other one had said to me "oh, I've been called for breast screening but I can't be bothered, I haven't got time."

<q> She had breast cancer? </q>

 She did and it went undetected until it was too late, yes.

<q> So when you talked with her, what were her reasons for not going? </q>

 She was too busy. I've never had anything wrong with me she would say so there won't be anything wrong now, why should I worry? It didn't do her any good [laughing]. (woman, breast screening, 50-59, interview 02)

It seems clear that the way the interviews are edited indicate a firm choice of favouring screening practices. If women seem to accept more eagerly screening procedures (which are also part of a UK national screening programme), the same does not hold for men; in the PSA screening interviews (section prostate cancer), it is possible to find interviewees who do not agree with massive screening programmes. However, the way that questions are sometimes asked seem to imply that men are discriminated against for not being involved in wider prevention programmes, as in the following extract:

(34) <q>Would you like to comment on the fact that there isn't a national screening programme then for men, for prostate cancer like there is for women with breast cancer?</q>

Well I know there's a lot of issues about breast cancer and whether the, how useful it is but I would've thought that if the PSA test were a categorical black and white test then I would think it would be recommended for everybody because it would be completely clear. But since it's so contingent it seems and it's, the information it gives is conditional in some way I don't know that it would be the right test to offer for everybody because yet again it would only cause possibly unnecessary anxieties. (man, PSA test, 51-60, interview 03)

(35) <c>Suggests there is no UK screening programme because of false positive results, because some cancers are very slow growing, and because of cost.</c> (man, PSA test, 51-60, interview 10)

In the following case, the pro-screening policy of the HT website is marked by the use of the inverted commas, which indirectly provide a (negative) comment on the interviewee's words:

(36) <c>Says that a raised PSA result may lead to an unnecessary biopsy. Prefers to live life in an 'optimistic way', having a test only if really necessary.</c>

<q>So one of the main reasons for not having a PSA test at this stage is unnecessary anxiety?</q>

I think that's true. I mean a lot of people who live their life in fear and want to insure against everything and one of the minor, they have sort of an anxious attitude towards life and I think that, I have a sort of sense, this is completely

ridiculous really but I sense that this actually can create the condition or very largely and I'd rather live life in a more optimistic way and only take action when it's clearly necessary. (man, PSA test, 51-60, interview 02)

4. Result(s)

The keyword *result(s)* is the 30th in the KW list with a standardised frequency of 733.86 PMW (393 hits in the corpus). The main clusters are *get the results, wait for the results, abnormal test result*. The first two clusters generally present a negative semantic prosody due to fear and anxiety, as in the following examples:

(37) I had ehm a needle biopsy taken from the breast and was called back ehm to get the results when I was absolutely shocked ehm to find that it was breast cancer. (woman, breast cancer, 30-49, interview 14)

(38) When I get the results. And they gave me a piece of paper and that's when I knew I'd had a core biopsy. Didn't even know, they say ehm "have you got any questions?" but you need some input to ask questions. And I hadn't anything to - no guidelines whatsoever so, nothing to go on. So...so, that was - that was where we were from there. (woman, breast screening, 50-69, interview 12)

(39) I haven't heard back from the GP in terms of whether it's positive or negative, and this is some time ago I did the test so I can only assume that it's negative [laughs]. That does concern me slightly and in fact I have rung the doctors just to, just to chase up and try and get the result. But it was a specific PSA test and it was at my request. (man, PSA test, 40-50, interview 01)

(40) I think one of the worst things is the waiting times in between everything. So you get your letter saying you have got something wrong with you. You have got to go in. So you have got to wait for them few weeks to go in. Then you go in and they take a biopsy. Then you have to wait for the results of that. So, you go through another week where you are waiting for the results. (woman, cervical screening, 31-44, interview 14)

The third one is only found in the editorial lines of the cervical screening section, as for instance:

(41) <c>She has had more than one abnormal test result and so she has been referred to the colposcopy clinic for investigations.</c>(woman, cervical screening, 31-44, interview 02)

(42) <c>Don't panic if you have an abnormal test result and make sure you go for another test.</c> (woman, cervical screening, 31-44, interview 12)

(43) <c>It is important to be treated personally when receiving an abnormal test result for the first time.</c> (woman, cervical screening, 45-59, interview 03)

In the BNC spoken (where *result/s* has a standardised frequency of 124.43 occurrences per million words) few instances of *result* refer to the medical field, clearly because this is a general corpus, which does not specifically deal with medicine.

5. Procedure

The KW *procedure* ranks 53rd in the list with 347.32 instances PMW. It generally refers to medical exams: e.g. colonoscopy, smear test, LLETZ, biopsy etc.

(44) I think it's probably a relatively straightforward procedure [diathermy loop excision treatment] so you know, just get on with it [laughs]. (woman, cervical screening, 45-59, interview 10)

(45) But ehm the actual procedure itself was I thought pretty... simple. And not really that bad at all. (woman, cervical abnormalities, 25-30, interview 05)

Borrowing the concept of *implicature* from Grice (1989) who refers to what is suggested in an utterance (even though neither expressed nor strictly implied), the examples 44-45 may imply a negative meaning: since these biomedical procedures are believed to be uncomfortable, the respondent in the first case softens her statement by means of hedging devices (*I think it's probably a relatively straightforward procedure*), whereas in the second case the implied meaning is more overtly signalled by the expression *not really that bad at all*. Moreover, switching the analysis to the reference corpus, it is noteworthy that the word *procedure* occurs many times in the autism and mental health sections, with a specific reference to bureaucracy and an overall negative semantic prosody:

(46) But with the statement, it is a very formal procedure you have to go through. (autism, up to 11 years, parents, interview 04)

(47) But it just seemed like a very tedious procedure [getting the diagnosis], do you know what I mean? (autism, up to 11 years, parents, interview 08)

(48) And then there was this person asking me everything which I felt had been there, and recorded quite a few times before, or millions of times I would say. And I think underneath, it didn't seem to me that there was any understanding really.

Because they didn't understand my situation, and I went through the procedure because I think, I had to, I had contacted the mental health service managers to say, look they've withdrawn this CMHT person from my brother and I feel very upset about it. And I needed to be, for myself, I needed to be doing something for my brother, to making sure that he got some kind of service, or have-. And so I went through this procedure of going to see the service manager and talking to him and opening my heart and crying my tears. And he said, right, you know, maybe I could go through this assessment. So I went through this assessment. And really there was no understanding and then as I expected, surely a letter arrived on my doorstep saying that, at this stage they didn't think there was anything else they could do for my brother. So it just kind of was confirmation of what I knew already. And yet in a way, being forced to go through the system. (mental health, ethnic minority carers, interview 02)

Another word (despite not being a keyword) showing a similar semantic behaviour, with both a biomedical and a bureaucratic meaning is *system*. In the cancer interviews, it generally appears under the bigrams *immune system* and *blood system* as in the following examples:

(49) I didn't know what to expect. I was told I had to drink lots of fluids, had to keep my immune system up. And I wasn't quite sure how I was going to do that because I'm not a very good drinker, I never drink and I never eat. (woman, DCIS, under 50, interview 08)

(50) And obviously they can overtake the bad cells. And then they count you down from I think it's 15 days, minus 15, 14 and then when you get to zero your immune system is apparently back up and working fine. (man, testicular cancer, 31-40, interview 05)

However, switching to the reference corpus, the word *system* frequently refers to the (UK) National Health System or to the education system. This seems especially the case within the mental health and autism sections (that is, in conditions which by their very nature do not require invasive screening techniques). The semantic prosody is negative, in that many respondents complain of the lack of support from the institutions, as in the following excerpts:

(51) You know, I have had so much negativity from the education system (autism, up17yo, parents, interview 10)

(52) You know, I mean, he is extremely talented in all sorts of ways, but the education system as it was and maybe even as it is doesn't cater for people like Luke (autism, 18+yo, parents, interview 05)

(53) And as well as teaching him all the stuff that a kid with Asperger's needs which is all the social stuff and a lot of the time because ADHD [Attention deficit hyperactivity disorder] accompanies, autistic spectrum thing, Asperger's or autism, people in the education system or in the medical profession only see the ADHD and they see this great big buzz of activity and don't realise that underneath it is still the same confusion as someone that is sitting in a corner with their face to the wall. (autism, 18+yo, parents, interview 05)

(54) So again we have inflexibility on the education system. And that is why you need to have the diagnosis, you need to have the support, so that these children are able to then carry it with them and be more selective in the areas that they are very good at, you know. (autism, up11yo, parents, interview 02)

(55) <c>She feels society is too concerned with perfection. There needs to be more debate about support for people with disabilities.</c>

<i>I don't think I'm so much worried about the amount of information. I'm slightly worried about what I perceive in society, which is the pressure towards perfection. […] What does that mean about our attitude towards people who aren't perfect and how are we going to handle that? [...] all of us actually are disabled in one way or another. Some of us have more patience, some of us, you know - in different sorts of ways, there are none of us are actually perfect, and it's something we need to work towards, which is a sort of theological position, really. And so working towards physical and mental perfection in children is a sort of worrying subtext at the moment for me. […] So I mean I do recognise that there is a whole moral question about if you have a disabled child, should you expect the State, in the form of the NHS and the education system and so on, to actually bear the burden of that, when you didn't actually need to do that? (pregnancy, antenatal screening, NR, interview 17)

(56) And I think the difference is now is that I kind of behave better then I used to, and I think maybe that's, you know, in some ways it is because I am kind of better mentally, but in some ways I think it's also that I feel I have to behave in a certain way and, and appear to be normal, otherwise I'll, I'll end up in hospital again, or, you know, and I don't, I never, never want to go through that experience again. It was the most horrible thing. And I would rather be like, you know, in a low wage

job and living a life of, kind of a dull life rather than back in the mental health system. At least I'm like a free citizen as it were, now. And I can pass for normal. Yeah, I think I pass for normal. Probably if people get to know me too well they realise I am a bit odd, or they might realise that I'm a bit insecure about things. But I can probably pass for normal now, but I think that's probably as good as it gets. (man, mental health, ethnic minority experiences, up39, interview 07)

Interviewees with a minority ethnic background (mental health section) sometimes overtly accuse the health system of being racist:

(57) <c>Dolly says she thinks the mental health system "stinks" and suggests that people with mental health problems should have input into policy.</c> I think the system stinks actually [Laughs]. I have to say. I think it needs a lot of changing.

<q>In what way. What kind of changes?</q>

Well, most people who have gone through the system will tell you. What helps them. I mean, you know, I'm finally on the waiting list to have psychotherapy but this is after 22 years, since I first became unwell' I mean I've had to wait 22 years to get psychotherapy. And that's ridiculous. And, you know, I know from my kind of, my friends who are Black, they have to wait even longer, so the system is quite racist as well. So it's, I think the kind of policy has to change as well and it shouldn't be, the policy shouldn't be kind of dictated by the kind of doctors and managers, and policymakers, you know, service users should have input as well. In some hospitals they do, but, you know, it's still not enough. So I think, you know, where fundamental change can happen, it needs the service user kind of input, otherwise what's the point? You're just not listening to people who use the services, so.(woman, mental health, ethnic minority experiences, up39, interview 02)

(58) <c>Professionals need to be "culturally competent" and aware of people's "micro-ethnicity" so that they don't fall back on "old fashioned" stereotypes.</c>

It is a very, very ethnically diverse borough and a huge range of nationalities and religions and degrees of assimilation to British culture. You know, from people who have really just, just arrived and who don't speak the language to, to people who are ethnic in outer appearance but who've been born and bred in this country and who are, have kind of dual heritage but whose European-ness is probably more, more prominent to an impartial observer than, than their foreign-ness but

nonetheless within the mental health system it's their foreign-ness which is emphasised because it is their foreign-ness which is considered to, to shape their, their diagnosis and, and... […] I think we all have a kind of micro-ethnicity that you acquire a knowledge of through getting to know us but, you know, the form you fill in when you go in hospital is not really giving you that picture and, and if, if you determine somebody's mental identity and pathological mental identity, on that, that basis you're going to fall back on stereotypes. And so in fact very, very old fashioned stereotypes that don't belong in the 21st century.</i> (man, mental health, ethnic minority experiences, up39, interview 09)

(59) <c>Devon thought his hospitalisation was a mistake and talks about institutional racism.</c> […] Anyway it was at that point that I felt different in my body. My mind left me, my body was different. The way I was thinking was different, you know, like I had lost my spirit. I lost the drive. I lost myself. Due to what they gave me in the medication. It was an injection for me, they held me down and forced it upon me. One other, most of the problems, most of the situations was, was it wasn't so much racist it was more institutionalised racist. It's embedded within the system. Not actual racist coming from the mouth of the people. But it's embedded in the system, because it's embedded from the Empire as I am saying, from that time. […] The church, all institutions, the government, that is what they mean by institutionalised racism that is what it means, it doesn't mean racism from a person. It means it's embedded within the institutions and that is why they call it institutionalised racism. That is what it is yes, so it is embedded with them. So when the, the police came, 'Oh you've been smoking dope Devon.' So it is in the system, the police system, you know. Without questioning it or understanding it, it's in the system, so you have to deal with it, because it is part of the system. In the school you can't come to the trip, you're a Black sambo. All these different. It's in the system and that is what they mean by institutionalism racism which is different from racism and it's different from prejudice. They're the three areas, institutionalised racism is from the institution. It's still in it now. It's not going to come out for years yet. Because it is still in the institutions and the court system or the probation, it's all in there. Not because of the people working there, but from the past. It's still there. [...]</i> (man, mental health, ethnic minority experiences, up49, interview 03)

The last examples echo vividly both Foucault's concept of *disciplinary institution* (1975) and Goffman's notion of *total institution* (1961). The main point of the total institution is that many human beings are under bureaucratic control. These needs are handled in an

impersonal and bureaucratic manner. Typically, the inmate is excluded from knowledge of the decisions taken concerning his fate, and such exclusion provides staff with a special basis of control over and distance from inmates. People who enter a total institution are deprived of the supports provided by the social arrangements of their home worlds and undergo mortification of self via social and physical abuse. This is a “background” complaint which may be found throughout the corpus when analysing words relating to institutions (*school, hospital, health system, government*).

Moreover, the idea of *institutionalised racism* conveyed in the last excerpt seem to paraphrase Althusser’s Marxist analysis of *Ideological State Apparatuses* (ISAs, 1971): within capitalist societies, the human individual is generally regarded as a subject endowed with the property of being a self-conscious 'responsible' agent, whose actions can be explained by his or her beliefs and thoughts. For Althusser, however, a person’s capacity for perceiving him-/herself in this way is not innate or "given" but rather acquired within the structure of established social and ideological practices, which impose on individuals the role of a subject, by means of institutions *called Ideological State Apparatuses* which include the family, the media, religious organisations and the education system, as well as the received ideas that they propagate. Also Fielder (1996: 116) considers hospitals as soulless and inhumane (as rigidly hierarchical and totalitarian as a prison or army barracks) as well as anti-therapeutic places that teach patients to be sick rather than to get well. Illich (1976) labels this phenomenon *social iatrogenesis*. In his words,

> Medicine undermines health not only through direct aggression against individuals but also through the impact of its social organization on the total milieu. When medical damage to individual health is produced by a socio-political mode of transmission, I will speak of "social iatrogenesis," a term designating all impairments to health that are due precisely to those socio-economic transformations which have been made attractive, possible, or necessary by the institutional shape health care has taken […] Social iatrogenesis designates a category of aetiology that encompasses many forms. It obtains when medical bureaucracy creates ill-health by increasing stress, by multiplying disabling dependence, by generating new painful needs, by lowering the levels of tolerance for discomfort or pain, by reducing the leeway that people are wont to concede to an individual when he suffers, and by abolishing even the right to self-care. Social iatrogenesis is at work when health care is turned into a standardized item, a staple; when all suffering is "hospitalized" and homes become inhospitable to birth, sickness, and death; when the language in which people could experience their bodies is turned into bureaucratic gobbledegook; or when suffering, mourning, and healing outside the patient role are labelled a form of deviance. (Illich 1976: 16-17)

In the corpus it is possible to find several examples of hospitalisation conceived as an alienating and reifying experience:

> (60)[during radiotherapy] you know, you do feel like a bit of a slab of meat, because they pull you around and push you. I mean obviously just to get it right ehm and they probably do it all day so it probably drives them mad. But ehm you do feel like a slab of meat eventually, and-and that's ehm...and...yeah they probably don't talk, you know, they don't interact with you...in the same way that the chemotherapy nurses did, so I think I found that quite...an impersonal experience. (woman, breast cancer, under 30, interview 01)

Comparing this result with the BNC spoken, *procedure* (standardised frequency: 18.36 instances PMW) presents the same "bureaucratic" meaning as in the reference subcorpus, but it neither refers to medical tests nor gives evidence of a negative semantic prosody.

4.2.1.2. Semantic field: health care staff

Table 5. Health care staff KWs: rank and frequency

Keyword	Standardised frequency (per million words)	Rank (ordered by keyness)	Frequency in the corpus
1. Nurse	612.48	129	328
2. Surgeon	380.93	40	204

1. Nurse

The word *nurse* is 129th in the list, with a frequency of 612.48 instances PMW.

The main clusters are *breast care nurse* (8.23% of the occurrences) and *breast cancer nurse* (2.44%). The expanded KWIC indicates a positive semantic prosody, in that in the vicinity of the node word there are adjectives/nouns with positive connotation (*good, brilliant, really nice, helpful, wonderful, she was my rock, she gave me a cuddle, very relaxed, fantastic*) as in the following excerpts:

> (61) Well it just involved sitting there with the nurse and rolling up my sleeve and having, and she's one of the best nurses I've ever met, I mean she manages to take blood before you even realise she's actually done anything, it's quite

remarkable. But most practice nurses are very skilled in that regard, much better than GPs I should say, in my experience. (man, PSA test, 51-60, interview 12)

(62) I had epidurals for the pain, I had a catheter fitted so I had tubes down there. I had quite a few tubes, I was on a drip and I was in intensive care for the night. The nurse - and I shall never forget because I was quite awake - kept calling in every hour to check up on me and I kept smiling at her and then they took me back to the ward the next day (man, prostate cancer, 50-60, interview 04)

(63) <i>Well it just involved sitting there with the nurse and rolling up my sleeve and having, and she's one of the best nurses I've ever met, I mean she manages to take blood before you even realise she's actually done anything, it's quite remarkable. But most practice nurses are very skilled in that regard, much better than GPs I should say, in my experience. So I think that you know, no one should be put off. (man, PSA test, 51-60, interview 12)

(64) <i> Anyway to get back to the prostheses. Ehm this nurse, this Cancer Care Nurse, excellent, I mean it's really good having a person that, you know, you could phone up any time you wanted if you'd got any problems, it was great. (woman, breast cancer, 50-69, interview 08)

(65) So the breast care nurse came, ehm I mean she was marvellous, she was a-she-she was my rock in the end, even though she was patting my hand and, you know, all lovely and so on, that's her job. In the end she was actually somebody that I've really turned to and I-I felt an-an empathy with her. I had to hug her and, you know, she was sort of knowing how I was feeling, because whilst your family and your friends are so sympathetic and they come and see you, and they're all looking at you [laughs] and giving you that sad look and, "I'm going to be okay, I'm going to be fine", ehm but they don't know what it's like. (woman, DCIS, 50-54, interview 01)

With special reference to the representation of nurses in literature and in the media, Fielder (1996) states:

> The archetypal female profession has long been nursing. Nurse signifies "nurturer", which is to say Mother or surrogate mother. In the popular mind Nurse equals Woman, but, on an even profounder mythological level, Woman equals Nurse. This means that many ancient (male) stereotypes of females in general are transferred automatically to the specific category of nurses. The latter are often portrayed as being still what many women refuse to be: subordinate to men, faithful, passive executors of their orders. […] Sometimes [they are] conceived as Good Mamas, but [also] as Bad ones: bullying, blustering, or

> condescending to the full-grown men helpless in their hands ("It's time for us to take our medication. Why don't you sit up tall like a good boy?") as if they were children. All of us (women as well as men) lived once as infants and toddlers under a total matriarchy; and men especially have nightmares of regressing to that state of total dependence, nightmares likely to occur in a hospital bed and inevitably projected upon the attendant nurse. (Fielder 1996:122-123)

Fielder's reasoning seems to suit well Oliver Sacks' account of his own experience as a patient in *A Leg to Stand On* (1984):

> […] "You've torn the quadriceps off," he said. […] "You will have to be taken to hospital."
>
> […] Shortly after I had been settled in the little ward at Odda [Norway] – it was a cottage hospital […] – the nurse came in, a lovely creature, though indefinably rigid and graceless in her movements.
>
> I asked her name.
>
> "Nurse Solveig," she replied, stiffly.
>
> "Solveig?" I exclaimed. "That makes me think of *Peer Gynt*!"
>
> "*Nurse* Solveig, please – my name doesn't matter. And now, be so kind, please, and turn over. I have to insert the rectal thermometer."
>
> "Nurse Solveig," I replied, "can't you take my temperature by mouth? I am in a good deal of pain, and my damn knee will go out on me if I try to turn over."
>
> "I cannot help that," she answered coldly. "I have my orders, and I have to follow them. It is a hospital rule – rectal temperatures on admission."
>
> I thought to argue, or plead, or protest, but the expression on her face showed that this would be useless. Abjectly, I turned on my face, and the left leg, unsupported fell and prolapsed excruciatingly at the knee.
>
> Nurse Solveig inserted the thermometer and disappeared […] for more than twenty minutes. Nor did she answer my bell, or come back, until I set up a shindy.
>
> "You should be ashamed of yourself!", she said, as she returned, her face pink with rage […]. (Sacks 1991: 24)

In the corpus a similar condescending attitude may be found in the following extract:

> (66) The first person that came into the ward was the physiotherapist and she said "Right let's be having you out of bed", and at this stage after having major surgery I was frightened to get out of bed. There were tubes everywhere and I was

frightened to do any damage to those. Anyway, she said "Come on let's be having you." So I rolled out of bed, and she said, "I want you to sit in that chair," so I sat in the chair and she reassured me "You'll be alright," and went. So I sat in the chair for about 10, 15 minutes, felt a bit shaky, got back into bed and I thought well that's not bad. (man, prostate cancer, 50-60, interview 04)

It is noteworthy that these experiences are generally voiced by men. It could be advanced that, since maleness is a condition which is achieved through the hardship of differentiation from women (cf. Gilmore 1990, Badinter 1992), some men may feel more uncomfortable when confronted with situations (like hospitalisation) in which they are dependent on female figures (like nurses). As Badinter (1992: 15) puts it,

> *Devoir, preuves, épreuves*, ces mots disent qu'il y a une véritable tâche à accomplir pour devenir un homme. La virilité n'est pas donnée d'emblée, elle doit être construite, disons "fabriquée". L'homme est donc une sorte d'*artefact*, et comme tel il court toujours le risqué d'être pris en défaut. Défaut de fabrication, défaillance de la machinerie virile, bref un homme raté.

There are several examples of men's embarrassment in the presence of a female nurse:

(67) And whilst I can tolerate that up to a point in a dentist's chair if the dental nurse walks in and out it's quite different from when, put bluntly, your ass is sticking up in the air.[...] So it's at that kind of level that I think that privacy and dignity are not always well attended to. Although I hasten to add that I did have plenty of exposure to the other end of the spectrum as well. Some really admirable clinicians and wonderful human beings who did a first class job of plying me with information and also attending to my privacy and dignity.</i> (man, prostate cancer, 50-60, interview 10)

(68) I was lucky enough to have a chap [the doctor] who knew what he was doing. The most discomfort I found was the fact that you are overlooked by, in my case a young nurse, who stood at the front of you telling you not to worry. But it was more embarrassment than pain owing to the fact that this young girl was just stood alongside you whilst it was being done. But I certainly didn't feel a lot of discomfort. (man, prostate cancer, 61-65, interview 06)

(69) I had 15 staples, yes 15 staples which, metal staples in the area of the surgery ehm from on the left side a couple of inches below the belly button, stretching down to the area of the tumour. Now that, there was, the area of the wound had to be dressed every day, which involved the local nurse, practice nurse to come out to the home and bathe the area and change the dressing. Which

again is another part of the illness, a complete stranger is coming round to your house and changing dressings in a very private part of your anatomy but again you get used to it very quickly. (man, testicular cancer, 31-40, interview 14)

The following excerpt is interesting in that the patient seems to use the passive form as a linguistic index of his lack of agency, trying to convey an image of passivity (in this respect, it should be highlighted that both *patient* and *passive* stem from the Latin verb *patior*, which means *suffer, endure* as well as *allow, acquiesce, submit*):

(70) My hospital stay was a 3-day stay. So there was a pre-operative day, an operative day and one post-operative day and then I was discharged on that first post-operative day. So the day after surgery I was discharged. In terms of the process the pre-operative day I guess was relatively standard for any surgical procedure. It was about being clerked in, having assorted bloods and other investigations done, signing various pieces of paper, being visited by your anaesthetist, being visited by the surgeon, being visited by assorted other doctors and nurses. So, for example, I was seen by the specialist urology nurse. I was seen by the specialist continence nurse to make sure that I had an accurate grasp of how to do pelvic floor exercises correctly and appropriately and at the appropriate frequency and so on. So that first pre-operative day was just a blur of a steady succession of people wanting me to sign things or wanting to tell me things or wanting to investigate or analyse or stick needles in me or whatever. And it was all perfectly straightforward other than the usual doldrums of hospital food. (man, prostate cancer, 50-60, interview 10)

Moreover, from a discoursal point of view, the text also seems to contain a contradiction between the reported satisfaction, expressed in terms of tasks accomplished in a straightforward way and the bureaucratic anonymity/automaticity of the procedure, indexed by the passive forms, which may imply -along with the conveyed image of detachment- a deeper sense of discomfort.

2. Surgeon

The KW *surgeon* ranks 40th in the list, with a standardised frequency of 380.93 instances PMW. The main clusters are:

- *plastic surgeon*
- *my surgeon*
- *breast surgeon*

Most of them (85.7%) are found in women's files, with special reference to breast reconstruction after mastectomy. From the KWIC analysis, the word *surgeon* (as well as the semantically related *doctor/oncologist/anaesthetist*) seem to be referred to men "by default" (when this is not the case, woman is added as a prefix to specify, as in *woman/female doctor, woman surgeon* etc.). This is to say that within the realm of socially prestigious professions (the social prestige being the upshot of the modern trust in science and technology), the male figure is the "unmarked" one (cf. Eckert 2003: 21, Cameron & Kulick 2003) and implicitly taken for granted, unless it be specified that (contrary to expectations) it is a woman. This use in the corpus is found only in women's accounts, as in the following excerpts:

(71) And again the woman surgeon ehm said some very ehm sensible and sound- gave me some very sound advice, which was...she couldn't say categorically which way I should go. (woman, breast cancer, 50-69, interview 04)

(72) When I went into A&E [Accident and Emergency] they said to me, it was a female doctor who was brilliant, she said, "Look at the difference between that blood, the colour of it, and say blood from an old wound or a period. The period blood is darker. This is bright red. So it's a haemorrhage." (woman, cervical abnormalities, 31-35, interview 08)

By contrast, the word *nurse* refers "unmarkedly" to a woman, unless otherwise specified as in the following examples:

(73) I was brought into a nurse, care nurse [name]. She explained to me that […] (woman, breast screening, 50-59, interview 19)

(74).txt And a very, very pleasant male nurse was specialing me (man, prostate cancer, 71-74, interview 12)

(75) I spoke to the same Irish male nurse as I had spoken to with the sunstroke (woman, cervical cancer, 45+, interview 03)

This issue was further expanded in the analysis of the word *nurse*.

Moreover, and not surprisingly, the word *surgeon* shows a positive semantic prosody (especially in women's interviews), as in the following excerpt:

(76) So that the surgeon would know how far to go and how big to cut around it. And that thing was...fabulous. I mean, it was a team of three ladies and a male doctor. They were just so...focussed about...you in the middle and they're doing things to you. And they explained everything. And they've done the utmost to make

me comfortable as much as possible. **<q> Yeah. </q>** You know, it's like a different planet altogether. (woman, DCIS, 50-54, interview 04)

(77) And my surgeon that I wanted to see, the man that I'd seen with the mastalgia and liked, was away on holiday and wouldn't be back for about a week[…](woman, DCIS, 50-54, interview 15)

(78) I wouldn't have that, you know, I said to my surgeon I said 'I do not want a knife to go into the tumour' so I waited until I got some ascites and then a very nice man who normally does the antenatal ladies and does the amniocentesis […] (woman, ovarian cancer, 6y from diagnosis, interview 05)

In the following excerpts the women's positive appraisal refers to other types of medical staff:

(79) Ehm of course the day before the anaesthetist had come along as well, talk through your medical history, any allergies and that sort of thing and sort of reassured you that he was going to be there when you went in and he was a very nice man, very calm and reassuring and sensible seeming. (woman, cervical cancer 39-44, interview 03)

(80) On the 12th September I was called back to see [consultant], who's the top man, and he said the result was inconclusive but they were concerned. (woman, DCIS, 65-70, interview 02)

(81) My oncologist was a charming man, a lovely lovely man but he explained it all to me but I really wasn't, I didn't know enough about it and you didn't really ask about it, you know, you asked one or two questions but you really didn't go any further, so I didn't learn enough about it I must admit. (woman, ovarian cancer, 7-14y from diagnosis, interview 10)

In the following example, however, the use of *even* seems to imply that doctors are indeed criticized, more than nurses:

(82) Yeah, I find they're very nice, I've always ehm praised [hospital name] because I've never felt uncomfortable with [hospital name]. You know, ehm [hospital name] nurses and all that are fantastic, that is true, even the doctors there, I've never had any complaint about any of them. (woman, breast screening, 60-69, interview 16)

With reference to the positive appraisal of doctors, Fielder (1996: 108-109) states that since they have come to preside over certain rites of passage once considered sacred,

such as birth and death, medical doctors have become “not merely the servant of some reigning God, but a kind of god themselves, granting us an ersatz immortality with life support systems or organ transplants”. However, this faith in medical science is not without doubts, which is attested in the corpus by the presence of interviews complaining about medical staff’s behaviour and, more frequently, about the national health institution as a whole, as in the following examples:

> (83) She [the nurse] is retired, and she comes and she sat with me about an hour or so and explained whatever and they gave a lot of pamphlets after so you can read this, what food you should be eating, what should be done, all those things. I had more information from them than the doctors. And I think anybody going in for this they must go to one of these. They give you much more information than the doctors, that is my experience I don't know about the other doctors. So they gave me this treatment, it will be for 4 weeks starting in the month of March. (man, prostate cancer, 75+, interview 05)

Borrowing from Fielder (1996), this ambiguity in our relationship to physicians may be explained considering that we regard such secular practitioners with the same mingling of reverence and awe, horror and resentment with which our ancestors regarded “the wonder-working servants of deities in whom we no longer believe we believe” (Fielder 1996: 109). Moreover, the archaic horror and resentment we feel toward the new healers is exacerbated rather than mitigated by the fact that they have demystified and desacralized not merely (like astronomers and geologists) the heavens and the earth but our very bodies as well.

Another cluster which is worth examining is *the surgeon said* (4thcluster for *surgeon*)*/ the doctor said* (5thcluster for *doctor*), both followed by reported speech, as in the following examples:

> (84) At the [private hospital]. So that was, again, very strange, **<q> Yeah.</q>** yes. And then that lump was aspirated, that was done with a needle. I wanted an anaesthetic [laughs] and the surgeon roared with laughter and he said to me "By the time I give you an anaesthetic, I'll have done this and the anaesthetic will hurt more than taking the fluid out." (woman, breast screening, 50-59, interview 02)

> (85) He said "Come for the results of the test, it’s positive and it’s spread throughout the milk ducts and there are no options in the surgery, the whole breast would have to be removed. And he could offer the operation tomorrow or next week." He described the procedure [reading from papers] and also would remove

4 to 5 lymph nodes which would be tested to see if any cancer cells has spread to them. He said if there was...he said if there were any need...they'd look for any need for further treatment and [my husband] asked if it were already cancer or a potential, i.e. something leading up to cancer. And the surgeon said "No, it was cancer". (woman, DCIS, 50-54, interview 08)

(86) So I went down for the operation and I saw the anaesthetist the day before and I told him about feeling really drugged the last time. And he said "I can't really change it", I said "Could you not give me less?" and he said "No I can't really change it". (woman, DCIS, 50-54, interview 10)

(87) Following on from that I went into see the plastic surgeon. The plastic surgeon had obviously been told by the breast care nurse that I was worried because I wasn't having radiotherapy. He bounced in because he's quite a character and said, "I'm pleased you're not, don't need radiotherapy, it would have played havoc with my implant." Oh like this. And I said, "Well I'm glad somebody's pleased." And he said, "Why, what is it about, what is it that worries you?" And I said, "I just feel that I won't know because the implant is there." And he said, "No, no, no," he said, "Your chest wall is now on the top, not underneath the implant" he said. "Because your chest wall, the muscle was lifted to put the implant underneath, it's your chest wall that's holding the implant." So this bit here is chest wall, muscle, my chest muscle. So the breast is sat on top of this bit. So he said it's now on the top. So he said if there was any hint of anything that was left behind, you would get a local reaction. And that's when I felt more confident. I walked away and I said, "Now I'm happier."</i> (woman, DCIS, 50-54, interview 12)

This issue points to a phenomenon highlighted by Cheshire & Ziebland (2005), according to whom patients tend to report their interactions with doctors in the form of direct speech, which may be a linguistic index of the higher status these health care professionals enjoy. Indeed, this cluster was not found in the analysis of the word *nurse* (**the nurse said*).

From the KWIC analysis, it also emerged that women sometimes use self-irony when speaking of mastectomy, as in the following examples:

(88) The other one [operation] was ehm to take the ehm the tissue and the fat from the stomach ehm and then reconstruct. Now my problem with that, or not so much a problem, was the fact that she said that I didn't have enough there to-to ehm to rebuild the same size. Ehm but in actual fact that didn't bother me, ehm so ehm she's saying that she - if I go down a size, what will happen with that type of reconstruction for me, is I will ehm she'll be able to do a size less with what I have

of my own tissue from my stomach and she will then ehm be able to reduce the other one in six months' time. So, for a while, I'll be a bit lop sided [laughs], but I'm not that huge, so...But so she's going from a D cup to a C cup and she said, don't worry, I'll do a fabulous job for you. And when she said that, I thought to myself, hey, you know, Pamela Anderson, eat your heart out [laughs]. </i(woman, DCIS, 50-54, interview 14)

(89) <i> I saw [the plastic surgeon] on the 31st of January and he said, "Oh I don't need to see you now for another six months." Where I'm going to have, ehm what do I call it to the girls? Oh my boob done on the-on the-on my left one. Which again I was quite surprised because when [the plastic surgeon] first saw me he said, "Oh we'll...do your left as well." And I thought, "Ooh." I just thought they'd take this one off and that would be it. But no, quite concerned that yes they would match me up. And if I wanted it increased, well not increased but decreased, ehm I could if I wanted. But...no, I said no because I was-I went in a 38DD. We all laugh about it now because I'm a DD this side and an E this or I think it's a C this side or something [laughs]. (woman, DCIS, 65-70, interview 01)

It seems that in these cases women make a different use of irony if compared with men. In the case of testicular cancer (see examples n. 18-19 and Chapple & Ziebland 2004) men use irony as a socialising tool to show to an ideal circle of male peers that they do not fear their difficult situation and that they can cope with it; moreover, humour seems also aimed at avoiding male peers' embarrassment in dealing with life-threatening issues, and is also used as a way to reassure them that despite cancer, they are the same persons as before and deserve to be treated normally, as nothing particular had happened. In the women's case, it seems that the irony is more focused on the self and not projected outwards, with an aim to be accepted by an ideal circle of female friends; further, women's humour seems also meant to make fun of certain masculine judgements on women's assets (see "size of cup").

4.2.1.3 Semantic field: identity-related words

Research on language and identity is highly interdisciplinary, involving fields as diverse as anthropology, linguistics, psychology, sociology, history, literature, gender studies and social theory (Bamberg 2006:1). These multi-faceted studies have foregrounded the fundamental role of linguistic processes and strategies in the creation and negotiation of identities. According to Bamberg (2006: 2), a particularly useful approach to the study of discourse and identity is *social constructionism*, drawn largely

from the work of Erving Goffman (cf. Schiffrin 2006: 105), which assumes that identity is neither a given nor a product, but rather a process which:

- takes place in specific interactional occasions;
- provides clusters of identities instead of individual, monolithic constructs;
- does not simply stem from the individual, but from processes of negotiation and contextualization which are eminently social;
- entails "discursive work" (Bamberg 2006: 2).

According to Schiffrin (2006: 105-110), Goffman proposed a *sociogenic explanation of the self*, that is, a way to bring society and self into a single conceptual framework. Traditional views of identity conceived of it as fixed and continuous, something that belongs to the individual (Mishler 1999: 111). By extending classic theories of Emile Durkheim (on social facts), Marcel Mauss (on reciprocity), and George Herbert Mead (on human development), Goffman developed an account of the self as a social construction; in so doing, he bridged the theoretical and analytical divide between self and society by re-conceptualizing how "other" and society are related to one another and how both are related to the self. In Goffman's view, "other" is a microcosmic representation of society; other/society and self are interdependent and mutually complementary.

Identity is not just a product of a stable social structural organisation, but rather a fragile construction of different facets of "self" and "other", within social exchanges such as interactions, encounters and situations during which we draw on various material and symbolic resources (including but not limited to language) for continuous substantive and ritual support. Therefore, individuals position themselves differently at different moments and places, in accordance with interlocutors, topics, situations and the variety of roles that they may be playing (Woodward 1997).

Giddens (1991) remarks that self-identity is neither a distinctive trait nor a set of traits, but rather a person's understanding of his/her biography: this implies that the stability of the self is given by a sense of autobiographic continuity which the individual communicates to others, and whereby s/he can keep his/her life story going.

Another important insight into the performative nature of (gendered) identity is provided by Ochs (1992); in her view, identity is a negotiated process of exposure and interpretation of social positions, affiliations, roles, status and other social categories, achieved through *indexicality*, described as "a property of speech through which cultural

contexts such as social identities (e.g. gender) and social activities (e.g. a gossip session) are constituted by particular stances and acts" (Ochs 1992: 335).

Foucault (1984) and Fairclough (1989) also highlighted that identity is a process embedded in social and discourse practices, meaning that both social and discourse practices frame the way individuals and groups present themselves to others, negotiate roles and conceptualise themselves. This process is inherently dynamic and entails that definitions of identity may change in time and space.

If we consider gender as part of our identity and language as a tool through which gendered identities are *performed* (Butler 1990, Cameron 1997, Eckert 2003), then we may say that gender identities are not fixed, but are themselves ongoing processes, involving the use of linguistic strategies which change from one situation to the other. According to Johnson (1997: 23), this means that, in performing gender, men and women may draw on linguistic resources which are perceived to be appropriate by their gender group, in the same way that they may dress in a manner which conforms to gender expectations. This dynamic concept of gender centres on the premise that the notions of male and female are sociocultural transformations of biological categories and processes. That is, social groups organize and conceptualize men and women in culturally specific and meaningful ways (Ochs 1992: 339).

On these grounds, in this subsection I will linger on potentially identity-related words, represented by the keywords *woman/women*, *age, sex* and *masculinity.*

Table 6. Identity-related KWs: rank and frequency

Keyword	**Standardised frequency (per million words)**	**Rank (ordered by keyness)**	**Frequency in the corpus**
1. Woman Women	257.69 750.66	75 8	138 402
2. Age	423.88	167	227
3. Sex	296.9	43	159
4. Masculinity	31.74	286	17

4.2.1.3.1. Woman/women

The word *women* ranks 8th in the KW list (standardised frequency 750.66 PMW) , while *woman* is 276th (standardised frequency 257.69 PMW)..

Three clusters seem to be worth investigating: *to other women*, *a lot of women, less of a woman*

The cluster *to other women* appears 19 times and has a peculiar distributional pattern, in that it is mostly employed in the editorial comments (13 occurrences) as in the following examples:

(90) <c> She took HRT for a year and then changed to a herbal remedy that she recommends to other women. </c> (woman, breast cancer 50-59, interview 01)

(91) <c> Says that screening saved her life and she recommended it to other women. </c> (woman, breast cancer 50-59, interview 10)

(92) Linda was having worrying side effects with tamoxifen. After talking to other women on the internet and her GP, she switched to Nolvadex. </c> (woman, DCIS, 50-54, interview 01)

(93) <q>Do you have any message to other women about ovarian cancer based on your experience?</q> (woman, ovarian cancer, 2-5y from diagnosis, interview 11)

(94) <q>Is there anything you'd like to say to other women who find themselves diagnosed with ovarian cancer, any kind of message to them?</q> (woman, ovarian cancer, 2y from diagnosis, interview 01)

This cluster is not paralleled by **to other men* in the corpus. One possible explanation (which will be expanded further on) is that the website explicitly decided to create a discourse of female solidarity to support screening practices, in compliance with the NHS directives which provide for compulsory screening for women, but not for men. In that regard, in the edited comments, the cluster *to other women* is often used with verbs of suggestion as in the examples 90-91.

Furthermore, in these comment lines, it is possible to highlight a specific pattern:

Name of woman respondent/she + urge/advise/encourage/recommend + women+ to + [expressions indicating screening or medical practices]

For example, if we consider the verb *advise*, it is noteworthy that among its (14) occurrences, 86% are from edited comments (*advises women to…)*, as in the following concordance lines:

- advise women to go for their smears regularly.
- she advised women not to be afraid of having it.
- Anna advises women to attend all appointments
- Advises women to be aware of any breast changes and comments on […]
- Advises women to be breast aware and to see their GPs if they
- Jacky advises women to be breast aware and to see their GP about any
- She advises women to get as much information as they can.
- advises women to go for screening.
- Michelle advises women to go for cervical screening when invited
- she advises women to have smear tests.
- Jane advises women with larger breasts to consider whether they
- Katie advises women to talk about CIN3 [cervical intraepithelial neoplasia]
- Laura advises women never to miss their cervical screening test.

This pattern is not used as frequently in the men's interviews, as can be seen in the following concordance lines:

- Advises people to set goals and keep fighting.
- Advises others to have regular PSA tests
- they advise taking selenium tablets, supplements.
- I'd advise anybody to make sure that their local chemist

It is also possible to interpret the pattern supposing that the website (unconsciously?) creates a *community of practice* (Lave & Wenger 1991, Eckert & McConnell-Ginet 1992, 2003). A community of practice (CoP) is, according to cognitive anthropologists Jean Lave and Etienne Wenger, a group of people who share an interest, a craft, and/or a profession. By virtue of engaging overtime in common endeavour, the participants

develop common knowledge and beliefs, ways of relating to each other, ways of talking, that is, *practices* (McConnell-Ginet 2003: 57). The group can evolve naturally because of the members' common interest in a particular domain or area, or it can be created specifically with the goal of gaining knowledge related to their field. It is through the process of sharing information and experiences with the group that the members learn from each other, and have an opportunity to develop themselves personally and professionally (Lave & Wenger 1991).

Moreover, it is through participation in a range of CoPs that people participate in society and forge a sense of their place and possibility in society. CoPs can exist online, for example within discussion boards and newsgroups, or in real life, such as in a lunch room at work, in a field setting, on a factory floor, or elsewhere in the environment. Since CoPs emerge as groups of people respond to a mutual situation, it could be that the website backs the idea that women are more apt to create bonds, and are consequently a more suitable target for successful raising awareness campaigns. This seems also to be supported by linguistic studies (Lakoff 1975, Coates 1986) which give a linguistic account of the general tenet that women are cooperative while men are competitive (this essentialist position, however, has been much debated by feminist scholars).

However, it should be added that there is no evidence to ascertain that the “creation of a CoP” was done purposely, as a way of conforming to medical/governmental guidelines - another explanation being that this result is achieved unintentionally.

The rhetoric of persuasion does not seem not to be the only one used in the corpus; it is also possible to find a “rhetoric of anxiety”: indeed, the message given in some stories is that women should partake in early screening, lest cancers are detected too late to be cured. These messages are conveyed by reporting stories of late detection or by stressing that seemingly mild abnormalities should not be overlooked, as shown in the following excerpt taken form the concordance of the cluster *a lot of women*:

> (95) I-I do know quite a lot of women who, in fact I would say nearly all the women I met in hospital...had had some sort of trauma or difficulty. I mean, most people have had traumas in their life by the time they get to their mid-life, but there was a surprising number who'd had ehm... difficulties of one sort and another ehm and they'd ended up with breast cancer[…] <u>And just as soon as you find anything that worries you, go to the doctor. It's not just a lump. It can be a skin change. Ehm...A lot of women don't realise if they get puckering of the skin, or ehm problems with nipples ehm that they should go and get them looked at.</u> (woman, breast cancer, 30-49, interview 01)

(96) So I hadn't had a cervical smear for quite a while because like a lot of women I don't particularly like having them and it had just sort of lapsed. So I thought well I'd better go and have one done. Which I did at my local GP and it came back with some abnormalities and... surface abnormalities. (woman, cervical cancer, 39-44, interview 01)

When checking WS tools for clusters of the KW *woman,* the first on the list is *less of a woman*. This expression conveys a sense of loss of femininity as a consequence of major surgery (mastectomy, hysterectomy, salpingo-oophorectomy). As aforesaid, it seems that women are more struck than men by the experience of losing a sex-defining part of the body, as can be seen in the following excerpts:

(97) It wasn't so much losing a breast and being any less of a woman, it was getting rid of the cancer that was the main issue. (woman, breast cancer, 30-49, interview 15)

(98) I think I said about, although I'd got my family, I hadn't got those issues that I'd lost my fertility, you know, oh my gosh I'm never going to have children. I was very, very lucky that I'd completed that part of it. But I wasn't expecting how I was going to feel as, I felt less of a woman, I don't know why. I think, I really don't know why actually. I just did. And I felt that I had to make more of an effort, that I had to, you know wear more make-up and I wore high heels. I've never worn high heels in my life. I'm a trainers girl. And I felt that I had to make more of an effort to feel more womanly. To, you know, I don't know whether that was anything to do with hormonally, or whether that was just me perceiving it the way I did. I don't know (woman, cervical abnormalities, 31-35, interview 02)

(99) Ehm and I think-my hairline receded and you just begin to look very different, no eyebrows, no eyelashes. And that is...and I was fatter...so it-it really-that was quite devastating. You felt your femininity was sort of...coming out with the sickness really. (woman, breast cancer, 50-69, interview 09)

(100) It wasn't so much losing a breast and being any less of a woman, it was getting rid of the cancer that was the main issue. But having said all of that when you look down and see a nasty big scar where you used to have a nice breast, it's not nice. And it's something you've got to just get past, you've got to look down. I didn't want to at first, I didn't for the first 3 or 4 days, but eventually I did. I looked down and it wasn't as bad as I'd imagined it to be. Although it was bad, I'm not going to flower it up, it was bad but it wasn't as bad as I imagined it to be. (woman, breast cancer, 30-49, interview 15)

(101) They do say that some women don't feel like women anymore after having a hysterectomy. It didn't enter my head at the time, it really didn't. Ehm it has done since. It doesn't make me feel less like a lady, or like dressing up and putting make-up on and things like that, but in the sense that no other man would ever want me if my relationship didn't work out because I can't have children, then that makes me less of a woman and I wouldn't feel I had anything to offer to a man at all. Ehm so my self confidence in that sense has gone but that has been a progressive thing, it wasn't there at the beginning. (woman, cervical cancer, 31-38, interview 06)

(102) Felt less of a woman because her 'female bits' had been removed.</c>

I think also there's an issue with having your female bits taken away. Even if you're not consciously aware of it, you know, obviously you have a scar and you know that your ovaries are not, I don't know why that should affect you but it does, you know you don't feel as much of a woman because of that. And I think, that equally must be the case if you have mastectomies as well but that's more evident because it's obviously external. (woman, ovarian cancer, 2-5ys from diagnosis, interview 07)

(103) <c>Felt less of a woman because her surgery left her with a colostomy.</c>

<q>And is your colostomy permanent?</q>

I pray God that it will never be permanent, because it's not a good thing for a lady because every day you bath, when you change, you cannot even, you know, I feel that I'm half a woman, you know, I don't know how to put it, I'm little bit confused because it sometimes you mess around without knowing what is happening. (woman, ovarian cancer, 2-5ys from diagnosis, interview 12)

(104) <c>Felt deformed to have no navel after her hysterectomy.</c>

I have no navel, which I find quite horrendous, you know. I must, it must feel like somebody that has breast cancer that loses a breast, as much as you think your navel doesn't mean a lot, it does if you don't have it. You know, it is quite strange to have no navel [laughs]. But that's just, I mean it doesn't matter, I can live without it, but that's like a deformity to me, you know. (woman, ovarian cancer 2-5ys from diagnosis, interview 05)

If compared with men having undergone a similar “gender-threatening” experience, few women report a smooth psychological aftermath of this kind of surgery. Another

explanation for the paucity of “bereavement” accounts among men is that they can cope with the anatomical loss provided this does not harm their sexual performances. This seems especially true for young patients of testicular cancer, in that their self-esteem does not ebb away if they report having a normal sexual life, if compared to the more complaining reports of prostate cancer patients who are more liable to suffer from impotence as a secondary effect of prostatic cancer surgery and/or therapies. This issue will be deepened in the analysis of the KW *sex*.

4.2.1.3.2. Age

The keyword *age* ranks 167th in the list, with a standardised frequency 423.88 instances PMW. The analysis of this keyword proves interesting both for the patterns and for the social issues it raises.

According to Eckert (1997: 157), age is sociolinguistics' under-developed social dimension, in that "only the middle-aged are seen as engaging in mature use, as *doing* language rather than learning or losing it". Indeed it is evident that in contemporary Western society there is a gerontophobic bias, that is, a climate of veiled antipathy that surrounds the very concepts of ageing and late life (cf. Coupland 2001).

The psychoanalytic roots of generalised social gerontophobia are to be found in the repression of death, to which old age is a precursor. Nevertheless, as Chambers (1995: 146, cit. in Coupland 2001: 186) writes, age exerts an irrepressible influence on our social being, since it is “an immutable social fact". Unlike social class, where mobility is possible, and unlike gender, where gender roles are nowadays "less confining", our ages remain a fixed and “autocratic” (Coupland 2001) variable in our social lives, in the sense that they cannot be changed because of the irreversible elapsing of time. As Coupland (2001: 195) puts it, sociolinguistics can explore the extent to which age is (re)negotiated in different settings, also considering that this dynamic perspective on identity and age-identity in particular has an established pedigree: it can be found very explicitly, for example, in Mead's (1932, cit. in Coupland 2001: 195) process model of identity, which assumed that the self emerges through interactional experience. Moreover, borrowing from Giddens’ (1991: 214) concept of “reflexive project of the self”, it can be said that illness prompts a negotiating process which may eventually lead to self-transformation (cf. also Charteris-Black & Seale 2010: 208), where the variable “age” plays a key role. As an example of this process, it is worth quoting this line taken from the reference corpus:

> (105) <u>But I have learnt to be happy within my limitations, and before I wasn't</u> […] (woman, chronic pain, up60, interview 18)

The WS 5 concordance tool shows that the main 4-word clusters of the keyword *age* are *the age of 50, the age of 70* and *because of my age*.

As regards the expression *the age of 50*, it is equally found in men's (section PSA screening) and in women's interviews (section breast cancer screening), where it refers to the age at which it is advisable to start breast cancer screening and PSA test for prostate cancer.

> (106) I think with ehm I've always known that you can get mammograms ehm once you reach the age of fifty on the NHS and you-you should be called routinely. And I thought it's coming up to my fiftieth birthday. This is my fiftieth birthday present to myself. So [laughs] I actually paid for a mammogram privately as a fiftieth birthday present. (woman, breast screening 50-59, interview 07)
>
> (107) So if we are going to test gentlemen from the age of fifty then it's got to give us really accurate results at least you know we've got to be looking in the area of possibly eighty, eighty five per cent accuracy, we can't ask for one hundred per cent you know [laughs]. But that's what we've got to be looking at, anything below that then it's almost like throwing money away and we all know the implication of that, the taxes go up and this sort of thing. (man, PSA test, 40-50, interview 03)
>
> (108) <q>Women have mammograms, after the age of 50, they're screened for breast cancer. But men don't have regular screening for prostate cancer. Have got any thoughts about that?</q>
>
> I think, I think I would be in favour of it on the whole. I have a regular screening now for colon cancer because that's what my father died of at 68 and I find that reassuring the fact that some, that it's being monitored my situation because they have found the polyps that precedes cancer, as they have with my younger brother as well. So from that point of view some kind of monitoring process has been very much to our advantage and possibly this would be. I don't know quite, whether there are the resources to do it but yes I'm, in principle, I'm in favour of it. (man, PSA test, 71-80, interview 06)
>
> (109) Yes basically I went for a PSA test primarily due to someone, a friend of mine who every time he met me, when I reached the age of 50, kept saying "Have you been and had your PSA test?" And his logic was that he knew two or three men who had had prostate cancer and his argument was if only they'd had the PSA test earlier it might have been trapped before it became a kind of major problem. And his logic was that would you, we have our teeth checked regularly,

we have our car checked regularly, women have check-ups for cancer, you know why are men so afraid and why don't, don't they go? So I suppose on one hand there was the logic of his argument, on the other hand I'm very much a person who says well why go looking for a problem if there isn't one and if it's not broke why fix it? So basically I filed it away as a good idea". (man, PSA test, 61-70, interview 14)

These are further examples of the pro-screening position endorsed by the HT [*healthtalkonline*] website (see above the analysis of the keyword *woman*). Moreover, as for the cluster *the age of 70*, it is only found in the interviewer's questions (likely due to the semi-scripted character of the interviews), where it relates to an age limit for breast cancer screening, as in the next examples:

(110) <q> And...you will be invited up until the age of 70 now? </q> (woman, breast screening, 60-69, interview 11)

(111) <q> If they say it's up to you after the age of 70, whether you want to go for 3 yearly mammograms or not, would you want to continue? </q> (woman, breast screening, 50-59, interview 09)

(112) <q> In terms of breast screening, women are invited up to the age of 70, up to the age of 70, they receive a letter. After then it is up to them whether they want to go for screening. They would have to phone and make an appointment. Would you want to carry on after the age of 70 to go for screening? </q> (woman, breast screening, 60-69, interview 09)

The insistence on screening, besides NHS guidelines and evidence-based results, may also be interpreted in the light of the general bio medicalization of ageing, which is worded by Coupland (2001: 197) as the "biomedical concerns that have swamped gerontology" (cf. also Illich 1976 on the medicalization of life). As regards the cluster *because of my age*, it is mostly found in women's interviews (6 times out of 7 occurrences):

(113) <c> Some mammograms hurt more than others and this depended on her menstrual cycle. </c>

<q> Has it ever been painful? </q>

 I think...yes because...I think that at certain times of the month because of my age, I'm still on HRT and I do get tender breasts. (woman, breast screening 60-69, interview 03)

(114) <c> Patricia knew straight away that she would prefer a mastectomy and was pleased with how the operation went. </c>

 I was asked if I would go in to see the breast cancer nurse, and it was the breast cancer nurse that spoke to me about the ehm that there were some cancer...cells and I would need to...speak with - the consultant was wanting to speak with me about it and she advised me about how I wanted to approach, whether I would, you know, if they needed to give me a mastectomy, did I want just a piece taken away, things like this. And my-my response was that, if I had cancer in the breast, I wanted the breast removed and I was very positive about that. Ehm I think because of my age at the time, I think if I was a lot younger I may not have been. (woman, DCIS, 50-54, interview 07)

(115) And, because I've a fairly ehm stressful occupation and work relatively long hours and I had been thinking, because of my age, I had been thinking about it's time to sort of think about taking it more easily (woman, cervical screening, 45-59, interview 10)

(116) <c> Comments that while she would not want reconstruction at her age; she feels it would be different for someone younger. </c>

 Also, although I didn't have a choice, I wouldn't have had any implants or reconstruction because of my age then. I've got a stable marriage and that was it. I can cope with the prosthesis. But I will say this, anybody that's young [...] and got a you-a young husband and all that [...] I think it is more traumatic for them than it is...than it was for me. [...] Also we-sex and that sort of thing is out in the open now a lot more. We weren't brought up like that and that's a big, big difference. (woman, breast cancer, 70+, interview 04)

The last example quoted seems to replicate word for word the examples quoted below in the analysis of the KW *sex*, (examples 120-121 related to men's reaction to therapy-induced impotence). However, the lady's words seem to add a further element, in providing a framework to explain why an impairment of sexual life should be more difficult (she uses the strong adjective *traumatic*) for young people to bear: *I think it is more traumatic for them than it is...than it was for me. [...] Also we-sex and that sort of thing is out in the open now a lot more. We weren't brought up like that and that's a big, big difference*.

This concept is expanded by Elliott and Lemert (2006: 113-115), in whose words over the past few decades there has been a marked series of changes (a product of both

consumer capitalism and globalisation) affecting sex, intimacy and eroticism within the advanced societies of the West. This has led to the rise of what they call *discursive sexuality* (Elliott & Lemert 2006: 113); that is, sexuality increasingly becomes a terrain colonised by ideas and ideologies of global capital. This view borrows from philosophical doctrines of post-structuralism and post-modernism, according to which the cultural fascination with sex has, in fact, been an imposition, a complex effect of the forces of power and domination.

For the late cultural historian Cristopher Lasch (1979), the Western infatuation with all things sexual is itself symptomatic of an escalating culture of narcissism. This is particularly clear in terms of the ways in which sexuality is framed and regulated today through advertising, mass media and information culture. Furthermore, sexuality has become a key focus of personal identity, a reflexive condition of meaning in social relationships, intimacy and eroticism.

4.2.1.3.3. Sex

The keyword *sex* ranks 43rd in the list, with 159 occurrences (standardised frequency 296.9 PMW). As aforementioned, the analysis of this KW gives interesting insights, since it seems to involve many issues related to questions of gender identity, especially if the sexuality domain is undermined, in a sense, by surgery concerning primary and secondary sexual organs. The following are relevant excerpts from the corpus:

> (117) <c>He suffered elements of 'post-traumatic stress' for several weeks after he passed blood in his sperm.</c>
>
> <i>[…] Probably the most traumatic thing about the whole experience for me in terms of the PSA testing and the biopsies and visiting the consultant and all the discussions, quite apart from the difficulty with the, "Having sex in a coffin" comment was the fact that I was not prepared for the effect of the biopsies on my sex life. And what I mean by that was the consultant said, "You may find that you pass a little bit of blood in your urine." In fact it isn't blood in your urine which is the most significant thing it is the fact that when you have a sexual experience and you ejaculate it is a bit like the film 'The Alien' if you're not expecting it. What happens is that you ejaculate what looks like very florescent strawberry jam. And I actually, according to my wife, was traumatised by this and subsequently suffered elements of post-traumatic stress for several weeks.[…] it meant that I was wearing a condom which I hadn't worn since I was in my early twenties and basically I had a very, very difficult time which was quite shocking for me because I'm a very forthright confident person in my life, I'm a very, or always had been very confident

in terms of my sexuality and I had some difficulty with that for some weeks and months after that and the whole thing seems rather bizarre to me because basically I went for a PSA because of my symptoms which were to do with restriction of urine flow. (man, PSA test, 51-60, interview 08)

This example may be related to n. (19) on the use of irony in patients with testicular cancer; in this case too irony seems to work as a distancing device (cf. Charteris-Black and Seale 2010: 54-55) when patients are confronted with the verbalisation of worrying thoughts; another clue of this displacement strategy might be that the respondent vicariously reports his being traumatised as his wife's opinion (*And I actually, according to my wife, was traumatised by this and subsequently suffered elements of post-traumatic stress for several weeks*).

Another potentially interesting finding is that the expression *sex drive* (which, according to the *Merriam-Webster 11th Collegiate Dictionary*, is "an urgent, basic, or instinctual need: a motivating physiological condition of an organism < e.g. a sexual drive>"), despite being gender-neutral, is only found in men's interviews, as in the following examples:

(118) I mean the freakiest thing was that I lost my sex drive, well not completely, but I lost a lot [...]when I have injections, my sex drive seems to be as strong as the day before (man, testicular cancer, 20-30, interview 06)

(119) <q>How did that make you feel as a man having female hormones?</q>

Terrible, that's when your masculinity really goes. Forget about the sex drive when you get them implanted in you, you just get a crazy mixed up kid for want of a better word because you're doing these terrible things, you know it's not you, you know it's not part and parcel of your upbringing because as I said you'll snap, you'll rant and rave, you just, your total outlook on life is different. It changes your attitude and your attitude to the ones that you're living with, your attitude to your family, you just don't want to know them. (man, prostate cancer, 61-65, interview 06)

It may be interesting to elaborate on whether men (in the quasi-formal setting of the interview) feel more entitled than women to talk about their own sexual life. As it will be discussed under the keyword *masculinity*, this might be a repercussion of an ideology of hegemonic masculinity (Kiesling 2006, Gramsci 2007); in other words, by referring to themselves as sexually competent even after illness (whether consciously or not), men reproduce an underlying logic of masculinity in terms of agency (which often implies

women's passivity, cf. Cameron & Kulick 2003: 31). The feminist Catharine MacKinnon once wrote: "Man fucks woman. Subject, verb, object" (1982: 541, cit. in Cameron & Kulick 2003: 29); this statement vividly encapsulates a main theme of gender and sexuality: that only men can be active sexual subjects, while the role of women is to be passive objects of male desire.

In any case, the analysis of the corpus clearly shows that sexuality is an important factor in shaping men's identity, in that especially young male respondents seem to be concerned with the potentially negative consequences of surgery and/or therapies on their sexual performances, as shown in the following excerpts:

> (120) <c>Recalls that after the initial diagnosis he was mainly concerned that he would not be able to have sex again.</c>
>
> <i>And the immediate blow was, in fact it actually felt like a punch in the chest, because we, still at this point I didn't realise any, I didn't realise any of the sort of, any of the medication they had like testosterone injections, I didn't realise that these things existed. So immediately, my immediate thought was well basically that it [sex] was just all over, you know that I was going to lose the power to, well just lose my sort of manhood and I just thought it was all over. But the doctor saw, I mean I think he saw the look on my face of just complete horror and then of just, you know complete sadness. (man, testicular cancer, 20-30, interview 06)

In this case it is interesting to note that the respondent explicitly equates *sex* with *manhood* and *power* and the thought of its prospective loss with *complete horror* and *complete sadness*.

The following example seems to imply that you might not be able to have "a full and fulfilling sex life" after surgery unless you have "a loving partner and someone who cares and understands":

> (121) <i>Through no fault of anybody else's, and I think it's because of how I felt myself, I felt almost as if I'd been emasculated, mutated. I didn't blame anybody because it wasn't as if it was a mistake by somebody, this was something that had happened to me and I found that I was in the position where I didn't know whether I could ever have sex again, I didn't know what the future held for me, would it spread, and a whole manner of things. And there wasn't much in the way of help for people that had both testicles removed. […] That is not because of the testicular cancer, that is because you are totally stressed out. If you have a loving partner and someone that cares and understands there is no reason whatsoever

that you cannot have a full and fulfilling sex life. […] With regard to my story, going back to my story with the removal of one testicle you know it was a tremendous blow. I can understand now why women get so really uptight about cancer that affects, goes direct to your sexuality. If I'd have had a tumour in my lung or in my leg or another part of my body I don't think it would've affected me as much as something that goes to the core of my sexuality. I mean you hear on television some of the expressions about men brimming with testosterone or whatever and it comes as a shock. (man, testicular cancer, 41-50, interview 10)

By contrast, in the following excerpts respondents provide a more assertive stance, which, again, could be linked to the male "heroic ethos" (see discussion under *masculinity* and Charteris-Black & Seale 2010: 55), according to which a traditional "strong" and "stoical" masculine identity requires men to demonstrate that they can cope with the challenges of illness just as they can deal with other everyday challenges. In the following except the stress on sexual skills, along with the use of expletives (although auto-ironical: *me being an awkward bugger*) seem to index a traditional masculine performance, which might possibly be strengthened as a (psychological?) reaction in the face of an "exogenous" diminution of masculinity by means of surgery or hormonal treatment (which is more overtly expressed in the example 123: *I found that I wanted sex more. Maybe that's a psychological thing of losing the testicle*).

(122) <c>Explains that he continued to have sex during chemotherapy, and his wife didn't notice any difference in sensation.</c>

<q>Did it affect your libido for a while, I mean during treatment?</q>

No actually it didn't, no it didn't affect anything like that, no [laughs]. My wife thought it would and it should, uh and I said 'Don't worry about it, it'll only burn you [laughs]'

<q>Were you told to take different precautions when you were having chemotherapy?</q>

[…] I wasn't told to avoid sex or anything like that. I don't think they actually thought I'd be capable of it to tell you the truth[laughs]. But me being an awkward bugger, I obviously I was, yeah, I've still got erections through and after treatment, yeah [laughs].

<q>And they didn't tell you to wear a condom or anything like that?</q>

No, no. Mind you I just used to tease the Mrs and say 'It'll burn you girl[laughs]'.

<q>[laughs] But she didn't notice any difference?</q>

No. […]

<q>So is sex just the same? [after removal of a testicle]</q>

Afterwards I mean, to be quite honest with you, I enjoyed it more [laughs]. But uh, no I mean there's no, I couldn't find any difference at all with sex at all. There is none […] (man, testicular cancer, 51-55, interview 02)

(123) As far as my sex life was concerned three weeks after I had the operation we managed to have full sex. So if you can imagine even though it's [the operation] very invasive, there was no real problem. You have to be so careful because you're very tender, especially where the incision was. The swelling had gone down quite dramatically by then. But it was still, still say orange size! Or small orange size, Satsuma size or maybe or whatever, on that side, but there was still, the, the actual effects of the swelling wasn't stopping us now from enjoying sex if we wanted sex. I was finding, I wasn't as, shall we say randy as I normally was but within two weeks of the first time I was back to being my normal self, if not more than my normal self. I, I found that I wanted sex more. Maybe that's a psychological thing of losing the testicle I don't know but it was, it definitely was the case and it hasn't gone away yet; to my wife's annoyance! But no, so as far as sex is concerned it doesn't seem to have an effect at all. (man, testicular cancer, 31-40, interview 11)

In the example above it is noteworthy that the use of self-irony (*the swelling was orange size, Satsuma size*) seems not to defuse embarrassment but rather to add to traditional "strong", "pain-enduring" masculine style (*the actual effects of the swelling wasn't stopping us now from enjoying sex if we wanted sex*). Moreover, besides asserting his resilience, the speaker overtly attributes his (masculine) self to sexual performance, as in *I was back to being my normal self, if not more than my normal self. I, I found that I wanted sex more. Maybe that's a psychological thing of losing the testicle I don't know but it was, it definitely was the case*.

(124) <c>Explains that although he was anxious about sex it was just the same as always, and he wasn't affected psychologically.</c>

I thought so originally, I wondered was I going to function the same way er you know what was sex was going to be like in the future. The very first time I was terrified, I wondered you know have they tied up all the tubes up properly, you know am I going to have a leak or something. And it was, it was nerve-wracking it was worrying. I needn't have bothered it's not affected me physically since and that was what 17 years ago. Had no, no side effects, I'll still go swimming, whatever. (man, testicular cancer, 41-50, interview 06)

In the example above it is noteworthy (as already remarked by Charteris-Black & Seale 2010: 81) how the element "sport" adds to men's identity: it seems to influence their self-esteem and may be generally related to a competitive dimension of traditionally masculine discursive style.

Unlike the previous excerpts extracted from younger patients' accounts, in the following ones it can be noted that elderly men seem more at ease accepting impotence as a possible outcome of hormonal therapy:

(125) <c>Explains how a younger man would have more problems with impotence than he would.</c>

<q>And how do you think it makes men feel these side effects of hormonal treatment?</q>

Well in a younger man I think the impotence would worry them because it might affect their married life, it depends how the relationship between the husband and the wife is. In my case as I say we've got 3 grown up daughters now and the wife isn't bothered in any way so it doesn't interest her any more so we get along quite well together you know. She says, actually the hormone, she thinks the hormone therapy has done me good because I'm more even tempered [laughs].

<q>Oh does she.</q>

She says I'm more relaxed now than ever I've been in all the years she's known me (man, prostate cancer, 66-70, interview 07)

(126) <c>Explains that impotence has not altered the relationship with his wife.</c>

<q>Do you mind me asking do the hormones affect sort of sex drive at all?</q>

Well I don't have any [laughs].

<q>Was it the same before and after or different?</q>

After the operation of course, no you don't lose your sexual instincts then, but since I've been taking, having this implant he did say to me 'You'll become impotent, impotent I should say,' and low and behold I have. But at 70 I'm not that worried, it hasn't altered any relationship between myself and my wife. I mean by the time we were reaching 70 it wasn't exactly the end of the world and it's just something, it just doesn't happen anymore that's all. I mean you don't think about it, I mean I'm, I think our relationship is fine, we're just as affectionate as we always were but no there isn't any sexual activity. (man, prostate cancer, 71-74, interview 02)

In both cases, the respondents seem to cope well with the sexual impairment, as shown by the paralinguistic cues *[laughs]*: at the same time, they underline the balance achieved in the couple dynamics (*She [wife] says I'm more relaxed now than ever I've been in all the years she's known me; it hasn't altered any relationship between myself and my wife*) which may involve a sort of psychological negotiation or adjustment to a novel condition, which may also be part and parcel of the ageing process.

In this respect, as Coupland (2001: 203) puts it, in the context of ageing, identity work assumes a more profound personal importance, since the negotiation of one's identity as an older person subsumes the self-appraisal of one's own worth as a "time-travelling" person. Moreover, as far as gender identity is concerned, it does not seem that their perception of masculinity is much jeopardized by sexual impotence.

In the following examples we see that women's perspective on sexuality seems more biased by the anatomical losses due to surgery:

(127) <c>No longer felt she was a sexual person after surgery, though her husband was still attracted to her.</c>

Okay. I think initially, again I felt so ill from the surgery and the chemo that it wasn't really an issue. I completely lost my libido but then I assumed it was because of all the treatment I was having. Unfortunately it didn't come back. It wasn't until quite a long term after the surgery that I realised they'd removed quite a bit of my vagina, and that did have a profound impact on me sexually because I didn't feel like a whole person. It hadn't bothered me having my uterus removed but when I found out some of the vagina was gone that, it did affect me. I just had no libido at all because I didn't feel like a sexual person any more. And so that's been a very, it's been a problem for us because my husband has been very keen

to show all the way through that it's not affected his, he still feels very attracted. And, you know, he feels it's important to let me know that he does, and he's been a real sweetheart that way. But the problem is I don't want to know. I think I just feel that my body is just been so broken and beaten that I find it hard to think of it as something to celebrate, and I think my sexuality was very wrapped up in that. And I just don't really have any more because of that. (woman, ovarian cancer, 7-14ys from diagnosis, interview 07)

(128) Ehm but yeah. I don't know. I just think some kind of, you know, it's the stuff nobody likes to talk about. But like a slightly [laughs] more informal fun version, which is like all the stuff after CIN3 treatment that you didn't want to hear. It's kind of... yeah, good to know actually that other people get a bit worried about that. It is a bit weird though and kind of like - you're just so paranoid that you're going to make everything worse. It's like they've done surgery there and you're kind of like, "Oh... uh-uh." […] And now I'm really scared [laughs] because I don't want it to get worse again. And so I'm kind of like... I don't know, I'm just like... oh my poor boyfriend [laughs]. But still I just, I'm really, really worried about it because... I don't want to like kind of knock anything [laughs], or like make it bleed again. [...]It's funny because you kind of think that boys aren't going to be bothered about that, but they're not that heartless. They probably are concerned that [laughs] you've just had massive treatment, and are you feeling alright and hope you get better. But in your head as a girl I think you're like, "Oh my God, we can't have sex for six weeks, they're going to leave me". But... no, he's been pretty good. (woman, cervical abnormalities, 25-30, interview 11)

(129) <c>She would have liked more information about how her hysterectomy would affect her sex life.</c>

On one of the appointments, when I went up to have the bowel and bladder investigation a nurse came to see me and asked if I had another queries or problems. I explained that I was worried about the lymphedema thing. I also had begun then to worry about our sex life [laughs] and whether we would be able to continue to have a sex life and in what way it might affect things. […] It did worry me because we have a good relationship, we've been together for a very long time, but sex is still something that's quite important to both of us, and I felt that I wanted to know what was going to happen. (woman, cervical cancer, 45+, interview 03)

By contrast, the next excerpt is an example (although relatively rare in the corpus if compared to men) of how post-mastectomy breast reconstruction has strengthened the respondent's feminine identity, also in terms of sexual performance:

> (130) I really hadn't anticipated the emotional response after the reconstruction. I love my new breast. I think it's wonderful. Love at first sight. And it's just so nice that it's, you know, part of me.
>
> <q> Did you love it straightaway, without the nipple? </q>
>
> Oh absolutely. As soon as I came round and felt it and it was warm. And it's there and there's a lump. Ohh it's just wonderful. But one of the problems, unforeseen, was that, after this emotional experience of the reconstruction, I became much more passionate. Not that I could do much about it for a while because I was a bit sore [laughs] when you've had your tummy sort of tummy tuck, it's a big op. But I'm much more passionate and I think my husband was rather surprised. But I felt emotionally much more, much more alive I think.
>
> <q> And you mentioned that after the reconstruction you thought more about issues to do with femininity and everything else. </q>
>
> Oh absolutely.
>
> <q> ...afterwards, even though you had another breast. </q>
>
> Yeah. I'd been quite a tomboy in my youth and I'd always been very much, you know, down to earth and sort of, clothes, I liked to sort of look nice but I never wore much make up or anything, from my teens. I did in my teens but I've always been sort of, if it's comfortable that's fine, you know, and I didn't buy many sort of new clothes and I tended to go for things that covered me up. And then when I came through and got this new breast, I wanted sort of strappy tops and, not saying in a sort of promiscuous way, but I was so proud of them. And I'd hidden them away for years, when I had two perfectly normal ones I'd hidden them away. (woman, DCIS, 50-54, interview 13)

4.2.1.3.4. Masculinity

The keyword *masculinity* ranks 286th in the KW list, with a standardised frequency of 31.74 instances PMW, the majority of which are found in the testicular cancer interviews. The analysis of the context in which this KW is embedded is useful to gain insight into the respondents' perception of masculinity, which one could hypothesize is impaired by surgical removal of one testicle in testicular cancer or by oestrogen therapy in prostate

cancer. The results seem to indicate a difference between testicular and prostate cancer patients: the people suffering from testicular cancer do not generally feel that their masculinity is harmed by the loss of one testicle, as shown by the following examples:

(131)<q>Before you go on can you just expand a little bit about your sense of loss, was it, I don't want to put words into your mouth?</q>

A.F.: Well...

<q>In a sense of your masculinity or part of your body or...</q>

A.F.: Both, both I mean there's this common expression, at least in North America where you talk all the time about balls you know "that really took balls," or "he's really got balls," and all of a sudden you don't have balls, you've got no ball and so there is a kind of threat at least to masculinity. It was important to me to realise very quickly that sexual function wasn't impaired at all er and really that the funny thing (laughs) is that once I got used to having one testicle which was really again very quick it all of a sudden seemed incredibly clunky to have two. I mean the idea of "well don't they bump into each other" and they do bump into each other and all of a sudden having one just seemed like a very natural and even sort of preferred way to go through life. (man, testicular cancer, 51-55, interview 03)

(132) <q>Did you have any sort of feelings at that time that it might affect your masculinity or anything?</q>

No, not at all. At the time I weighed almost 18 stone er I was pretty big and I was known for being big and I was, I was a bouncer at the local university and I didn't, I still didn't, I felt almost invincible. And this minor operation, what I felt like, well it is I think a minor operation hadn't affected me whatsoever. I was actually back training lightly a week after the operation, much against obviously medical advice (laughs) but I was. (man, testicular cancer, 20-30, interview 01)

(133) <q>Can you say a little bit more about how the whole experience affected your sort of feelings of self-identity and masculinity. You mentioned you wanted to have a prosthesis because you thought it might be better from that point of view?</q>

Mmm, I didn't feel I was any less of a man because you know, because of what was done, I think if I'd lost both testicles I'd feel that would be a considerable loss, relying on hormone injections and so on. But I don't think gender identity is about body shape anyway, it certainly isn't purely about that.

<q>What do you think it is more to do with then?</q>

It's very much more a state of mind and it's about how you see yourself and how other people see you. Again my wife was probably the most important part in this, was very emphatic that from where she was standing it wouldn't make any difference. I talked to her about the question of prosthesis and what would she think about it, whether I should have a prosthesis or not, and she said it wasn't an issue for her but if it was an issue for me then may be that would be a good idea. But you know I don't think, I don't think her perception of me as a man is, has a great deal to do with appearance. (man, testicular cancer, 41-50, interview 01)

(134) <q>What about sense of masculinity, do you think it affects guys' sense of masculinity at all or temporarily?</q>

I think it does to a degree. Initially, especially early on. As I said I had a prosthesis and I think that had, that had something to do with why I decided I would have it. Part of it I think was automatic, I'm losing a testicle, I want one back. And as I said early one with the surgery it was so rushed between diagnosis and surgery that I'm not sure I was making a 100% rational decisions all the time. So thinking back I'm really not sure why I decided to have the prosthesis. I think part of it is vanity, part of it is the self-image, part of it is sort of masculinity and sexuality. There is a severe worry, you know, as I said you know the idea of someone close to my genitals with a sharp knife makes me still very nervous. Probably even more nervous now I've only got one testicle than I did when I had two. But yes it is worrying. (man, testicular cancer, 41-50, interview 05)

(135) Never, no mention, absolutely nothing. I've been asked so many times by people "Oh I guess you had an artificial one put in." No mention, no, never got asked. Which people were so stunned about. They're like, "You are joking?" and I'm like "No."

<q>Would you consider having that done now if you were offered one?</q>

No. Again as I said I'm not ashamed of it, it doesn't bother me one little bit, you can't hardly tell to look at it. It doesn't, you know obviously if people want to stare at my, you know, my private parts, then obviously that's their problem, in the showers and things, but you know (laughs) if someone said to me "Oh you've only got one," I'd say, "Well what you looking for?" you know that would my obvious reply to them. But it doesn't bother me. But again would people, should people be

asked? I guess so, they should be asked if they want to have an artificial one put in. (man, testicular cancer, 20-30, interview 04)

(136) <q>So how did the idea that you were now losing two affect you?</q>

Through no fault of anybody else's, and I think it's because of how I felt myself, I felt almost as if I'd been emasculated, mutated. I didn't blame anybody because it wasn't as if it was a mistake by somebody, this was something that had happened to me and I found that I was in the position where I didn't know whether I could ever have sex again, I didn't know what the future held for me, would it spread, and a whole manner of things. And there wasn't much in the way of help for people that had both testicles removed. [...] They've removed a part of my body, but the rest of my body is whole, the rest of my body works very well, and there is no reason whatsoever for man to feel any less of a man. And that is very, very, important; don't ever feel any less of yourself because a small part of your body has been removed. (man, testicular cancer, 41-50, interview 10)

By contrast, the prostate cancer respondents seem more prone to mourn over a loss of masculinity, which is linked to impotence, a secondary effect of either/both oestrogen therapy or/and prostatic surgery:

(137) Well this again it's not easy for me to talk about but I mean of course I am totally impotent and I'm even worse than that in that I am disgusted by anything sort of sexual. [...] Yes, yes I mean I feel that I've lost all masculinity, I'm not a man any more. I mean I'm just not. I mean if I were walking along with my wife, very slowly these days, and somebody accosted her I would sort of run away. I have no masculinity left. [...]

<q>How does that [impotence due to hormone therapy] make you feel?</q>

Awful, I think that really, that is the worst side effect by far. I think it's important that other men know how you feel about that.

<q>How does that make you wife feel, does it affect your relationship?</q>

Well I wouldn't know. It's very funny women don't talk about things like that you know, I'd never ask her for fear of her, she's taken it magnificently but that worries me of course it does. [...]

<q>Have the hormone injections had other side effects?</q>

I don't know, I think so in that I, now I can't think of the word, you'd know the word, I'm ever so lazy, I don't want to do anything, if it weren't for my wife I wouldn't even get up in the morning, I'm too bone idle (man, prostate cancer, 75+, interview 03)

In this case the respondent (a mature person) presupposes that masculinity equates with an aggressive/defensive demeanour (see Gilmore 1990) and that his loss of masculinity is due to impotence and lack of sexual desire, which implies that masculinity refers more to a gendered performance than to a biological/sexual given (cf. example n. 20). In this respect, the following example seems even more eloquent:

(138) Yeah I did feel threatened for my masculinity because I actually had, I had a chip on my shoulder at school about people finding out that I had one ball and it was quite a strong chip on my shoulder. I think that's why I found it so hard, the idea when I got cancer, I mean may be it would've been different for me if I'd had two, and they were just taking away one you know.

<q>Mmm of course.</q>

Because you know you can, I know for a fact you can live a normal life on one, you get the right amount of testosterone, you can, things are very normal. But I remember at school when it came to like taking showers and stuff I was really quite paranoid about that. So when it came to someone offering you know to have two [false testicles] I thought, I think I was bringing in that sort of insecurity of like my childhood, I thought about it, oh wow, I can make it alright now by having two. So I think yeah my masculinity was definitely threatened. Because I know as a child just the idea of people finding out I had one and may be questioning my masculinity that "Oh you've only got one testicle, you know you're not a real man," you know the whole playground tactics, I was always worried about that. And so yeah when he [the doctor] said that, [that he could have two false testicles], I was like yeah give me two, anything to make you know strong like a man, two testicles. Now it's quite, I just don't know where it all came from, because now like I said, I wouldn't even mind if the prosthesis that I have wasn't there because at the end of the day it's purely, you know it's just, it's not part of me anyway you know. (man, testicular cancer, 20-30, interview 06)

In this case it is noteworthy that the respondent attributes the essence of masculinity to the prosthesis, which is charged with the almost magical power of “making him strong like a man”. However, one should also consider that the account is given in the past tense,

which conveys the idea that he had overcome these worries at the moment of the interview.

It is interesting that the removal of a testicle, an organ responsible for the production of testosterone (the male hormone *par excellence*) does not seem to involve a sense of internal loss. That is, even after removal of a visible, external part of body, and besides a primary sexual organ, some patients do not generally feel "less of a man". By contrast, the respondents affected by prostate cancer, who may have undergone prostatectomy, tend to report a reduction of their masculinity. In this regard, however, age could be a decisive variable, in that the incidence of testicular cancer is higher among younger men (25-40) whereas prostate cancer is very rarely reported among men before the age of 50. It is more likely that, especially in prostate cancer respondents, the word *masculinity* is used as an euphemism for "sexual activity" (which seems to be supported by the surrounding context) or, more generally, that (hetero)sexual acts are integral to the interpretation of masculinity (cf. Gilmore 1990: 33). This point seems to be supported by the analysis of the keyword *sex*, as shown before. In a nutshell, prostate cancer patients feel "less of a man" because their sexual activity is hampered by pharmacological therapy, while the (usually younger) testicular cancer patients seem to cope better; indeed, neither the sexual nor reproductive function is impaired after removal of one testicle, since the other one can make up for both testosterone and spermatozoa production.

This argument does not seem to be paralleled in women's experiences of mastectomy (due to breast cancer), hysterectomy (surgical removal of the uterus because of cervical cancer) and salpingo-oophorectomy (surgical removal of the ovary/ies in ovarian cancer). In the corpus examined, it seems that women feel more deeply affected by the loss of a part of their body, either biologically (ovaries, uterus) or symbolically (breast) linked to femininity (see examples n. 102-103); however, in this case too age plays an important role, since younger women in fertile age might feel more deeply hit if deprived of the possibility of having babies, rather than menopausal women or fertile women who at the time of surgery already had children. The same regards the issue of body image after mastectomy, since younger women are generally more eager to undergo breast reconstructive surgery than mature women.

It is also worthwhile adding that, contrary to *masculinity*, the word *femininity* is not a keyword. This may in part be explained because the word *masculinity* is sometimes elicited in the male respondents' experiences by the interviewer's explicit questions (see examples n. 131-134), whereas the correlative idea of "loss of femininity" is expressed with a different wording (e.g. *less of a woman*, see above under *woman*). One could also hypothesize that since masculinity is conceived as a hard-achieved, prestige status (cf.

Gilmore 1990, Badinter 1992) the fear of losing it may prompt a deeper form of verbalised negotiation among male patients (if compared to femininity), which, in the case of testicular cancer, is aimed at providing a form of (self-)reassurance ("I've lost a testicle but I'm still a male"). Nevertheless, from a different perspective, this argument may be interpreted as the by-product of a discourse of *hegemonic masculinity* (Miller 2009: 116, Kiesling 2006: 268).

Masculinity may be conceived as a "hegemonic" (rather than "powerful") identity, because people in hegemonic positions do not always feel powerful, and in fact they may not directly dominate anyone (Kiesling 2006: 261). Hegemony, as described by Gramsci (2007) involves maintaining dominant social positions through less obvious but more basic means than direct coercion (for example, by controlling the basic ideologies in a society rather than ruling by force. The most important facet of hegemony (other than dominance) is its ability to change in the face of challenge. That is, ideologies which challenge the *status quo* of a dominant group can be appropriated and changed slightly in order to allow the dominant group to remain powerful and legitimise its power.

Although Gramsci related his concept of hegemony to an elite of intellectuals, this idea has been revised by post-structuralist scholars (e.g. Foucault 1980) and also used in gender studies (cf. Whitehead 2002). From this viewpoint, hegemony does not function through ideologies controlled by elites, but is created and perpetuated by a discourse which encompasses practices, ideologies and social structures; as Kiesling (2006: 262) puts it, this kind of discourses are a system of understanding and expectations which are not controlled by any single person or group and are hegemonic in the sense of being powerful and changing (although, as aforesaid, those who engage in the production and reproduction of such discourses need not be powerful).

Within the framework of *gender ideology*, defined by Eckert & McConnell-Ginet (2003: 35) as "the set of beliefs that govern people's participation in the gender order, and by which they explain and justify their participation", a hegemonic discourse will typically divide society into socially relevant groups such as men and women, Black and White, heterosexual and homosexual. Connell (1987 cit. in Miller 2009: 116) applies the notion of hegemony to gender relations (especially masculinity) by remarking that Western European and North American white male (hetero)sexuality is isomorphic with power, in the sense that men seek global dominion and desire, in order to oppress women and gay men. A way through which hegemonic masculinity may be expressed is the cultural model of *heroic manhood* (Gilmore 1990). An echo of this model can be tracked in the corpus (see examples n. 132, 135, 136) with the underlying thought "Although I've lost a testicle,

I’m all the more a man, since my virility was tempered through suffering and enduring the hardships of illness”.

The celebration of heroic masculinity resounds through literature and the media industry (e.g. Hollywood Westerns, Rambo/Terminator etc.) and is paradigmatically epitomized by Norman Mailer (1968: 25) who states: “Nobody was born a man; you earned manhood provided you were good enough, bold enough”. Echoing Simone de Beauvoir's (1949: 285) aphorism, "On ne naît pas femme: on le devient” (“One is not born, but becomes a woman"), Mailer's remark points toward what Judith Butler (1990) calls the performative constitution of gender identity, which also involves the inevitability of failed performances - that is, of not living up to “earning manhood". This is especially true if we consider, along with Miller (2009: 117), that hegemonic masculinity (straight, strong, domineering) oppresses not only women, but also the many men excluded from it, while even “supporters” may find its norms of ultimate power and authority to be unattainable.

The unease about the articulation of hegemonic masculinity is meaningfully expressed in the following excerpt from the reference corpus:

> (139) <c>He initially thought therapy was for the mad upper classes and anorexic girls, but then found he liked therapy, expressed his deep emotional pain, and felt better after talking. </c>
>
> <i>I don't come from the kind of background that goes to therapy. Therapy is anathema in my family, you know you just, we're not from that world, we're not from... that class. And so it took a hell of a lot for me to go to therapy. You know A: nutters go to therapy, B: therapy makes you a nutter. These were the kind of things that I grew up with. And it doesn't help. You know, so hostile kind of lower middle class sort of feeling about that sort of thing. We're not the sort of people that do it, do you know what I mean, it's like people from Hampstead go to therapy, we don't... I was sent to the counselling at university, and I fucking hated that, it was probably just the wrong time of life'. The sort of walking in, and you're surrounded by pale skinny fucking anorexics you know and you think A: I'm a bloke, B: I'm not one of you lot. I'm sorry I'm voicing what I felt then, I'm not saying what I feel now. You know, I looked around the room and there was these sobbing anorexics and I'm just thinking fuck you, you know what am I doing here? And you get in there and there's the little box of tissues and you just think oh piss off. And, "How did you feel?" and all that stuff, that's how I felt it was just like my whole thing was completely negative about it. So you can see where I was coming from. It's not easy for blokes, especially not blokes from that kind of background. You know if

> you've got parents who've been through this stuff then it's alright, I'm not sure many people have, but I can still access the kind of hostility I felt then […](man, mental health, depression, up39ys, interview 02)

This excerpt is telling in that it contains explicit oppositional dualities enforced by hegemonic masculinity (cf. Eckert 2003):

- Man/woman
- Strong/weak
- Brave/timid
- Aggressive/passive

As Eckert (2003: 36) states, these dichotomies are extremely powerful, both because of their place in gender ideology, and because of the ways in which their representations permeate society. This excerpt also reveals the violent misogyny and self-hatred which are potentially related to the overt oppositions *I am a bloke*/*I am not one of you lot* vs. *you are pale skinny fucking anorexics girls/nutters*. However, one should also add that the respondent explicitly apologizes for voicing these feelings, which he assumes were part of his old *persona*: (*I'm sorry I'm voicing what I felt then, I'm not saying what I feel now*). In any case, the passage clearly sustains Chodorow's (1978) hypothesis on the different psychoanalytic process of identification in men and women. Chodorow argued that the processes of female identification are *relational*, whereas male identification is *oppositional*. This points to the difficulty for men to carry out a process of "dis-identification" from the mother, with its corollaries of negation and rejection of femininity.

According to Chodorow, the origin of male identity is more negative than positive, and lingers on the concepts of differentiation, distance and denial of the affective relationship. The path to achieving manhood goes through what Adler (1938) called a "masculine protest": from childhood onwards, masculinity is more a reaction than an adhesion. The ideal male defines himself through the oppositions *I'm not my mother, I'm not a baby, I'm not a girl*, which are deep-rooted in his unconscious (cf. Badinter 1992). The American psychiatrist Stoller (1985) stressed the concept of *protofemininity* in the baby boy, as a reaction to Freud's theories of the innate nature of masculinity: in the first stage of life, the baby is not able to psychically differentiate himself/herself from the mother, with whom s/he lives in symbiosis: however, the baby girl accepts her femininity in a primary, unquestioned way, thus explaining that women's gender identity is more solid than men's (Stoller 1985).

By contrast, in order to become a man, the baby boy will need to differentiate himself from the mother and to repress in his unconscious the primeval symbiosis with his mother. He will be educated to be a man; in this regard, the etymology of *education* is from the Latin *ex ducĕre*, which means *to get something out*, but may also mean *to remove, to root out*. And indeed, all societies, as anthropology has widely shown with the study on the rites of passage (see Gilmore 1990), require of young males to achieve manhood by (symbolically and culturally) rooting out femininity. Moreover, the socially acceptable male demeanour involves many defence manoeuvres: fear of women (misogyny), fear of displaying any trace of femininity, including tenderness, passivity and –last but not least- fear of being desired by another man (Badinter 1992: 79). In that respect, Seidler (1989: 18) regards masculinity as an essentially negative identity learnt through defining itself against emotionality and connectedness. Such fears and negations point to what Stoller (1985) defined the first duty of a man, that is *not being a woman*.

If we relate all that to illness as experienced and recounted by male patients, we can say that in most interviews of testicular cancer, respondents tend to conform more to traditional gender norms, in presenting 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, it is also evident that many men are overwhelmed by the experience of illness and find it difficult to adopt such heroic attitudes (see next examples). In this respect, the crisis of masculinity in late modernity (Connell 1995, Giddens 1991) may have more relevance for men experiencing illness or other challenging biographical event (Charteris-Black & Seale 2010: 54-55).

Furthermore, from a psychoanalytic point of view (Badinter 1992), the virile man embodies activity, but such activity is but a reaction against the baby's passivity and impotence. This reaction is a continuous combat for men, and also involves a fundamental ambivalence: the fear of passivity is all the more pronounced given that regression to a pre-oedipal, symbiotic stage is one of the strongest and most repressed desires of human beings: however, in men, giving way to regression is doubly feared since it carries both a social stigma for not abiding by the social manly model, and a psychological dread of breaching a taboo. Therefore, the struggle to assert one's masculinity is a never ending one and, what's more, the battle never definitely won.

> (140) <c>Says the models of being male are either macho or too soft, with little middle ground, so it is hard to admit vulnerability.</c>
>
> <i>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... I went to a boys' school it was pretty rough [laughs]. You know it had its rough old moments, and it just wasn't the kind of place you admitted vulnerability. (man, mental health, depression, up39, interview 02)

(141) So it turns out that he took quite a time finding the lymph node after cutting my foot, consequently the anaesthetic was running out. Then I started feeling him cutting into my foot, and I'm watching it as well, I can see it at the end, and there's this parade of women radiologists looking at me. I'm trying to stay macho and actually I was crying because it was very painful which then affects my pride in front of all these women. (man, testicular cancer, 41-50, interview 03)

(142) I think a lot of men get embarrassed to talk to others and they still think they're the macho man and if they're in a crowd of men they're not going to be saying 'Oh well I've got problems,' and brag about it, if that's, you know if that's the word to describe it. I think men, they don't want to know because it's against their nature, they just keep going and going without complaining. Whereas women, if we took a leaf out of their books and went [to the doctor], I think that would be one of the best cures or at least one of the best step forwards that you could get where illness in the male is concerned. (man, prostate cancer, 61-65, interview 06)

These words seem to evoke Rudyard Kipling's poem *If* (1895):

[…] If you can make one heap of all your winnings

And risk it on one turn of pitch-and-toss,

And lose, and start again at your beginnings

And never breathe a word about your loss;

If you can force your heart and nerve and sinew

To serve your turn long after they are gone,

And so hold on when there is nothing in you

Except the Will which says to them: 'Hold on!'

[…]

Yours is the Earth and everything that's in it,

And - which is more - you'll be a Man, my son!

Kipling's ideal of masculinity is clear: being a Man (with a capital M) is achieved only through great deeds and it is more than owning the Earth: indeed, an "imperial" ideology consonant with the building of the British Empire. This "heroic" masculine ideology, softened and thwarted as it might be, continues to run through popular culture.

4.2.2. Part-of-speech KW analysis: verbs

This subsection will be devoted to the analysis of the following verbs:

1. *Worry*
2. *Remove*
3. *Wait*

Table 7. Part-of-speech KW analysis- verbs: rank and frequency

Keyword	Standardised frequency (per million words)	Rank (ordered by keyness)	Frequency in the corpus
1. Worry	569.53	87	305
(Worried)	522.85	101	280
(Worrying)	154.99	169	83
2. Remove	595.67	104	319
3. Wait	379.06	223	203

4.2.2.1. Worry

Three forms of the verb *worry* are found in the keyword list:

- *Worry* (Keyword 87, standardised frequency 569.53 instances PMW)
- *Worried* (KW 101, standardised 522.85 PMW)
- *Worrying* (KW 169, standardised 155 PMW)

The WS5 *Concordancer*, shows that the most common 3-word clusters are: *nothing to worry* (44.82% of the instances of *worry*); *I was worried* (26.73% of the instances of *worried*), *a bit worried* (11.88% hits of the instances of *worried*).

4.2.2.1.1. *Nothing to worry*

Among women respondents this cluster is commonly found within the pattern *[GP/doctor]+ said (that)+ (it/there) was nothing to worry about* as in the following excerpts:

> (143) I would say in about 1997 ehm there was a lump on my breast, I could ehm I could see it and I went to the GP about that and he had a look at it and he said there was nothing to worry about. And that he could actually ehm remove it, ehm you know, nothing to be concerned about, so, and I wasn't concerned about it I suppose. And that was fine, sorted out. (woman, DCIS, 50-54, interview 07)

> (144) In 78, 79, I went to my GP because I had a lump. He said it was nothing to worry about but I did worry about it. Then I got to the point where I actually was too frightened to do anything else about it. I was getting in such a state that a friend of mine picked me up from work one lunch time and took me straight up to emergency in the local hospital. They sat me in front of the mirror and said "Look your left breast is much bigger than the right breast, you can see that there's something wrong." And so I changed my doctor immediately to another GP who had me in hospital within a week and I had the lump out. (woman, breast screening, 50-59, interview 03)

The previous example is reminiscent of Kitzinger's study (2000) on the ways that women with breast cancer resist exhortations to "think positive" in talk. According to Kitzinger, these forms of resistance to discourses perceived as damaging can be done in private as well as public talk and academia, and are not the privilege only of those who perceive themselves as activists.

The examples below show the cluster *nothing to worry* embedded in a reassurance discourse (itself a part of an overarching persuasive strategy supported by the website) aimed at enhancing women's confidence in undergoing screening practices (cf. *screening*, examples 27-34).

> (145) <c> Says women should attend for routine mammograms because any pain is short-lived and far outweighed by the benefits. </c>

> It [the pain] isn't for very long, it only lasts a second or two and it's no worse than...well what can I say? Just as...like...the prick of an injection or something like that, and it's just one of these things that you've got to put up with. And ehm the benefits that you gain are enormous and it's well worth it, only once every few years, just...just endure a little bit of discomfort really. **<q> Yeah.</q>** There's nothing to worry about, it's...it's very sweet and kind and they treat you very gently

and it’s done very quickly. And you're in and out in...two or three minutes and it's...it's something that's...worth it. (woman, breast screening, 70+, interview 01)

(146) <c>Paula believes we are lucky to have cervical screening freely available and encourages others to go regularly for screening.</c>

And I think that the other thing is that in this country, we are so lucky that we have the screening in place, and... to people, I mean I know there is people, who are scared to go to smear tests and they have not been screened for years and years and years and years and years. And I think, you know, people should just be very aware that we have got this screening in place. It's nothing to worry about when you go and have the procedures done. Ehm so I just say to people go and get your smears and then if there is anything wrong then there is lots and lots and lots of help out there for you. And the medical profession are great. And they know what they are doing and they can sort you out. If everything is caught early and in time, then you will be okay. (woman, cervical screening, 31-44, interview 14)

(147) I think I did, I just felt like, "Am I sort of making this worse in my head? Am I exaggerating? Am I a bit of a hypochondriac?" [laughs] Do you know what I mean? **<q> Yeah. **</q> Because, you know, I didn’t know how to react and I just felt so on my own. Even the doctors were, "Oh it’s nothing to worry about." See what I mean. Yet you do, you worry so much about it, it’s unreal. (woman, cervical abnormalities, under 25, interview 01)

Here it is worth noting the use of quotative *like* and *were*, typical of youth talk (Biber 1999: 1120).

(148) <c>Explains how she worried about every symptom after her treatment but felt supported by her GP.</c>

There were still nagging doubts, I'd be a liar if I said there weren't. Even now sometimes I sort of think 'oh I wonder what if'. I became very aware of every ache, pain, itch, lump, bump, you name it, and I probably went backwards and forwards to my GP more during the first couple of years after that than I'd ever been at all in my life […] And I'd go to the GP and particularly when my new GP was there, I said to her one day "You must think I've turned into a hypochondriac." And she said "I'd rather you came to see me 100 times or more and me be able to say to you ehm "That's okay, it's nothing to worry about, it's just whatever or that's okay," than for you to sit at home and worry and get yourself, work yourself up into a major stress,

or to ignore something which could be important." She said "So don't worry about it, come as often as you need to," and she was great. Ehm so that was good. (woman, cervical cancer, 31-38, interview 02)

As regards the male respondents, the expanded context of the cluster *nothing to worry* not only hints at an emotional reassurance that doctors give to patients who undergo screening (which is more common in women's excerpts), but also contains more technical data in the form of figures/range values:

(149) Yes on what one should expect. Because I, in fact strangely enough when I went for my first check-up I was a little concerned because it had gone up from .4 to .8 which you know in pure mathematical terms is double but I was assured there was nothing to worry about at this stage and it was probably partly due to the hormone treatment wearing off slightly. But I think one of the, looking at it from a logical point of view I think for my age before the treatment and anyone who actually got, or been diagnosed with prostate cancer for my particular age a normal figure is anything from 3 to 4.5 and one assumes that if it's in this range there's no cancer present. But it has been proven that this is not necessarily the case, that cancer can be there even when the so-called normal range of PSA is shown in your blood test. I find that to be slightly worrying. (man, PSA, 61-70, interview 17)

(150) Then I went back to see my surgeon and of course he by then had my Gleason score from the biopsy. It was a semi-formal interview, we are on friendly terms anyway and he said, "Well let's look at all these results together" and he said, "Well, the PSA is excellent, 7.2 and the bone scan looks splendid" and he said, "Nothing to worry about in the shoulders we've decided. And the MRI, nothing to be seen, and it seems to be the tumour is actually confined to the gland." And he and I said, "That's excellent." And he said, "You're now 67 and you haven't got any relevant history but I'd like you to have a cardiologist's opinion but if that is alright I think we should go ahead." (man, prostate cancer, 71-74, interview 12)

(151) Now the PSA was, I think it's the magic figure of whatever they check in your blood system to see if that goes down it's good. Well I started off at 1.9 in May and then in September it went down to 0.6 and now December it went to 0.8 but it's nothing to worry about […]. I feel pretty good actually, no problems, no pains. (man, prostate cancer, 75+, interview 08)

This phenomenon is also described by Charteris-Black & Seale, who define a traditional masculine style as "a discourse of distancing and avoidance" (2010: 53). In their view,

men following traditional masculine styles use more nouns relating to time and measurement (numbers, dates, etc.); this behaviour could be related to gender ideologies and to men's need to feel "experts", that is, persons who have achieved the mastery of a set of replicable techniques. This has a linguistic counterpart in a "hybrid" discourse, where emotional issues prompted by illness melt with a medical discourse, which gives more room to abstractions and technicalities.

It could also be that men's higher reliance on numbers serves the double purpose of endorsing mainstream science values (the appeal of "the voice of medicine", Waitzkin 1989) and of attempting to detach themselves emotionally from what is happening to their own bodies (Charteris-Black & Seale 2010: 71). Another variable which might be at stake here is social class and education, since it is likely that a well-educated individual might be more easily acquainted with technical jargon and perhaps more willing to use it (cf. Eckert and McConnell-Ginet 2003: 47-48 on *physical vs. technical masculinity* as a reflex of a social dichotomy between working class and upper-middle class models of masculinity). It is to be noted that socio-economic stratification was not used as a parameter to build the present corpus.

> (152) <c>Recalls that he recovered rapidly after the operation, and asserts that there is nothing to worry about.</c>
>
> I was, I came out of the hospital on the Thursday - and I like to swim a lot for health reasons - and on the following Monday I was swimming and by the end of the week I was back to my swimming my usual mile a day. There's no, there was no pain whatsoever and in actual fact things like swimming and having hot baths helps it to heal up. As I said the only thing was a nuisance was when the pubic hairs were growing back, that was the only thing that caused me any - uncomfortable. And they seemed to catch on to your underwear and everything else so all that, so that was basically the only thing. No, there is nothing to worry about. There is really nothing to worry about. (man, testicular cancer, 51-55, interview 01)

In this example it is noteworthy that the assertiveness of the message is embedded in a "sports" discourse, which is another typical masculine way of framing their self, as noted in the example n.124 (cf. also Charteris-Black & Seale 2010: 76-82).

4.2.2.1.2. *I was worried*

The analysis of this cluster hints at gender stereotypes, in that women express a more emotional reaction:

(153) <c> Comments on her hair loss resulting from chemotherapy.</c>

 Well I was worried when my hair started coming out. But they tell me-they told me before, when the ne-when the nurse come to interview me, the nurse that-that used to give me the chemotherapy, she told me that my hair was going to fall out. (woman, breast cancer, 50-69, interview 07)

(154)I was terrified. I was imagining all sorts because I wasn't worried about conceiving because I'd asked that question and they said "You should be fine". I was worried about the actual physicality of giving birth, and what would happen to my cervix, and how would it all happen and work and what would happen if it all went wrong and... (woman, cervical abnormalities, 31-35, interview 08)

By contrast men seem to hide emotional features behind a "stoical" veneer: more specifically, these respondents assert that knowing more about prostate cancer treatment had a relieving effect on them:

(155) When he said I had bone cancer, I've never asked too many questions and that was where I would go wrong, really you should ask. And while I thought, once they said it had gone to my bone I was worried. Was that, was that going to spread elsewhere and if it is going to spread elsewhere is that the prostate cancer or is it some other cancer? Or you know those kinds of things, I didn't know anything about. And they turned round and told me that it's only the prostate cancer and the treatment I'm having for prostate cancer will also treat the bone cancer. So you know that put my mind at ease a lot more because I'm thinking that is doing me well anyway. (man, PSA test, 61-70, interview 16)

(156) <c>Explains that learning about the high cure rate was reassuring.</c>

Well I was worried but not over, I don't know, I wasn't as worried as I thought I would be, I was, yeah I was worried you know I think anyone would be worried but I'd read, I had read about it which helped because I knew about it. Knowing about it […] took away a lot of the worry, though I was still worried as anyone would be because there's always that margin there that it won't work. (man, testicular cancer, 51-55, interview 07)

As regards the relation between stereotypes in language and gender research, Eckert & McConnell-Ginet (2003: 85), in wondering what lies on the road between a stereotype and scientific finding, state that "stereotypes are the starting point of much research on language and gender, since any research begins with hypotheses, [… which themselves] have to come from somewhere". In their words, if gender stereotypes are part of our

sociolinguistic life, they need to be examined; this is not to dismiss the existence of difference, but to point out that ”the quality of research depends on the approach that one takes to finding and establishing such differences” (Eckert & McConnell-Ginet 2003: 89).

4.2.2.1.4. *Pre-modifier + worried*

Another pattern which seems worth analysing is *pre-modifier + worried*: *a bit worried, quite worried, really worried*.

As regards *a bit worried*, this cluster is found almost exclusively (91.6%) in women's interviews:

> (157) <c>Explains that she was worried because her teenage son didn't want to talk to her about his feelings.</c>
>
> But I was a bit worried about my son because I did explain everything to him from the first day, I didn't hide anything because I thought, I'm going to lose my hair so if I don't tell him why, what am I going to tell him. […] That was - my main problem was my son because I didn't know what was going inside his head. (woman, cervical cancer, under 30, interview 04)
>
> (158) And...the next thing, I was a bit worried having never had an operation, never been in a hospital before. (woman, breast cancer, 70+, interview 01)
>
> (159) <c> Hilary was anxious about having surgery at 67. Although she felt groggy after coming round, the operation went well. </c>
>
> I had my appointment for the 5th...4th of...December for my operation on the 5th. Ehm again I was...a bit worried because I'm sixty-seven. I've never had an operation before. How am I going to cope? And little things like I've got false teeth. And I've got to take my teeth out and things like that [laughs]. Which I know is silly but, you know. (woman, DCIS, 65-70, interview 01)

This finding seems to concern also the expression *really worried*, which is mostly used by women (95%), whereas *quite worried* is equally used by men and women. As remarked by Biber et al. (1999: 966), *quite* and *really* are both *stance* adverbials, that is linguistic devices which express personal feelings, attitudes, value judgements or assessments, as in the following examples:

> (160) My mammogram was clear. But ehm he informed me that there are some types of tumours, in his words, they hide, they can hide from a mammogram and a

mammogram will not detect them. So...that really worried me as well. (woman, breast screening, 50-59, interview 17)

(161) I went to the appointment. And when I went in I remembered the nurses and they remembered me, so we were chatting. And I was saying, "Oh no, it's come back, I'm really worried". (woman, cervical abnormalities, 25-30, interview 13)

(162) […] it was a year and a half that I'd been going through it and still got all these abnormal cells and everything. **<q> Yeah. **</q> And it really was affecting me, I was worried, really worried. (woman, cervical abnormalities, under 25, interview 01)

(163) So I went to the Colposcopy clinic. Ehm prior to going to the Colposcopy clinic I was really, really worried about what was going to happen and I was worried about the whole procedure […] (woman, cervical screening, 31-44, interview 14)

(164) I was actually quite worried, because I said to the surgeon, "Should I have... (woman, breast screening, 50-59, interview 11)

(165) I was really quite worried because it was just so close to the IVF treatment (woman, cervical abnormalities, 31-35, interview 10)

4.2.2.2. Remove

The analysis of the keyword *remove** (KW 104th, standardised 595.67 PMW) allows issues of identity and self-image to be dealt with, as well as the negotiating work that patients have to engage in order to cope with major surgery, which may potentially be disfiguring (especially mastectomy). The verb is generally found with subject pronoun *they removed* and in the causative/passive construction *I had the cancer/lump/breast/cyst removed*, which seems preferred to the active construction *remove a tumour*.

The following are relevant examples:

(166) and not being able to find any DCIS in the breast they removed. I'm still not really a hundred per cent certain that I understood it, but I can't think of any other explanation other than they removed from my breast in the biopsy the only DCIS cells there were in my whole breast. **<q> Yeah. </q>** They were two tiny spots of less than one millimetre. [...] And I had my whole breast and five lymph nodes removed for that. <q> Yeah. </q> (woman, breast screening, 60-69, interview 04)

(167) you-you hear of people who have had a lump removed, but haven't had their breast removed, and I'm thinking, 'Well, if this is pre-cancerous, why am I having this mastectomy?' (woman, DCIS, 50-54, interview 01)

(168) So she had a look at the breast to see what the situation was. I was about a 32, 34A, possibly B cup before. She had a look at it. And she said she thought that the result cosmetically, she didn't think I would be happy with it if I had just a small piece more of the breast removed. And that it would look, I think she described it as beak like, where the breast sort of hangs down and the nipple sort of points downwards. And she didn't think I would be happy with that look. (woman, DCIS, 50-54, interview 02)

In the following excerpts, the respondents report breast surgery in terms of unease, loss of femininity and "bereavement":

(169) <q> And has-has it has it been easier with time, when you look at yourself in the mirror, has that...changed over the time, or you still feel the same? </q>

 Not really. No. No, I...feel, I don't feel right. I really don't feel right. The scar is healing quite nicely, ehm as they should do I suppose ehm but no, I just - if both breasts had have gone, and I'm thankful to God that it hasn't, I wouldn't bother. I really wouldn't bother. Ehm but to have one breast and...and the other is just flat is...it's very strange, it's very strange to get used to. Ehm a lot of women do, a lot of women don't bother, and all well and good and that's fine ehm but I can't live like this. (woman, DCIS, 50-54, interview 01)

(170) The doctor said: "No, if we do that it may be...75% assurance, so mastectomy is the best thing." I wasn't happy with the mastectomy...but anyway in the end I had to...agree because my doctor also said "It's better if you...go ahead with the mastectomy". So...I was very hesitant to have, you know, the whole breast removed. Anyway...so I had a mastectomy...and...and I stayed in hospital...I think eight...to nine days. (woman, breast cancer, 50-69, interview 14)

(171) <c> Explains that, despite her doubts about future relationships, she has met a new partner. </c>

 And...ehm I felt and believed that the ro-romance in my life was completely over, that I was never going to ehm be ehm desired or feel ehm desirable or have-have ehm any sense of desire myself. That I was going to have something awful done to my breast. I would not be a woman in that sense any more. But ehm I was fortunate, it was small, it was a lumpectomy and in reality I have an almost

> indistinguishable scar in a very good position. It's about on the bra line, on the side, underneath my arm. And my right breast is very slightly smaller than my left breast, but ehm with a good-good bra you just never notice it. You feel ehm a sense of invasion and you go through a very bad patch of self-doubt. But you come out the other side. And ehm I have a very happy ever after story because as a result of my ehm diagnosis I met the most wonderful man in the world... who could cope with it because his wife died six years ago of lung cancer. And ehm I've found...a new partner for life and that's absolutely wonderful...So there was...life after breast cancer[laughs]. </i> (woman, breast cancer, 50-69, interview 16)

In the last excerpt, the respondent although feeling initially belittled by surgery, was able to overcome her worries, and sends a message of hope to other women, signalled by *but you come out the other side* and *So there was...life after breast cancer [laughs]*. In the following example it is worth noting a grieving process "in action":

> (172) <c> Gillian felt losing her breast was like a bereavement. She felt anger, sadness and depression. Eventually, she had some counselling. </c> I've had lots of emotions I think with having had my breast removed. I've discovered that it is like bereavement, and that is the nearest thing I can describe it to. Yes you've not lost a person. But you have lost a part of yourself and it's a part of yourself that you'll never have back. And it is an important part, I feel, to a woman to lose because it is part of being a woman or at least a lot of women do feel that. Some probably don't. But I did feel that. And I did feel that my body didn't look as nice as it was before. It did matter to me dreadfully. But I decided it was important that I had the operation. And it would prolong my life I felt to have the operation and that meant I could spend my time with my family and my friends. And that was important. Like a bereavement you go through various stages. [...] (woman, DCIS, 50-54, interview 02)

These words show an acute introspection, likely fostered by counselling. Moreover, the respondent conveys a proactive image of herself in terms of agency, with an active and conscious involvement in her decision-making (*But I decided it was important that I had the operation*). Another issue which may be noted is the way the argumentation is deployed via an "add-on" strategy, typical of conversation (Biber 1999: 1078-1079), whereby the body of an utterance is extended by adding another clausal unit through conjunctive coordination (*and*) or disjunctive coordination (*but*) (*And it is an important part, I feel, to a woman to lose […]. But I did feel that. And I did feel that my body didn't look as nice as it was before*).

(173) <c> Sandra is happier with her new breast now and plans to have her healthy breast lifted and nipple reconstruction. </c>

 My implant, I'm not noticing it now. Also the swelling is at last really, really settling and it's looking much more like my right breast. My right breast is obviously lower [laughs], but the plastic surgeon has said he will re-arrange the furniture ehm because I said I didn't want an implant or anything in my right breast, but he said, "No, no, no, you don't need that." He said, "We'll re-arrange the furniture, we take out tissue from the bottom, put it in the top and just shift the nipple up," and he said they do that at the same time as having a ehm reconstruction of the nipple because I have no nipple **<q> Yeah. </q>** on the left breast. So I'm up, okay. And whether I've got used to it, whether because all the swelling has gone down, it definitely looks better. I now...when I catch sight of myself in the mirror, I'm not having a double take now. (woman, DCIS, 50-54, interview 12)

In this excerpt it is all too evident the doctor's use of the word *furniture*, standing for *breast:* although it is likely that he employed it with a pinch of humour, it can also be interpreted as a linguistic reflection of a reification process (typical of modern scientific knowledge) whereby patients can become entities, objects of scientific interest (cf. Couser 1997: 24). The woman's reporting of the doctor's words also seems to imply a legitimation of professional empowerment and status gap, which is nonetheless achieved at the price of a detachment and loss of empathy towards the patient. Further, this aspect does not seem to be devoid of patronising and asymmetric features of doctor/patients relationships (Waitzkin 1989), which are also underlined by Bell's (2006) study, reporting the case of a woman who was diagnosed as having "a cervix like a hamburger" (Bell 2006: 248), a dehumanising term which, as Bell states, is evidence of the ways medicine (mis)treats women patients and of a play for power between doctors and patients.

In the following extracts, breast cancer patients stress assertively the need for keeping a positive attitude:

(174) <c> Maisie says that, although she had a double mastectomy and other treatment for invasive breast cancer and DCIS, she still feels positive. She advises other women to eat healthily and exercise. </c>

 What I'm saying to the woman and everybody that is going through it, they found the cancer early, they took it out. They reconstruct me, you had the operation, you went through the chemo. There's nothing to be, even if you have the chemo, you have the radiotherapy and everything, there is nothing to be... I look at it, there is nothing to be sad about because they are trying to make you

better and you're still getting on with your life. And that is the way I look at it, you know [...]. So at the moment I can't see any downside to it, I just cannot. You might say, "Oh, you haven't had my experience, you don't know what I'm going through, you have your husband for backup." But even if I think, you must have somebody, even if I think I didn't have my husband I would, I still wouldn't see, apart from having the cancer which is a downside, I still wouldn't see a downside because I'm getting the treatment and I'm getting better. **<q> Yeah. </q>** You know, and that's the way I look at it. So all I can see is a positive side to everything. Oh I think that's all I have to say [laughs]. (woman, DCIS, 50-54, interview 17)

In the excerpt above it is also possible to note that the respondent frames her argumentation by means of a dialogical exchange with an imagined/projected interlocutor, as in: *You might say, "Oh, you haven't had my experience, you don't know what I'm going through, you have your husband for backup." But even if I think*[…]. The following example provides a non-stereotypical image of femininity:

(175) <c> Explains that she has a positive attitude towards her illness but might consider if diagnosed with a recurrence.</c>

 I'm a great believer in-in...being very positive and mind over matter. And ehm I keep saying that I'm not going to be ill because I don't have time to be ill. Ehm and...I always felt that the chemotherapy was going to work and work really well and it did. Ehm I don't know where my positiveness went with the surgery but I think that was out of my hands. Ehm and I just...I just keep a positive...frame of mind. […] Ehm I'm I'm a very down to earth, practical...person ehm and that's that's how I've treated my cancer. You know, just straight down the line, and none of this nonsense [meditation/complementary therapies]. (woman, breast cancer, 50-69, interview 20)

Here the respondent assertively claims identity-shaping qualities which are traditionally perceived as masculine (cf. Cameron & Kulick 2003: 141-142), like strength, willpower (*I keep saying that I'm not going to be ill because I don't have time to be ill*), pragmatism (*I'm a very down to earth, practical...person […] You know, just straight down the line, and none of this nonsense*) and rationality (*I just keep a positive frame of mind*).

However, as Cameron (2003) asserts, the construction of a gendered identity is not always accomplished by deploying gender appropriate styles of speech. "Masculine" or "feminine" speech style can be used by men and women to "perform" gender (Butler 1990), by using styles that are strikingly at odds with the expected gender norm (Cameron

& Kulick 2003: 59). What is conveyed by using any particular style of speech cannot be interpreted in isolation from questions about the context and content of talk.

In the following example, instead, the respondent gives perhaps a more traditionally feminine (nurturing) image by stressing the importance of staying positive for the sake of her children:

> (176) They're [my children] worrying now, they are worrying and I know that, […] and I can-I can deal with it, and they can see that, and so, you know, them seeing me happy, whether inside I'm a fumbling wreck, you know, because I don't like the surgery, ehm you know I'm not quite there yet, I've got two weeks till surgery, so... (woman, DCIS, 50-54, interview 14)

This woman describes herself as a self-sacrificing, devoted mother, so framing herself (and also her *self*) through what Hays (1996: 108) calls an "ideology of intensive mothering", exhibiting a logic of family and private life that requires a moral commitment to relationships grounded in affection and mutual obligations (Hays 1996: 152). The excerpt above abounds with hesitations, uncompleted sentences and discourse markers, which, besides being linked to a more traditional feminine style- as remarked by Lakoff (1975), may also be the discursive cues of an inner struggle between a mothering/nurturing ideology and the "wounded" (Frank 1995) self, which airs the preoccupations aroused by illness.

4.2.2.3. Wait

The keyword *wait** ranks 223rd in the list, with a standardised frequency of 379.06 instances PMW.

The main clusters highlighted by WS5 clearly relate to waiting list or to the waiting time before getting the results of a test: *you have to wait/I had to wait/waiting for the results:*

> (177) The first screening was just after I was 50 so that was 6 years ago and I was absolutely terrified [laughing] and waiting for the results seemed like an eternity. And that was okay, that was clear. It wasn't painful, slightly uncomfortable, and I was surprised because so people had said, "ooh, it hurts." (woman, breast screening, 50-59, interview 02)

> (178) But ehm...I suppose it was-the worst day was the Wednesday and when I got there, when I got there waiting and had the x-ray done and waiting for the results. That was the-that was worst...like it's just the unknown, not knowing one way or the other. I mean, if I'd had a problem I would just have to naturally face it w_bs_70over_02.txt

(179) Waiting for the results of this biopsy was like walking a tightrope to nowhere, it was awful. It was worse than actually facing the doctors with the bad news. (woman, breast cancer, 30-49, interview 13)

(180) Then you go in and they take a biopsy. Then you have to wait for the results of that. So, you go through another week where you are waiting for the results. And then I was told that, you know, I had to have to more treatment, so I then had to wait for that and then you have the treatment and then you have to wait again for the results of that to confirm that it was only at the stage that they said it was. (woman, cervical screening, 31-44, interview 14)

(181) <q>What was it like waiting for the results, those days?</q>

Not good. The, the first, the first signal of the PSA being high, raised, because I knew that the first one was 2 and the second one was 7.2, that, that immediately put alarm bells into me that something was drastically wrong. Unless it was an absolute false test then I was very, very worried. And, and subsequently when the second test came back at 6.2, that further increased the, my worry that there was something, there was something seriously wrong. (man, PSA test, 51-60, interview 10)

(182) <c> Sam had abnormal results several times and found this very worrying. Waiting for results was especially hard and she would have liked more information about what was wrong. </c>

 I had the three month biopsy done. And that again, it came back as moderate, and that's when I did start sort of ringing and asking well "Why-why am I still going through it, why-why...isn't it going? Aren't you going to do anything about it?" […] It's the wait more than anything, you know, so such a long...thing to go through because you have to wait three months, then six months, and you have to wait six weeks for the results. **<q> Yeah. **</q> And the waiting is really hard. (woman, cervical abnormalities, under 25, interview 01)

(183) <c>Waiting times in between appointments and for results was one of the hardest things to deal with.</c>

I think one of the worst things is the waiting times in between everything. So you get your letter saying you have got something wrong with you. You have got to go in. So you have got to wait for them few weeks to go in. Then you go in and they take a biopsy. Then you have to wait for the results of that. So, you go through another week where you are waiting for the results. And then I was told

that, you know, I had to have to more treatment, so I then had to wait for that and then you have the treatment and then you have to wait again for the results of that to confirm that it was only at the stage that they said it was. (woman, cervical screening, 31-44, interview 14)

A result which is worth analysing is the digram *watchful waiting* which ranks 10th among the clusters of *wait** (10.83% of the occurrences), all related to men's interviews (section PSA test for prostate cancer), 54.5% from respondents, 31.8% found in editorial comments, 13.6% in the interviewer's questions.

(184) <q>Did he mention that just active monitoring was another option?</q>

He did mention that which he called watchful waiting. In fact in some ways he did put quite a bit of emphasis on that by saying that this would be done by doing regular PSA tests and if they remained of a similar reading to what was apparent for the diagnosis it was thought the cancer would be relatively quiet, and not causing immediate problems. (man, PSA test, 61-70, interview 17)

(185) Now we discussed, a formal talk on you know, radiotherapy versus surgery or even watchful waiting and he said that in his view this would not be a good one for watchful waiting. (man, prostate cancer, 71-74, interview 12)

(186) But on the other hand, watchful waiting is a little bit more than doing nothing, it's actually knowing and monitoring, and therefore being in a position to make decisions as to what treatment you might go for. (man, prostate cancer, 50-60, interview 08)

(187) <q>And one of the options was watchful waiting?</q>

Watchful waiting, yes, oh yes very much and I thought well, so that was the... (man, prostate cancer, 75+, interview 04)

(188) <c>States that he was informed watchful waiting is not recommended for those of African descent.</c>

It [watchful waiting] was presented or discussed as an option but the consultant then suggested that this was not an appropriate procedure for me because she was involved in some, in setting up some research and the preliminary indications were that men of African descent, that their particular prostate cancer in them, the prostate cancer in men of African descent was more active and aggressive than it would be in Asian or people of European descent and therefore if there was another route, another treatment available she'd prefer to do that rather than the

watchful waiting. So there is some indication around that in the male of African descent that the prostate is much more aggressive.</i> (man, prostate cancer, 71-74, interview 04)

One could elaborate on why this collocation is only found in men's experiences, and specifically in the PSA section. In the reference corpus *watchful waiting* occurs only with a standardised frequency of 1.19 instances PMW and in the same interview (section Non-Hodgkin lymphoma):

(189) You just get to the point where you're busy with other things, life is happening, and you can sort of put it to the back of your head. When you have to go to the hospital and sit in the waiting room and it's in the front of your head again and you have to consider all of the options that are available to you. But some people I understand really struggle with the watchful waiting because they want to get on and do something. And I was fortunate: I'm busy, I was working, and that filled the gap, I suppose that filled the worry hole that could be there. (Non-Hodgkin lymphoma, interview 07)

The collocation is absent in the BNC spoken but it is found in the written section with a frequency of 0.06 instances PMW, 80% of which are found in articles of the *British Medical Journal*, as in the following examples:

(190) By ignoring the complex natural course, however, they mistakenly assume that, because waiting times are often considerable, children who present with effusion have had glue ear for some time and will continue to do so without treatment. **Watchful waiting** is more likely to establish persistence and reduce the unacceptably high dry tap rates reported in several of the studies reviewed. [British Medical Journal, 1978]

(191) The authors do not state whether they actually treated the patients found to have prostatic cancer. The patients' symptoms of bladder outflow obstruction may well have been due to benign prostatic hypertrophy and the coexistent prostatic cancer may have been an incidental finding. For patients in the usual age group who present with symptomatic outflow obstruction and have "incidental " well differentiated prostatic cancer confined to the gland, most urologists in Britain would perform a transurethral resection to relieve the symptoms but adopt a policy of **watchful waiting** regarding the cancer. [British Medical Journal, 1981]

(192) […] On the basis of a literature review the most recent Effective Health Care bulletin questions such frequent intervention. Its authors recommend a period of " **watchful waiting** " before proceeding to surgery. [British Medical Journal, 1993]

It seems clear that the expression is borrowed from the medical jargon. According to the definition of the National Cancer Institute[1], *watchful waiting* refers to seeing whether symptoms progress, stay the same or improve before patients' undergoing medical or surgical treatment. Moreover, the expression is widely used in reference to urology conditions including kidney stones, mild urinary tract infections, early-stage kidney cancer, prostate hypertrophy and prostate cancer[2].

4.2.3. Part-of-speech KW analysis: adjectives

The keyword adjectives which will be analysed in this section are: *painful, radical*

Table 8. Part-of-speech KW analysis- adjcetives: rank and frequency

Keyword	Standardised frequency (per million words)	Rank (ordered by keyness)	Frequency in the corpus
1. Painful	496.71	113	266
2. Radical	115.77	74	62

4.2.3.1. Painful

The adjective *painful* is the KW n. 52, with a standardised frequency of 496.71 occurrences PMW. It can be interesting looking further at the L1 modifying adverbs which are more frequently found to collocate with *painful*: *very painful, not painful,* and *quite painful*.

[1] http://www.cancer.gov/cancertopics/pdq/treatment/CLL/Patient/page4

[2] http://www.prostate-cancer.com/watchful-waiting/treatment-description/watchful-description.html

4.2.3.1.1. *Very painful*

The expression very painful occurs in the corpus with almost the same frequency in male and female interviews. Some excerpts are quoted below:

(193) By this time I should say that my breast was really red, sore and swollen and very, very painful. They did the biopsy, the biopsy was extremely painful. A mammogram, which was very painful, it's painful enough on a good breast but when your breast is invaded with inflammatory disease it was really, really painful. (woman, breast cancer, 30-49, interview 13)

(194) I had half of my chemotherapy, then they asked me to...go ahead for radiotherapy. I was pleased...because chemotherapy was very painful. So ehm then doctor told me after six months that ehm I should have ehm another part of chemotherapy. Then I refused. (woman, breast cancer, 50-69, interview 14)

(195) <c> She'd heard breast screening was painful but still attended. </c>

 It was all very new to me. No, I mean...some people had said to me ehm it's not very pleasant, it's very painful ehm or some people would say "Oh, I wouldn't go". I mean some women who I knew they were much, much older than me, maybe in their sixties, had never went for breast screening because some people had said to them "it's horrible", "It's awful", "it's so painful", " I wouldn't go". Ehm so that's the only thing that I've ever been told about breast screening. But at the same time I thought...well I've had four pregnancies and I've been throughout all that, and it can't be that bad, you know, so I was going into the unknown, so I was. (woman, breast screening, 50-59, interview 18)

(196) <c>Explains that she found it painful when her vaginal packing was removed after her cone biopsy.</c>

I found the vaginal packs painful. I did find them very painful coming out. Ehm I spoke to a friend who'd had a vaginal pack and she found - two friends actually had found it painful. Because I thought maybe I was being a baby but they definitely were painful. And I think you definitely need some sort of pain relief when you have them taken out. (woman, cervical cancer, 31-38, interview 08)

(197) <q>So they, did they use a little bit of local anaesthetic? You mentioned a cream?</q>

They used some GTN [glyceryl trinitrate] cream, which they applied rectally, and gave me some antibiotics when I had it. But to be fair that, that didn't, that

didn't ease, ease the procedure. Then they gave me some standard gas and air, which I could take while I was having the procedure. Which I did take. However the procedure I found very very unpleasant. (man, PSA test, 51-60, interview 10

(198) <c>He was told that the biopsy would be uncomfortable but he found it very painful and wouldn't let the doctor take all the samples.</c>

So when I went back now to have the, the biopsy [laughs] that was painful. However, but he explained to me what was, how it's going to be and I went and I lie down on the bed and the doctor, he explained to me that I would hear like a little 'Pouf' going off, "But it's not painful and it's nothing, it, it's just discomfort." (man, PSA test, 61-70, interview 19)

(199) <c>Suggests that doctors should use less technical terminology when talking to patients.</c>

I was waiting for the operation the doctors would come round and they'd draw on parts of your body and say "Right this is what we're going to do," but they were using the technical terms perhaps like testicles, penis er pubic hair, stuff like that. And it, I was a little bit embarrassed to be honest with you, perhaps shying away. I'd rather them perhaps use terms that I would use personally day to day and relax me more. You know if they'd perhaps just said "We're going to move your old man to the right a little bit so we can shave your pubes," rather than, you know "We're going to move your penis to the right and shave your pubic hair. We're going to take one testicle out," use the word bollocks for Christ's sake, that's what men are used to on that yeah. And they'll, definitely I think it would relax them more.

<q>Right.</q>

It relaxes me more, just using everyday terms that I'm used to. […]

<c>Stresses that men should get to 'know' their own bodies, check themselves regularly and go to the doctor if worried.</c>

But to be honest with you, a message to other men is you know your own body, the doctor can feel you but he doesn't know your own body. […] And the main message really is to men is you know, if you're in the bath it takes you 2 minutes to check yourself if you don't want to do it yourself get the other half to do it, make it perhaps a little bit more enjoyable (laughs). But, and if […] you feel something is slightly odd, go straight to the GP, and to be honest with you now always ask for a

referral if you're not happy with the GP's explanation to see a specialist. (man, testiculat cancer, 20-30, interview 05)

This excerpt is interesting for two reasons: first, it gives an account of a kind of "hegemonic (heterosexual) masculinity" (see *masculinity*), expressed through a boastful (if not "swashbuckler") style, which uses expletives (*use the word bollock for Christ's sake*), sexual allusions *(if you don't want to do it yourself get the other half to do it, make it perhaps a little bit more enjoyable (laughs)* and the imperative mode. These are linguistic indices of a certain form of "performing" (Butler 1990) masculine gender, which presuppose an ideal audience of men who are not taken aback by a barrack room language, in that it may be conceived as a (masculine) way of doing what Kiesling (1997, 2005) defines "homosociality".

The other noteworthy point is the complaint of doctors' excessive reliance on medical terminology, which, however, seems to contain an ambiguity. On the one side, the patients may mean that the use of "expert-ese" increases the gap between doctors and patients: the jargon separates the illness form the patient and brings it into a discursive system of reification and depersonalisation. On the other hand, however, it is debatable that doctor-patient communication is going to be enhanced by replacing, as suggested, *penis* with *your old man* and *testicles* with *bollocks*, since they are not definitely technical terms; the point raised by the respondent can be interpreted again in the light of a hegemonic masculinity: actually, he seems to imply that if the doctor used "the everyday terms that I'm used to", the patient would "relax more", but this situation seems to presuppose that the doctor is male. It is likely that the respondent conveys his unease for being treated in an impersonal, reified way; this is counteracted by evoking a comrade-like relation with an ideal doctor, which is imagined as a male and a peer.

The following excerpt provides a further example of the masculine use of irony, as both a means of exorcising death and a way to avoid dealing with personal issues in an "emotional" way, so abiding by a socially accepted masculine style (see also keywords *cancer* and *masculinity*):

(200) <c>Recalls that his colleagues thought he was going to die.</c>

Now I was actually a shift leader so I was in charge of my shift of people. I went back for those couple of weeks, I still had my hair, excuse me, and was feeling okay. People knew what I had and wouldn't mention it. They assumed, and I found this out later that people thought I was going to die. So they wouldn't talk about it, either because of the way I made jokes about it, which upset some people because they wouldn't talk about it. And they, someone actually said, "How can

you joke about it you know if you're dying?" I didn't feel I was dying because I felt at that point I was going to beat it and I felt you had to be positive anyway. […] So it was quite funny in an odd sort of way that people wouldn't talk about it.</i> (man, testicular cancer, 41-50, interview 03)

It is also worth noting the use of the war trope in *I didn't feel I was dying because I felt at that point I was going to beat it and I felt you had to be positive anyway*, which was examined by Susan Sontag in her work *Illness and Metaphor* (1991: 96-97). In her words, the understanding of cancer supports quite different notions of treatment which are framed through warfare metaphors: "The treatment is worse than the disease." The patient's body is considered to be "under attack" so the only option (treatment) is "counterattack."

Sontag says the controlling metaphors for cancer are drawn from the language of warfare. Cancer cells don't multiply, they are "invasive." Cancer cells "colonise" setting up tiny outposts in distant sites in the body. The "fight against cancer" is a colonial war. The body's defences must obliterate the tumour. We have radical surgical interventions. Scans are taken of the body's landscape. Radiation treatment "bombards" us with toxic rays. And, again, chemotherapy is chemical warfare. Treatment aims to kill cells, hopefully without killing the patient. Moreover, the military metaphor implements the "otherisation" of particularly dreaded diseases like cancer, which are framed as alien "other", and it also contributes to the patients' stigmatisation.

4.2.3.1.2 *Not painful*

The expression *not painful* is mainly employed in women's accounts (91.6% of the occurrences), both by respondents and in editorial comment lines, as in the following examples:

(201) You have this-this appointment where you're measured up and then you're sort of done again when-in-in the-the x-ray rooms. Ehm...and that again was measuring and drawing with felt tip pen and things, and...and actually quite an interesting thing [radiotherapy] to go through, it's certainly not painful, it's just a bit uncomfortable. (woman, breast cancer, 30-49, interview 01)

(202) <c> Had a core biopsy, which was not painful. </c> (woman, breast screening, 50-59, interview 11)

(203) That it [mammogram] was painful, not painful, uncomfortable, I don't think you can really call it a pain, you know, uncomfortable, not pleasant. The second time and the third time I was prepared and I think there was nothing to it, just a few minutes, you go through and feel a little squeeze on your glands, and that's it. It

wasn't a traumatic dreadful experience. (woman, breast screening, 50-59, interview 20)

(204) <c> Michelle advises women to go for cervical screening when invited. It can be embarrassing but it's not painful. If abnormalities are found, they can be treated early. </c>

 So, for the - for the fact of going for a smear test which takes five minutes, it's just, I mean it's so worth it. And you know, cervical cancer, and the rates are dropping because the screening is there now. Ehm if you prefer like to have a woman doing it, that's absolutely fine, but you know, one of the reasons I didn't go was because I was embarrassed. And then, you know, look at the process I had to go through […] And-and if you find that embarrassing, the smear test, then obviously you're going to have further tests which you'll probably find worse to be honest. So, I would say to anyone that it isn't really that bad, it's not painful. It's not difficult. Ehm and if you find it is at any point, you can always ask them to stop, and you can ask for somebody else to do it. (woman, cervical abnormalities, 25-30, interview 16)

(205) <c>Her smear test was uncomfortable but not painful and she believes if you want to be sure you are well you need to have it done.</c> (woman, cervical screening, 31-44, interview 05)

(206) <c>It is better to be safe than sorry. Two minutes of feeling uncomfortable is worth it to know that your cervix is healthy.</c>

I think it's literally 2 minutes of feeling uncomfortable, not painful, having something quite cold just pushed inside you while they run a little wooden spatula. It's worth it because from experience in the surgery so many people have had routine things and things have been picked up so early and because of all the fear especially of carcinomas I think yes I would have no fear at all, you know better to be safe than sorry. And as I say I know, we do know a lot of patients, especially single ladies don't really want it done but you know for 2 minutes, and it's just uncomfortable, it's worth it. (woman, cervical screening, 60+, interview 02)

These seem further examples of the overall strategy, aimed at raising women's awareness of female cancers and at enhancing their participation in screening practices (cf. examples 27-34 and the KW *screening*).

4.2.3.1.3. *Quite painful*

The use of the adverb *quite* as a premodifier of amplification/mitigation (cf. Biber 1999: 545-546) is found in the corpus only within women's interviews (7.51% of the occurrences of *painful*). Below are a few examples:

> (207) My mother had a double mastectomy in her early 30s due to several breast lumps that she'd developed which had been quite painful. (woman, breast cancer, 30-49, interview 14)
>
> (208) But in actual fact thi-this taking the lymph nodes out is-is-is very, very- afterwards, it's extremely uncomfortable and quite painful. But I think I had painkillers once that-that's all. (woman, breast cancer, 50-69, interview 05)
>
> (209) Ehm I went to the doctor the next day, who - it was quite painful, the lump was quite painful, and she assured me that it's-most likely, it would be a benign cyst, so I was referred to just our local hospital. And they did an...Oh, was it a biopsy? Yes, and it was just a cyst. (woman, breast screening, 50-59, interview 17)

This finding might be explained as a feature of women's language, who, according to Lakoff (1975) rely on hedges of all kinds more than men. However, the question is, as Cameron (2003: 56) puts it, whether gender is indexed directly by language. Indeed, Lakoff's model of women's language (WL) was later to be questioned by scholars O'Barr and Atkins (1980, cit. in Cameron & Kulick 2003: 57), who stated that the features described by Lakoff would be better labelled "powerless language": in their opinion, Lakoff had in effect misidentified what was signified by the use or avoidance of so-called WL features, which was power rather than gender.

4.2.3.2. Radical

The keyword *radical* ranks 74th in the list, with a standardised frequency of 115.77 occurrences PMW. The context of use is exclusively medical, with particular reference to surgery. Indeed the main clusters are *radical prostatectomy* (men, 16.2% of the instances of radical) and *radical trachelectomy* -surgical removal of the uterine cervix (source: Merriam Webster Medical Desk Dictionary 2003) - (women, 8.06%). Although the ratio women/men is roughly 2/1 in the gender corpus, it may be noteworthy that men use twice as much the adjective *radical* when referring to surgery:

> (210) <i>The doctor came round, marked on my left thigh what testicle it was you know that they were going to be operating on. Then a consultant came in, he said that did I know what the operation entailed? I said, "Yes removing the lump." He said, "A radical orchiectomy," I said "No removing the lump," he said "Yeah." My

girlfriend commented on the look on my face, when he used radical I knew that it wasn't probably just going to be removing the lump. So then my doctor came round with a consent form and said, "Did I have any questions before I signed it?" I said "Yeah one big question that's burning inside me what are you actually going to do?" He said, "We're removing the testicle." And I just looked at him in amazement. And I remembered back to the Monday that I was told that I was going to have the operation and I remember his exact words "We are going to remove the lump." At no point did he say that we are going to remove the testicle. So I sat there in amazement. I signed the form. I wasn't going to go back. I knew that it was the best thing for me. He said that operating on a testicle with a lump on it, if it was cancerous that would encourage the cancer to spread. (man, testicular cancer, 20-30, interview 04)

(211) <c>Describes how some found it surprising that he looked normal</c>

<q>And how has people's reaction been to you?</q>

Well they were quite surprised because I was fine, I was doing everything that I'd always done. I remember I play bowls and I was on the bowling green in a match one day and I just happened, it came up and I happened to tell somebody and he couldn't believe it (laughs). 'You can't be, you look normal,' well of course I look normal. […]

<q>You had radical prostatectomy.</q>

That's right.

<q>Is that what they call it?</q>

Yes, I could never remember that full name and I used to call it drastic instead of radical (laughs) but because the urethra had been cut and sewn together then obviously the catheter had to go in until that was all healed. So that stayed in a number of weeks and it just worked and was fine. Of course you have to drink during this time and a lot of people were loath to drink (man, prostate cancer, 61-65, interview 04)

The excerpt above provides a further example of the frequent use of sports (see examples 122, 151) and humour (see examples 18, 19 on testicular cancer) in men's interviews.

As regards *radical trachelectomy*, the expression is only found in comment lines, maybe due to its high technicality:

(212) <c>She describes how she felt physically immediately after her radical trachelectomy.</c> (woman, cervical cancer, 31-38, interview 08)

(213) <c>She describes what is like having a radical trachelectomy.</c> (woman, cervical cancer, 31-38, interview 10)

(214) <c> Describes the shock she felt about having a mastectomy.</c>

<i> I left the hospital and...returned for the 29th of November, which was a very short period of time. Ehm in the interim I had been told that there was no way that they could save my breast, that the...the tumour was quite large for a breast tumour, it was 5.2cms, that ehm there was dottings ehm about the back of the breast, ehm so it just was...impossible to save it. So it was decided on a radical mastectomy. (woman, breast cancer, 30-49, interview 02)

The adjective *radical* collocates (less frequently) with other female conditions, such as *radical mastectomy* and *radical hysterectomy*. A possible explanation why women use the adjective *radica*l less than men is provided by this respondent:

(215) <c>She found the Internet useful to find information about her planned hysterectomy.</c>

<i>I think I wanted to read... about this catheter, the fact that, because she kept, when I went and I was told I was booked in for this radical hysterectomy which I hated the word, the radical bit but then read in the internet that it's just the fact that they have to go to the outer limits, as far as they can go with regards to the hysterectomy. Radical, it's just such a horrible word isn't it, it just sounds so absolutely dreadful and kind of drastic. Ehm and I got a little, she gave me a leaflet about cervical cancer and she said you know "You know that you're going to have a catheter and you'll probably go home with the catheter," and at that point I didn't really know what that was or you know whether that was something in my stomach or how, you know, but it's not, through your urethra and into your bladder that way. But I didn't know that at the time so I wanted to go looking on the internet, find out about hysterectomy, radical hysterectomy, how the incisions are done, how big the incisions are done and this catheter. So that was quite, is that going to hurt, is that going to hurt when it comes out, how will that work and that kind of thing, yeah. And the tube that was in my stomach as well because that sounds horrible as well. But that kind of thing really just reading about the surgery. And also the stages, the stages of the cancer, the fact that I was Stage 1B and I was like "oh what does that mean?" and you know "what does 2 mean?" and just reading about the different

stages of the cancer it's quite interesting. I think knowledge does definitely help the situation like that, to know where you're standing and the options.</i> (woman, cervical cancer, under 30, interview 02)

Here perhaps the respondent is complaining of two issues: on the one hand, she feels disturbed by the "drastic" and "dreadful" nature of the adjective *radical*, which in this context bears a semantic negative connotation and is probably perceived as an expression of the impersonal (hence frightening) and reductionist way that biomedicine frames the human being as an anatomo-pathological body-unit made of organs, tissues and cells (see also the examples n. 56-59). A related issue that she voices is that the terminology employed for the disease is too distant from the way she had hitherto conceived herself as a person (*And also the stages, the stages of the cancer, the fact that I was Stage 1B and I was like "oh what does that mean?" and you know "what does 2 mean?"*) or, to put it differently, that the technical language of *disease* does not comply with the personal dimension of *illness*.

4.3 Comparative Keyword Analysis: Male vs. Female cancer

Another step performed in this research was a comparative keyword analysis (Charteris-Black & Seale 2010: 32-33), a procedure whereby the keyword lists of two subcorpora (male/female cancer) obtained from the overall HT [healthtalkonline] corpus were extracted through *Wordsmith tools 5* and *AntConc* and then compared to each other.

It should be noted that I did not include in the female KW list three keywords (replacing them with the following ones in the KW list), namely, *ehm, yeah* and *t*. The first two can be considered "technical artefacts" due to my editing of the corpus (see methodology, § 3.3.1), since I manually added filled pauses (verbalised as *ehm*) and backchannel cues (*yeah*) to the original website transcripts while checking them against the audio/video versions; however, due to time constraints, I managed to do that only for the female sections of the whole corpus, but not for the male files. The letter *t* indicates the contracted forms of verb+*not* as for instance in *don't, can't, won't* etc., that the software considered separately from the verb. This is why these keywords (interesting as they might be for further studies) are not suitable for a comparative analysis. The following table is a list of the first 20 keywords of both lists:

Table 9. Comparison of male/female cancer KW lists

Keywords male cancer	Keywords female cancer
1. psa	1. she
2. prostate	2. her

3. test	3. breast
4. his	4. mammogram
5. the	5. smear
6. men	6. husband
7. testicle	7. women
8. he	8. mastectomy
9. wife	9. dcis
10. blood	10. cin
11. testicular	11. because
12. is	12. know
13. prostatectomy	13. letter
14. catheter	14. colposcopy
15. of	15. i
16. urine	16. just
17. may	17. really
18. recalls	18. felt
19. injections	19. cervical
20. brachytherapy	20. reconstruction

4.3.1. Men KW list

As can be seen from the list above, many of the "male" keywords are expectably content-bound, in that their higher frequency is due to the nature of the corpus (which deals basically with testicular and prostate cancer), as for example *PSA, prostate, test, testicle, prostatectomy, brachytherapy*. Other keywords like *he, his,* and *recalls* can be explained because of their high presence in the comment lines:

> (216) <c>His PSA result came back from the hospital after about 10 days.</c> (man, PSA, 40-50, interview 03)
>
> (217) <c>He decided to have a PSA test when his father-in-law developed prostate cancer.</c> (man, PSA, 40-50, interview 01)
>
> (218) <c>Recalls that he expected only to have the lump removed and was shocked to discover he was having a testicle removed.</c> (man, testicular cancer, 20-30, interview 04)

The presence of technical keywords is not surprising because they are highly related to diseases which are not present in the female corpus, and which are therefore comparatively more frequent. However, it can be noted that the male KW list contains

more technical keywords than the female one, and no evidence of interactive/pragmatic devices - more focused on conversation – which, by contrast, are present in women (*because, know, just, really* - see next paragraph for discussion). Among non-technical keywords, it may be worth elaborating on *the, of* and *wife*.

Table 10. Comparative KW analysis: men

Keyword	Standardised frequency (per 100000 words)	Rank (ordered by keyness)	Frequency in the corpus
1. The	4231.18	5	6897
2. Of	1937.37	13	3158
3. Wife	72.39	9	118

4.3.1.1. *The/of*

I decided to analyse in the same section the two KWs *the* and *of*, because they collocate together in the first clusters of both words; the main 3-word clusters are the following:

- *The PSA test*
- *One of the*
- *The fact that*

The PSA test is an "expectable" cluster, related to the technical nature of the corpus; as regards *one of the* and *the fact that*, these clusters are instances of what Biber et al.(1999: 988-989) call *lexical bundles*, that is, extended collocations, bundles of words that show a statistical tendency to co-occur.

With regard to the cluster *one of the*, it can be noted that it occurs often –as part of a larger extraposition structure (Biber et al. 1999: 1022) - within the pattern *one of the* (+ negative superlative adjective: *worst, most difficult*, etc.) + *experiences, things/reasons/causes/side effects* (+ *that*-clause), with a negative semantic prosody, as in the following examples:

> (219) I think one of the most difficult issues that that sets up is the problem of trust because then I really entered medical treatment for what finally was

diagnosed with a strong suspicion of the medical system that it had failed to diagnose me through these months of as I say very extreme pain. (man, testicular cancer, 51-55, interview 03)

(220) I think one of the worst things was having to go through the story and explain over and over and over again. I didn't mind telling people and I didn't mind talking about it, I didn't feel like it was a personal failing on my behalf that I had cancer […] (man, testicular cancer, 41-50, interview 05)

(221) It was one of the most harrowing experiences of my life ehm it was done in the x-ray department or the radiology department as they call it. (man, testicular cancer, 41-50, interview 03)

(222) Well one of the reasons that there is uncertainty is that prostate cancer is quite common, far more common than people realise, but it doesn't [always] kill people. (man, PSA test, 61-70, interview 04)

(223) So yes one of the big questions is why and the usual one, "Why me?" (man, testicular cancer, 41-50, interview 05)

(224) <q>After the operation, is there anything else you want to say about that?</q>

<i>Yes one of the things was that if you pass urine you're allowed home, if you're unable to pass urine the doctor said that you may well be on a catheter for up to 10 days, he said after which time you'd normally be allowed home and things would proceed normally. (man, prostate cancer, 50-60, interview 05)

The higher frequency of this lexical bundle in male interviews may be explained if we consider it as an item of a hyperbolic style typical of traditional masculinity (cf. the analysis of the cluster *one of the problems* in Charteris-Black and Seale 2010: 56-57), in that men following traditional styles of masculinity experience the disruption of illness as a linear sequence of reasons/problems/issues/experiences which jeopardises the way they are accustomed to dealing with life. Moreover, this bundle can also be considered as an expression of reification (cf. Charteris-Black & Seale 2010: 56) by means of which men can distance themselves from the emotional implications of illness.

A more pragmatic explanation of the cluster *one of the* is that it may be part of a stalling/hesitating strategy in the processing of the syntactic chain, with a function similar to a discourse marker, as signalled in the examples above by the neighbouring presence

of more overt hedging devices, as in *I think one of the most difficult issues […]; I think one of the worst things was[…]; So yes one of the big questions is […].*

Another cluster which can be considered as a lexical bundle is *the fact that*, considered by Biber et al. (1999: 1016) as a noun phrase with post-nominal clause fragment, implying a locative/logical relation and providing the basis of some finding or assertion, as in the following excerpts:

> (225) You shut down completely for a moment, I mean I've been living with the fact that I may have it for 4 or 5 years because of these high readings [PSA]. (man, prostate cancer, 66-70, interview 09)
>
> (226) I'm very anxious to do my bit in promoting awareness and also to promote awareness of the fact that the research funding is so totally inadequate when you think of the number of deaths. (man, prostate cancer, 66-70, interview 09)
>
> (227) So then having had a biopsy then to confirm the fact that it was a tumour then I was offered the opportunity of having treatment which I took which was hormone treatment to start with and that's what I'm still on the hormone treatment. (man, PSA test, 71-80, interview 05)

According to Biber et al. (1999: 650), this bundle is a stylistic index of academic prose (in this case scientific academic prose); therefore, its relatively high frequency in an oral corpus can be interpreted as an additional element supporting the hypothesis of register hybridization.

4.3.1.2. *Wife*

A keyword on which it may be worth elaborating is *wife,* since the KWIC analysis of both the keyword *wife* and of the related clusters *my wife/my wife and* show an image of manhood which seems at odds with the stereotypical (and probably overrated) image of rational, unemotional masculinity; the respondents indeed convey a more collaborative identity, appreciating wife's and family's support when faced with illness (e.g. *my wife's been a wonder with me all the time and she's been my right arm all the way through it*):

> (228) Okay, basically my wife and I went to see the consultant, we've been together a long time so we're mutually very supportive. (man, PSA test, 51-60, interview 08)
>
> (229) <i>Yes I've talked about it [PSA test] with my wife and I think we have rather similar views about screening tests, that if they're available as part of a proper

programme, that's a good thing and we take part in them. But if it were a one off individual demand that's probably not worth having. (man, PSA test, 71-80, interview 04)

(230) My wife and I repaired to a Starbucks and I broke the news to her over a cup of coffee [sighs] and suitable words of support and reassurance were extended. And then began the big quest to find better information and figure out what to do. (man, prostate cancer, 50-60, interview 10)

(231) <c>Discusses the impact on his wife and children.</c>

My wife was with me, she went, my wife's been a wonder with me all the time and she's been my right arm all the way through it. Obviously she's been concerned as much as me because obviously we've been married for 36 years. We were married at 19 years of age and it is a long time to live together with a happy marriage which is very hard to find these days. […] Yes we told my son and daughter what I had, but I don't really think it sunk in, I think, I don't really think they understood the implications of it at the time, even though they're in their 30s now my children. I don't really think, they think you're sort of invincible because you've not had much wrong with you over the years. […] So there's a lot of things go through your mind at the time, the financial one is one of them. Are you set up for, not for your wife, will I ever work again which at that time I didn't think I would be working again. But as you will find out later on, how things can change. (man, prostate cancer, 50-60, interview 01)

In the excerpt above, the interviewee overtly appreciates his spouse's moral backing, and also expresses a more pragmatic, masculine form of caring in worrying for financial issues. As regards the passage where the children are mentioned, it could be interpreted as a veiled confession of frailty and therefore a "non-conventional" masculine performance: by stating (and slightly complaining) that his children "*even though they're in their 30s now*" overlooked the seriousness of his disease (*I just think they just thought it was dad's got some sort of a bad stomach*) he also accepts his own frailty; this could be seen as a spur to a process of negotiating a new identity as a man confronted with ageing and illness (*they think you're sort of invincible because you've not had much wrong with you over the years*). The implied complaint is probably that his children are immature, slow or unwilling to go through a similar process of identity negotiation, which might enable them to display a more adult-like, caring behaviour towards the "wounded" father, who can no longer conceive himself subconsciously as an "omnipotent father/Father", according to the model portrayed by Freud in *Totem and taboo* (1999 [1912-1913]).

In other cases, it is possible to note a more cooperative dimension of shared decision-making:

> (232) <c>The decision to have a PSA test was made with the help of his wife and GP. He knew the test might lead to further investigations.</c>
>
> I mean it, it was, it was my final decision, but it wasn't a decision that I went off and did on my own. It was in combination with my family, with my wife and the GP. And we were all happy that we knew what we were doing, and all, we were all happy that, if I was going to have this PSA test, it could lead to where it did lead. (man, PSA test, 51-60, interview 10)

Other excerpts provide a more canonical, that is, aggressive and goal-oriented account of masculinity:

> (233) <c>Advises people to set goals and keep fighting.</c>
>
> Don't give up, just fight it and keep fighting it. I set myself goals. The first thing I wanted to see was my wife's 70th birthday, she's older than me, now I want to see mine which is next year and then I shall set myself another goal. I set myself yearly, annual goals trying to achieve, which is fine. And one other thing, I've got a mountain bike which is quite fun and I cycle around on that, not too far, I suppose the most miles I've done is about 10 but that's good, it's good fun. […]
>
> […] when I first realised that I had cancer and I think for the first fortnight I was a bit unbearable to live with because I could not accept it myself, I didn't want to accept it. But I think after a period of a fortnight you sort of take yourself away and give yourself a damn good shake and say 'Come on get cracking and start living.' And we did, my wife and I went off to Canada on a holiday and it was a hell of a job to get the insurance but it was well worth doing it. (man, prostate cancer, 66-70, interview 01)

Against the conventional view of masculinity as self-serving, egotistical and uncaring, anthropological research (Gilmore 1990: 229) has underlined that manhood ideologies always include a criterion of selfless generosity (e.g. in caring for spouse, family or larger group): therefore manhood is also a nurturing concept, different from and less demonstrative than women. The form of nurture also differs, in that women nourish directly, with their bodies and their love, but the same applies to men, although in a more indirect way. Men, as Gilmore (1990: 230) says, are nurturing in the sense of endowing and increasing: to be generous they must be selfish enough to amass goods, often by defeating other men; to be gentle, they must first be strong and even ruthless in

confronting enemies; to love they must be aggressive enough to court, seduce and "win" a wife.

4.3.2. Women's KW list

In comparison with the male KW list, the female list presents not only technical keywords related to the gynaecological/oncologic domain (*mammogram, smear, mastectomy, DCIS* [ductal carcinoma in situ], *CIN* [cervical intraepithelial neoplasia], *colposcopy, cervical, reconstruction*), but also words which are strictly related to the pragmatic/interactional nature of conversation, such as *know* (with 68% occurrences expressed in the form of the pragmatic particle *you know*)*, because, just* and *really*.

Such keywords fall within the wider category of discourse markers, which in this case can be conceived as "hedges" and "boosters" (Holmes 1995: 72) because of their effect on the utterances in which they occur. Hedges (which also include devices like fall-rise intonation, tag questions, modal verbs, lexical items such *as perhaps, conceivably, quite* and other pragmatic particles such as *sort of* and *I think*) reduce the strength of the utterance by weakening its force or intensity or directness. Speakers may use hedging devices in different context to mitigate face-threatening acts or to avoid imposing on their addressees (cf. Biber et al. 1999: 555, 1045-1047, Holmes 1995). While hedging devices weaken the strength of an utterance, boosters (such as *just, so, really*, *incredibly, absolutely, certainly*, etc.) intensify or emphasize the force.

The keyword comparison raises the issue of the different use of pragmatic particles in male vs. female conversation and is consistent with Holmes' (1995: 87-88) statement that women tend to use pragmatic particles to express positive politeness more often than men do (see *know* below). This finding may be linked to women's higher sensitivity to the fact that what they are saying may threaten face or to their higher attention to context when considering norms of politeness (Holmes 1995: 109).

The words which will be analysed in this section are *husband, know, because.*

Table 11. Comparative KW analysis: women

Keyword	Standardised frequency (per 100000 words)	Rank (ordered by keyness)	Frequency in the corpus
1. Know	932.19	15	3473
2. Because	724.44	13	2699
3. Husband	78.37	8	292

4.3.2.1. *Know*

The keyword *know* ranks 15th in the female cancer list, with a standardised frequency of 932.19 instances per 100000 words. It is noteworthy that the main clusters are *you know* (68% of the occurrences of *know*) followed (far behind) by *I don't know* (5% of the instances of *know*). Both are mostly used as discourse markers.

Discourse markers are linguistic, paralinguistic, or nonverbal (Schiffrin, 1987: 40) elements, which tend to occur at the beginning of a turn or utterance, and to combine two roles: (a) to signal a transition in the evolving progress of the conversation, and (b) to signal an interactive relationship between speaker, hearer, and message (Biber et al. 1999: 1074-1075, 1086-1087). Words and phrases which can be considered discourse markers are often ambiguous and open to debate.

According to Biber et al. (1999: 1086), the main items included in this category are *well, right, now*, and the finite verb formulae *I mean, you know, you see*. Schiffrin (1987: 24-25) pointed out that in addition to conveying semantic content or ideational meanings about the real or fantasy world, discourse markers can at the same time signal relations at the levels of exchange structure, action structure, or participation frameworks within discourse.

Participation framework, in particular, reflects the ways in which the speakers and hearers can relate to one another as well as their orientation toward utterances. Another important study on discourse markers was carried out by Erman (2001), who focused on the different use of discourse markers in adolescent and adult speech. According to her model, the principal function of pragmatic markers is to monitor discourse. As monitors of discourse they function in three main domains: the *textua*l domain, the *socia*l domain, and the *metalinguistic* domain.

As *textual* monitors, pragmatic markers are mainly focused on the text, in that the speaker by using them can create coherence in discourse, notably turning sometimes fragmented pieces of discourse into a coherent text (although, as she stresses, coherence should not be seen as a text-inherent property, but as the result of collaborative work between speakers and hearers), with an overall function to mark 'moves' between arguments, states and events in the text. By contrast, discourse markers employed as social and metalinguistic monitors are more focused outside the text (Erman 2001: 1340).

An example of the discourse marker *you know* used as a textual monitor in the corpus is the following:

(234) I actually don't know how people cope with this sort of thing without a faith, whatever-whatever religion you are. I'm a committed Christian.
Ehm and...in my lowest times God has been there and I've been able to talk to him. I've been able to...lean on him. Scriptures have just come out at me, you know, when I've read my Bible. […] And-and it is my faith that's kept me going and the prayers of people, you know, when-when I go for chemotherapy, they all know when I'm going. And I-it's-it's almost physical, I can feel being uplifted in prayer. (woman, breast cancer, 30-49, interview 04)

(235) <q> Has it [the mobile unit for breast screening] always been there? </q>
 Yes. My experience was in that, so you know, and nowhere else. So it is just...I don't know if another venue would be better. But because it is such a quick thing to do. But perhaps you need to wait half an hour, you know, as sometime like last time I went, there was no space to sit. You know, people had to...wait for some time until they called me. Ehm but I would definitely think it should be more space, if they want, you know. Because it is nice sometimes to have a little bit of room so you can chat with each other, changing you know, like me for example, I would talk. You know, I am shy, funnily enough I am a shy person, but if I, you know, if I have a little hint, I will carry on talking and exchanging experience anyway. But the atmosphere is a little bit better, the waiting room that it is. But the rest it is okay, I mean it just isn't equipped enough I guess for what they are doing. (woman, breast screening, 50-59, interview 20)

However, since in the excerpt above the interviewee's mother tongue is not English, *you know* could be interpreted as a form of hesitation or as a "verbalised" pause aimed at retrieving words or as points of forward-planning in the process of syntactic composition (cf. Biber et al. 1999: 1054).

As Erman (2001: 1344) states, another important function of *you know* at the textual level is to mark transitions between direct and reported speech, close in function to quotation marks in written text. This can be seen in the following corpus excerpts:

(236) Things that I've read hundreds of times have just...just come out at me and the promises of God, you know: "I will never leave you or forsake you. You have a future. I have plans for you." All these sorts of things. (woman, breast cancer 30-49, interview 04)

(237) <c> Raises some of the possible bureaucratic hurdles associated with living with breast cancer.</c>

[…]And you get all these things going through your mind, you know. Ehm "How long have I got?" That's-that was the first question, you know. Ehm..."Is it terminal? Am I going to die?" you know. "What are my chances?" I think, you get all these thoughts.[…] So I thought: "Well I must have been a-a bit of a bad 'un in my past life. "I must, you know, I must've done something wrong." And I just-I wanted someone to blame really. And it's-you can't find anybody because no one's given you it...you know. […]And I found this lump and I thought: "Well...what do I do about it?" You know, "It's nothing. I'm only young, I can't-it can't be anything." So I went to my GP...and ehm...she said...basically: "It shouldn't be anything at all, you know, considering your age." I was 19 at the time. No, I was 18 at the time. Nineteen in August. (woman, breast cancer, under 30, interview 02)

(238) <c> Explains why people's reactions towards her diagnosis surprised her.</c>

<i> Now then support's an issue that needs to be raised because ehm friends who I would have expected support from [<q> Uhm uhm.</q>] shunned me and that hurts. That really-that's really difficult to come to terms with. [<q> Uhm.</q>] That, you know, "What have I done, is it my fault I've got cancer?"[<q> Uhm.</q>] (woman, breast cancer, 30-49, interview 13)

Discourse markers as *social* monitors negotiate the meaning and management of discourse and ensure that the channel is open between the interlocutors. In so doing, the speaker can elicit involvement of the addressee, e.g. by asking for confirmation of a previous claim and/or to signal turn switches. Examples include tags (*wouldn't it, ok, right*) but also *you know* is frequently used with this function. Moreover, the speaker can be said to use discourse markers with a "social monitoring" function in order to make sure that the addressee has understood the message or that s/he agrees with it. These aspects can be seen in the following examples taken from the corpus:

(239) Ehm but the converse is true, people who I wouldn't have dreamed would've even...turned a hair were absolutely fantastic, overwhelming [<q> Uhm.</q>], you know. The people where my husband works, I don't even know them, they sent me all sorts of nice stuff.

Ehm neighbours who I hardly know visited, offered to do laundry, offered to do everything ehm you know. It's kind of one extreme to the other.

You know, people who you hardly know are falling over themselves to help and people who you'd expect would've had a kind word or even sent a get well card [<q> Yeah.</q>] nothing[<q> Yeah.</q>], you know. So make of that what you will. And apparently that, with the support group, that's quite common, you know [<q> Yeah.</q>]. People either run to the hills or they'll be right next to you standing by you.<q> Uhm uhm.</q> (woman, breast cancer, 30-49, interview 13)

In the excerpt above the occurrences of *you know* in some cases overlap with the interviewer's backchannel cues (*uhm, yeah*), signalling feedback to the speaker that the message is being understood and accepted (cf. Biber 1999: 1091); therefore the use of *you know* in this case can be seen as an attempt that the speaker makes to check the interviewer's agreement and/or her participation in the unfolding of the narration. The same seems to apply to the next excerpt:

(240) <q> Did you always go to this unit at [hospital name]? </q>
 Yes. I have been there the third time now. Just that one. I didn't know any other place, which is quite nice. You know, it is close...close for me to go. I had my son in [hospital name], so I am familiar with the ground and he had to go there, so I wasn't and the premises are not bad. They are not so unfriendly. It is a bit, you know, a...cubicle like, you know, not much space in it. (woman, breast screening, 50-59, interview 20)

As *metalinguistic* monitors, discourse markers are focused on the message, in the sense that they function as comments, not on the propositional content of the message, but on its implications and on the speaker's intended effect (Erman 2001: 1339).
Elaborating on Jakobson's (1960: 356) definition of the metalinguistic function of language (which is focused on the code proper and typically expressed in questions like 'Do you know what I mean? '), Erman (2001: 1347) goes one step further in considering that the metalinguistic function is operating whenever the speaker underscores the illocutionary force of the utterance as a whole. The most obvious instantiation of the metalinguistic function in everyday talk is in connection with emphasis. The following is an example that she provides:

<1> I didn't realize what I was doing. I dunno.
<2> You're so stupid! You know.
<1> Yeah, yeah erm.

(Erman 2001: 1347, adapted)

Examples of this kind of use were found also in the present corpus, as in the following excerpts:

> (241) I mean the furthest thing from your mind is having...sex. I want a cuddle or just to be held or...to talk, you know. (woman, breast cancer, 30-49, interview 08)

> (242) <c> Explains her concerns about her husband's reactions to her altered body image.</c>
> And coming home and facing my husband with this was a bit of a trauma too because I just didn't know how he would feel, and I didn't know how I would feel if he was disfigured in some kind of way or whatever. But I just beared up and showed him my scar and he kissed it and kissed me, and we were fine again […]
> My husband actually has just been, he never ceases to amaze me how marvellous he can be you know. He's just been so caring and so thoughtful and you know it's brought us closer together than anything else would've I think, you know.</i> (woman, breast cancer, 30-49, interview 15)

Here the speakers seem to be using *you know* to emphasise the illocutionary force of her utterance; from this viewpoint, as Erman (2001: 1341) states, metalinguistic monitors are basically modal, in that the speaker by using them informs the addressee about her/his commitment to the truth of the proposition or about the importance or value of what is being communicated. Previous research in the language of illness underlined that *you know* as a pragmatic marker was more frequently found among women than men (Charteris-Black and Seale 2010: 106-107). As regards this doctoral thesis, it should be noted that *know* is not a keyword in the male cancer corpus, although this should be qualified by adding that the male corpus is roughly a half smaller than the female one.

According to Holmes (1995: 87-90), the pragmatic particle *you know* conveys both referential and affective meaning, but women tend to use it with a primarily affective meaning and with an interactional function of other-oriented positive politeness, whereas men seem to focus more on its referential meaning, as shown in the following excerpts taken from the male corpus:

> (243) So I actually decided, well I mulled it over for a long time as to whether I should actually go and have a test and could I face hearing the result, whether it was you know positive or negative, did I actually want to know, and then trying to weigh up what the implications were of finding out. […] Well I'd sort of gleaned that from the web site as to, as to what, you know there's, on balance it, it [the PSA

test] can be more accurate than inaccurate but it's not 100% guaranteed. It's you know 70-80% hit rate as far as my understanding is concerned and 80% is a pretty good bet [laughs]. (man, PSA test, 40-50, interview 01)

(244) Yes well I, I've known about the PSA test, I've read articles about it and with differing opinions I should say about its validity and reliability as a, as a diagnostic for early you know prostate cancer. And I'm 57 years old when I, I've read at various times that men in their 50s should have tests like this, that it's one of those things that you know you should get checked (man, PSA test, 51-60, interview 12)

The higher use of discourse markers such as *you know* in women's speech falls within the broader study carried out by Lakoff (1975) on the characteristics of "women's language". The higher frequency of *you know* in female conversations can therefore be linked to their communicative style, which (according to Lakoff) tends to be more tentative, indirect, non-committal, and collaborative (if compared to men's competitive style).

It is noteworthy that most of these nuances can be covered by *you know*, which is therefore very versatile in conversation. Due to its versatility, speakers can employ *you know* to express high modality (as seen in the example n.. above), as a hedge within a mitigating strategy, as a hesitancy filler, or as an expression prompting a sympathetic circularity sequence between speaker's statement and addressee's agreement/feedback (as seen in the example n. 239 showing the link between the speaker's instances of *you know* and the interviewer's backchannel cues).

4.3.2.2. *Because*

The keyword *because* ranks 13th in the list, with a standardised frequency of 724.44 instances per 100000 words.

Because does not only function as a causal subordinator (Biber et al. 1999: 843, 845), but is also attested as a *coordinator* in conversational discourse (frequently occurring in conversation transcriptions in its aphetic form *cos* or *'cause*), with an aim to extend the body of the utterance through an "add-on" strategy (other conjunctions used with a similar purpose are *and*, *so* and *but;* cf. Biber et al. 1999: 1078-1079). Cheshire (2004) highlighted the role of *because* as a "story opener" in her study on illness narratives, where she states that "*because clauses* occur frequently in conversation, presumably due to their semantic role of explaining the speaker's thoughts, feelings or actions" (Cheshire 2004: 28). Ervin-Tripp and Kyratzis (1999) remark that *because* is used in conversation as a boundary marking device, along with markers such as *well, ok, now,* and *so*.

Boundary markers concern addressee expectations and participant roles, and therefore implicate participation frameworks (Ervin-Tripp and Kyratzis, 1999: 1327). However, Ervin-Tripp and Kyratzis also state that the boundary marking function is not easy to detect for *because*. As regards this doctoral thesis, it could be said more generally that it is not easy to identify with certainty the uses of because as a discourse marker; indeed, it is not always a straightforward task to ascertain whether *because* is used as a causal conjunction, as a boundary marker or as an "add-on" discursive device. In some cases it is clearly used as a causal conjunction, as in the following examples:

> (245) Ehm...A lot of women don't realise if they get puckering of the skin, or ehm problems with nipples ehm that they should go and get them looked at. Because there are other ways of presenting itself other than an obvious lump. (woman, breast cancer, 30-49, interview 01)

> (246) But it was not without its trauma, because a week before the surgery I still had some important questions, which I actually never got to the bottom of, about the lymph nodes, and that was what - I was really - I was far more...terrified about the surge-surgery on my lymph nodes than I was about losing my breast. And that was ehm because, although I didn't want to lose my breast, ehm it wasn't going to interfere with the rest of my body. </i> (woman, DCIS, 55-60, interview 03)

> (247) I ordered a book ehm which is called 'The Breast Cancer Book', which is ehm written by a journalist who had breast cancer and whose second operation was the full mastectomy with reconstructions, and she teamed up with her Macmillan nurse and they came up with the idea that it would be good to write it all down, just every day events that happened in her life. I started to read that but, because again her case is much more serious than mine, I kind of read it only a chapter at a time not the whole book in one go because it's heavy going.</i> (woman, DCIS, 50-54, interview 04)

In other cases, *because* seems to have a coordinating function, also signalled by the neighbouring expressions such as *I think, as I say, I mean, I suppose*, which act as discourse markers:

> (248) When I was first diagnosed it was through ehm my_my family actually upset me more than anything because, as I said, we'd buried my sister two years previous and me taken thus...they couldn't accept it because...ehm ehm it upset

them and every one of them was on the phone. They were coming on crying wh_which upset me. But it takes you...a while because as I say I broke my heart. (woman, breast cancer, 50-69, interview 21)

(249) Well ehm in my case I'm afraid ehm it saved my life and I think that it must be gotten across to-to...women and to men that it's not necessarily about feeling a lump. Because I think it gives the wrong messages out. (woman, breast screening, 50-59, interview 10)

(250) But I haven't, touch wood, had any problems, but I do still go. And I request to go. I think people over 70 need to request a recall every three years isn't it? Because I think it's important, I think it's extremely important to get these things seen to in the early stages with everything, every illness. (woman, breast screening, 70+, interview 01)

(251) And I was really quite matter of fact with it I think, I-I-it hadn't sort of...I think it hadn't sort of...hit me at that stage. Ehm I didn't cry or anything, you know, when he said it was malignant and needed to be done.
Because then I had to go home and it was beginning to sink in at that stage, what worries could be, you know. Ehm and I had to tell my husband. Ehm but I obviously didn't tell him very well because about...long after the operation, he asked me whether I'd had-whether I had got cancer.[laughs] […]
Ehm now I'd like to talk a little about the lymphoedema because I do think if it can-if doctors wore jackets ehm...If doctors had it and couldn't get into their jackets, they'd do something wouldn't they? I couldn't get my clothes on **<q> Yeah </q>** you see I can't now very well, ehm and I couldn't wear any suits. (woman, breast cancer, 70+, interview 01)

(252) I would've liked a little bit more information about the, because I think you can actually ask for your report can't you? So I wished I had the guts to have said, "Please can I have a copy?" But he didn't strike me as the sort of person that would probably like you asking that. So, but as I say, I've got this mammogram in a month's time, in June (woman, DCIS, under 50, interview 04)

(253) I mean most of it was "Hi how are you?" you didn't want to sort of get into too much of things because you didn't want it to be too jolly before you actually had to sort of drop this massive great thing. And to most of them I said "Look I really don't

know how to say this to you but I've been diagnosed with cancer." And I suppose most people sort of just either burst into tears on the phone or were just sort of completely sharp intake of breath and then you end up apologising and you say "God I'm really sorry." And so I think with a lot of it it's always having to... to think about how somebody is going to be affected by your news. (woman, cervical cancer, under 30, interview 05)

(254) And...and I was...very, very nervous on that day because I just didn't know what to expect. I didn't know whether it would hurt or if I'd be sick or what the reactions would be. Ehm that was...a very difficult time, very difficult because...the Hickman line and the...the ehm the chemo pack, the-the pump, were a constant reminder. And then you looked in the mirror and that was an-an even bigger reminder. So I went through a spell of being quite low. Ehm of feeling that I couldn't escape. […] And he taped the interview ehm and said the-that I could take that away with-with me so that, because they said: "We do accept that you're not going to take everything in and this is helpful.") (woman, breast cancer, 50-69, interview 20)

This coordinating use of *because* can also be found in the BNC spoken:

(255) when I got the car back on to the road, I mean I'm a, a complete bag of nerves and I'm, I'm not wanting to be walking along the, the edge of the bypass at one o'clock in the morning That's right. And erm the car's all over the place because the wheels are all covered in mud and everything so Joan for what it's worth erm and this is just something you might want to think about a mobile is worth its weight in gold. Yeah well my husband's talking about getting one of those **because** I mean after I didn't tell him all the details I was gonna say have you told your husband. Well I told him that, that I was getting very tired but he would've just worried about me coming back down you know I know. And I mean I've got it's not as bad going back from here cos it'll only be about a six hour then. Not the point though is it?

4.3.2.3. *Husband*

The KW *husband* is 8th in the list, with a standardised frequency 78.37 instances per 100000 words. The main clusters are *my husband and, my husband and I*, *my husband and my daughter/son/mum/family*. In this respect, words relating to the semantic field of "family" as *daughter, son, mum* and *family* are also keywords in the complete KW list,

whereas they are not present in the male list. This indicates that women use words for closer family relations more frequently than men, which was also noted by Charteris-Black and Seale (2010: 180). A possible explanation is that women tend to consider motherhood as an important feature of their identity.

With a focus on gender differences and on couple dynamics, Tannen (1991: 27) underlines that women and men differ in their ideas of decision making, since women generally appreciate consulting with their partners, whereas men tend to make more decisions without consulting their partner. However, as shown in the analysis of the male KW *wife*, when faced with the need of making major decisions relating to the illness domain, men also seem to be eager to involve their spouses; a possible explanation (among many others) is that in such predicaments the strength of character is jeopardised and uncertainty about the future prevails. A similar involvement is all the more visible in the female corpus, as shown in the following examples of the KWIC of the keyword *husband*:

> (256) And my husband and I talked about it for a few moments, it was as much as that, that we had to sort of make a decision and chose the one hospital which I was very pleased in retrospect that we chose it, but then we had a little bit of time outside while something was sorted and I shed a tear. I remember, just one. I didn't cry a lot. I thought, you know, "Sod it," you know, "I hadn't really expected this." (woman, DCIS, 50-54, interview 13)

> (257) <i> So I went there on the day on Wednesday, I think it was in October or November, I can't remember when it is. My husband and I went. And they said, "Well" They still couldn't find it anyway because it was way back over there. And we spent about seven hours in hospital and they looked for it (woman, DCIS, 50-54, interview 17)

> (258) But, but that Christmas, you know, my husband and I we talked over it and at that point particularly I didn't really know what the outcome was going to be but I thought well, you need to, the importance of getting the balance right. (woman, cervical screening, 45-59, interview 10)

The following excerpt adds to the previous discussion on the deflecting/avoiding function of humour in male discourse of illness (see examples n. 18-19), an interpretation of male humour which associates jocularity with strength in coping with a difficult situation:

(259) It's-it's difficult thinking: "Well what will I be like?" because obviously your main concern is-is: "I just want the cancer taken away."

I personally wouldn't have been...too upset because I have a very strong healthy marriage and my husband said: "I don't care what you look like afterwards, you-you're still going to be you." And...and when my-my scar had healed my husband kissed my scar which was very, very important to me.

Ehm but it-it's hard for men as well because...as much as they-they want to ehm to reassure you, and tell you that you are still the same person, it's difficult for them sometimes because they're going through it, although they're not the victim themselves, they-they're still upset, they're trying to reassure you, they're trying to be strong for you.

Ehm I feel my...my relationship with my husband is a lot stronger. Ehm he's a very caring person, was absolutely wonderful through all the treatment. Kept a very good sense of humour through it as well.

Ehm my husband actually said to the breast care nurses when they were explaining all the treatment: "Will-will she be able to swim after this?" And she said: "Yes, I don't see why not." And he said: "Well that's a good job because she can't swim now."

And...and humour is important, you know, with anything. If you can laugh through it and laugh with each other, ehm and sometimes laugh at the illness as well then, you know, laughter is the best medicine sometimes really. (woman, breast cancer, 30-49, interview 14)

By contrast, the following examples provide a less rosy picture of a husband's reaction to the spouse's illness:

(260) <c> Explains her feelings of anger towards her husband and lack of interest in sex, but that their relationship is improving with time. </c>

 And I was angry, I was angry with my husband. I was very angry with him because he can't deal with it, if I'm not being a strong person. I've always been the...strong person in the relationship and...he just can't cope with it.

He shuts down, and he doesn't talk to me. He hasn't coped really. And...I got angry with him and kind of locked in really for a long time. But...we are getting better now and it's...it's hard I think. I think it's harder for your partner than it is for you. Very hard. I think for [my husband] as well, I know he wanted to have sex after ehm the soreness went away. And I said to him, I just didn't feel like sex. I really didn't feel like sex at all, and I still don't. And I think he felt that I was rejecting him and maybe

he closed down. And I was in a way, I mean the furthest thing from your mind is having...sex. I want a cuddle or just to be held or...to talk, you know. I don't...feel like sex and I still don't. (woman, breast cancer, 30-49, interview 08)

(261) <c> Discusses the break-up of her marriage under the strain of her illness.</c>
<i> Then I had a month off...ehm when I finished chemotherapy...before I started radiotherapy. And...I suppose at that point, ehm I knew, at that point, that my husband emotionally had left me ehm at the end of the chemotherapy. Ehm it puts relationships through quite a lot of...strain. Ehm I didn't really understand that then. Ehm I know-know a lot, lot more about that now. Ehm I think particularly, I think men do find it difficult. Ehm maybe...we as women do so much and are...there as this sort of, maybe a mother figure a lot of the time. (woman, breast cancer, 50-69, interview 02)

Here the respondent states that women are more emotionally competent than men; in the example (260) the respondent provides an inside view of a couple dynamics where she overtly frames herself as the strong person in the relationship, and gets angry at the husband's unease in coping with her illness, which is perceived as a lack of sympathy and a sign of his fragility; however, she later tones down her remark by means of a generalisation: *I think it's harder for your partner than it is for you. Very hard*. In this expression it is noteworthy that the shift from her personal situation to the general concept "men find it harder to cope with the spouse's illness than women" is achieved through the impersonal *you*.

However, the shift *I-impersonal you* could also be interpreted as a distancing device whereby the speaker tries to (metaphorically) distance herself from the situation, with an aim to "objectify" it - as if she were looking at it from a distance or through the microscope; at the same time, the impersonal *you* subtly reduces the speaker's involvement and responsibility: *I mean the furthest thing from your mind is having...sex. I want a cuddle or just to be held or...to talk, you know* (cf. Charteris-Black & Seale 2010 on this use in men's speech).

The other respondent in the next example (261) shares a similar view on men's emotional inadequacy, but she adds that women's better coping strategies are due to the experience of motherhood, which is conceived as strengthening and empowering. Besides being an important issue of women's identity, being a mother is also a social role: societal norms and expectations associated with fulfilling the parental role not only partake

in women' identity but can affect the relationships to others. This aspect was much debated by early feminist scholars influenced by the ideas of Simone de Beauvoir (1952), who in *The Second Sex* maintained a negative view on motherhood on the grounds of the oppressive conditions it has traditionally imposed on women. However, it was Adrienne Rich (1976) who distinguished between the institution of motherhood within patriarchy (which Beauvoir condemned) and the experience of motherhood, which has the potential to be richly rewarding. In the excerpt above the respondent clearly gives a positive image of motherhood, and she uses an inclusive *we*, probably with an aim to involve the interviewer (who is a woman as well) and elicit her agreement as a form of female solidarity.

5. Conclusions

5.1. Discourses of masculinity and femininity in the HT corpus: outline

The corpus analysed in this doctoral thesis deals with people suffering from oncological conditions affecting primary and secondary sexual organs; the main points investigated concern the way in which men and women express the consequences of such illnesses on the self and, more specifically, on their personal beliefs on gender and identity.

According to Levin (1999: 105), cancer poses a significant epistemic challenge to our culture, since it is still mysterious, and prompts us to question its meaning in our personal lives. It was highlighted that identity is not just a product of a stable social structural organisation, but rather a performative act (Ochs 1992) and a negotiated process, and that individuals position themselves differently at different moments and places, in accordance with interlocutors, topics, situations and the variety of roles that they may be playing (Woodward 1997). Self-identity is a dynamic process embedded in social and discourse practices (Foucault 1984, Fairclough 1989) whereby a person understands and communicates to others his/her sense of autobiographic continuity (Giddens 1991).

If we consider gender as part of our identity and language as a tool through which gendered identities are *performed* (Butler 1990, Cameron 1997, Eckert 2003), then we may say that gender identities are not fixed, but are themselves ongoing processes, involving the use of linguistic strategies which change from one situation to the other. According to Johnson (1997: 23), this means that, in performing gender, men and women may draw on linguistic resources which are perceived to be appropriate by their gender group, in the same way that they may dress in a manner which conforms to gender expectations. This dynamic concept of gender centres on the premise that the notions of male and female are sociocultural transformations of biological categories and processes. In other words, social groups organise and conceptualise men and women in culturally specific and meaningful ways (Ochs 1992: 339).

As outlined in chapter 2.3, the notion of *sex* relates to biological differences between *male* and *female*, whereas *gender* is a more cultural notion, which operates as a *masculine/feminine* dichotomy linked to societal expectations (Baker 2008: 4). Moreover, while sex is a rather concrete and binary concept, gender can be characterised on a continuum, with masculine at one pole, feminine at the other pole, and various shades/mixtures of both types of culturally stereotypical behaviours in the middle (Baker

2008: 5). Accordingly, in the corpus respondents showed different degrees of “masculine” and “feminine” performances within their ways of coping with illness.

As regards men, performances of masculinity ranged between more traditional behaviour influenced by the model of *hegemonic masculinity* (Miller 2009: 116, Kiesling 2006: 268) and less standard, caring models. The concept of *cultural hegemony* (Gramsci 2001 [1947]) is also used in gender studies, and has been revised by post-structuralist scholars (e.g. Foucault 1980) who state that it does not function through ideologies controlled by elites, but is created and perpetuated by discourses which are not controlled by any single person or group and are hegemonic in the sense of being powerful and changing (cf. Kiesling 2006: 262).

Within the framework of gender ideology (Eckert & McConnell-Ginet 2003: 35) a hegemonic discourse will conceive society in dichotomous ways, as shown in the following table:

Table 12. Dichotomies in hegemonic masculinity (adapted from Jordanova 1999: 36)

Nature	Culture
Woman	Man
Oppressed (because powerless)	Oppressor (because powerful)
Weak	Strong
Passive	Active/aggressive
Timid	Brave

As Eckert (2003: 36) states, these dichotomies are extremely powerful, both because of their place in gender ideology, and because of the ways in which their representations permeate society.

Men conforming to the model of hegemonic masculinity are supposed to be *good at being men*, rather than *being good men* (Herzfeld, cit. in Gilmore 1990: 30). An expression of hegemonic masculinity is the cultural model of heroic manhood (Gilmore 1990).

In her work on the different psychoanalytic process of identification in men and women, Chodorow (1978) argued that the processes of female identification are *relational*, whereas male identification is *oppositional*. According to Chodorow, the origin of male identity is more negative than positive, and is based on the concepts of differentiation from

femininity, distance and denial of the affective relationship. From childhood onwards, masculinity is more a reaction than an adhesion. As Stoller (1985) puts it, the first duty of a man is *not being a woman*.

Furthermore, from a psychoanalytic point of view (Badinter 1992, see also table 12 above), the virile man embodies activity, but such activity is a life-long reaction against the baby's passivity and impotence, which also involves a fundamental ambivalence: the fear of passivity carries both a social stigma for not conforming to the social manly model, and a psychological dread of breaching the taboo of regression to a pre-oedipal, symbiotic stage with the mother, which is one of the strongest and most repressed desires of human beings. Therefore, the Sisyphean toil of constantly asserting one's masculinity is never ending and the battle never definitely won.

If we relate all that to men's accounts of illness, we can say that in most interviews about testicular cancer, respondents tend to conform more to traditional gender norms, in presenting themselves as heroic survivors or fighters, in order to sustain a "masculine" presentation of self.

However, the results of the present study also show that many men are overwhelmed by the experience of illness and find it difficult to adopt such heroic attitudes. In this respect the kind of cancer and age of the patient may be influential, since there seems to be a difference between prostate cancer patients (generally older than 50) and testicular cancer patients (younger than 50): the patients suffering from testicular cancer do not generally feel that their masculinity is harmed by the loss of one testicle - probably because neither the sexual nor reproductive function is impaired after removal of one testicle, since the other one can make up for both testosterone and spermatozoa production. It was observed that these respondents seem to cope better than prostate cancer patients, who often report a loss of masculinity. It was argued that in this case masculinity was framed as a (gendered) performance of heterosexual acts, since these respondents overtly blame their "lacking masculinity" on impotence and low sexual desire - both iatrogenic effects of oestrogen therapy and prostatic surgery.

However, not only do the men "do" illness differently, they also "do" gender in vastly different ways: indeed, counterdiscourses of hegemonic masculinity were also found in the corpus. Some prostate cancer patients reportedly coped well with impotence, without feeling their masculinity undermined, while other male patients were shown to appreciate their wife's and family's support when faced with illness. Contrary to gender stereotypes of rational, unemotional masculinity, contrasting versions of masculinity are performed in the illness narratives: some men prefer connection, whereas others keep emotions at bay.

Moreover, against the conventional view of masculinity as self-serving, egotistical and uncaring, anthropological research (Gilmore 1990: 229) has underlined that manhood also is a nurturing concept, different from and less demonstrative than traditional motherhood. As scholars now argue, we need to speak about masculinities and femininities, rather than assuming singular notions about gender (Connell, 1995; Coates 1998, Cameron & Kulick 2003).

With regard to women's experiences of surgery, it seems that they feel more deeply affected than men by the loss of a part of their body defining their biological sex (ovaries, uterus, and breast). However, also in this case age plays an important role, since younger women in fertile age feel more deeply hit if deprived of the possibility of giving birth. As regards the issue of body image after mastectomy, younger respondents were dissatisfied with their appearance and seemed more eager to undergo breast reconstructive surgery than mature women.

It may be inferred that young males and mature female respondents were more at ease in considering cancer as part of their sense of self, or at least as an event which served the purpose of redefining the self, and not necessarily as the exogenous, monstrous enemy which has to be fought at all costs. This result is interesting since men proved to be able to refer to themselves as *embodied selves*[3] (cf. Merleau-Ponty 1962), despite their alleged difficulty in dealing with their emotions. Nevertheless, this finding should be problematized: young men seem to cope better with cancer provided they can refer to themselves as sexually competent even after illness; in this case, either consciously or not, they reproduce an underlying logic of masculinity in terms of agency, which often implies women's passivity (cf. Cameron & Kulick 2003: 31). It was argued, as an example, that in the corpus the cluster *sex drive* was only found in men's interviews. Moreover, it was observed that during the interviews men feel more entitled than women to talk about their own sexual life and it was argued that this might be another index of hegemonic masculinity.

[3] In his phenomenological analysis of perception (how we become aware of the sensory world around us) Merleau-Ponty (1962) challenged the dualistic legacy of Cartesian thought, rejecting the subject/object division between mind and body and the notion that the mind is the locus of subjectivity. Merleau-Ponty asserted that perception is inherently carnal and stems from being open to the world. In other words, when our mind perceives (observes, identifies), it does so through a practical and sensual *embodied* location within the social realm. A practical understanding of the body accounts for a fuller understanding of the way culture, customs, norms and routines materialize through lived experience. Merleau-Ponty's phenomenological body highlights the difference between studying the body as an object and the idea of *embodiment*, which refers to a perceptive way of knowing and experiencing the world through our own bodies. As embodied individuals, we all hold incarnate knowledge. Incarnate knowledge moves beyond speaking in the physicality of bodies, instead speaking within a body that is somatically perceptive.

Lasch (1979) and Elliott & Lemert (2006) stated that sexuality has become a key focus of personal identity, a reflexive condition of meaning in social relationships, intimacy and eroticism; in this respect, the analysis of the corpus clearly shows that sexuality is an important factor in shaping men's identity, in that especially young male respondents seem to be concerned with the potentially negative consequences of surgery and/or therapies on their sexual performances. By contrast, women do not seem to linger on sexual issues as an identity-shaping factor, in the same way as men do; their concerns seem to be more focused on the effect that an "impaired "sexuality" may have on the couple (however, here again age may play an important role). This seems to be in line with previous findings (Tannen 1990, Holmes 1995) according to which, in general, women are more oriented to affective, interpersonal meanings and relational issues than men.

So far we have discussed hegemonic masculinity; as regards women, the traditional model in this case is the mothering/nurturing model, which stems from what Hays (1996: 108) calls an "ideology of intensive mothering", exhibiting a logic of family and private life that requires a moral commitment to relationships grounded in affection and mutual obligations. The mothering model is indirectly hinted at in the women's KW list by means of high-ranking keywords belonging to the semantic field of family. Some female respondents linked women's better coping strategies and higher emotional competence to the experience of motherhood, which is conceived as strengthening and empowering, as well as an important feature of women's identity. In this respect, Ochs (1992: 337) asserts that images of women are linked to images of mothering and such images are socialized through communicative practices associated with caregiving.

Yet, as we have seen for men, women were also found to display in some cases a non-stereotypical image of femininity; some women respondents indeed claim for themselves identity-shaping qualities - traditionally perceived as masculine - like strength, willpower, pragmatism and rationality. However, as Cameron (2003) asserts, the construction of a gendered identity is not always accomplished by deploying gender appropriate styles of speech. "Masculine" or "feminine" speech style can be used by men and women to "perform" gender (Butler 1990), by using styles that are strikingly at odds with the expected gender norm (Cameron & Kulick 2003: 59). What is conveyed by using any particular style of speech cannot be interpreted in isolation from questions about the context and content of talk.

5.2 Linguistic devices to express masculinity and femininity

The linguistic devices which were found to be relevant in this study can be divided into three groups: *lexical, syntactic* and *pragmatic* devices.

5.2.1. Lexical and syntactic strategies

In the analysis chapter it was noted that men make a slightly higher use of technical terminology than women. What seems to be peculiar of men in the corpus is their higher reliance on technical measurements (especially in the PSA section). This is consistent with the observation by Eckert & McConnell-Ginet (2003) and Cameron (2003) that men tend to display technical competence as a prestige "enhancer".

Also according to Charteris-Black and Seale (2010), men following traditional masculine style (defined as "a discourse of distancing and avoidance" (2010: 53) show a discursive orientation to technical jargon, measuring and counting entities and processes to talk of their condition. It was hypothesised that this behaviour is related to gender ideologies and to men's need to feel "experts". This has a linguistic counterpart in a "hybrid" discourse, where emotional issues prompted by illness blend with a medical discourse, which gives more room to abstractions and technicalities. It could also be that men's higher reliance on numbers serves the double purpose of endorsing mainstream science values and of attempting to detach themselves emotionally from what is happening to their own bodies. However, another variable which should considered in this case is social class and education: maybe well-educated individuals are more familiar with technical jargon and feel more confident when they use it (cf. Eckert and McConnell-Ginet 2003: 47-48).

Another typical feature of male respondents is their high reliance on "sports discourse", as a way of framing their self, which adds to their self-esteem and may be generally related to a competitive dimension of traditionally masculine discursive style. This result is consistent with a similar observation made by Charteris-Black and Seale (2010)

In the KW analysis it was also observed than men more frequently use the adjective *radical* with technical nouns belonging to the semantic field of surgery (e.g. *radical prostatectomy* more frequent than *radical hysterectomy* or *radical mastectomy*).

A possible explanation why women use the adjective *radica*l less in these phrases is that they might feel disturbed by its drastic nature and its highly negative semantic connotation; moreover, it is possibly perceived as an expression of the impersonal (hence

frightening) and reductionist way that biomedicine frames the human being as an anatomo-pathological body-unit made of organs, tissues and cells. To put it differently, the technical/abstract language of *disease* does not comply with the personal/emotional dimension of *illness*. This is a further point which favours the notion that men might feel more at ease when dealing with technicalities, since these also give them the opportunity to recount their predicament in a seemingly detached and objective way, so avoiding the danger of seeming too involved emotionally. The overall outcome is that their register is more prone to being colonised/hybridised by medical "expert-ese".

Generally speaking however, the whole spoken corpus examined displays features of register hybridisation, in both men's and women's files, mainly due to the presence of oncological terminology. However, as hinted at before, corpus analysis has shown that men in particular use two features which are clearly borrowed from the academic registers of science and medicine: the collocation *watchful waiting* and the lexical bundle *the fact that.*

The digram *watchful waiting* was only found in men's interviews; if compared to the BNC, it was observed that the collocation was absent in the BNC spoken but was reported in the written section in excerpts of medical journals (namely, the *British Medical Journal*). Narrowing the field, it was also found that, according to the definition of the National Cancer Institute, *watchful waiting* is widely used in reference to urology conditions and in prostate cancer, referring to whether symptoms progress, stay the same or improve before patients' undergoing medical or surgical treatment.

Another cue of the higher register hybridization in male interviews was given by the analysis of the lexical bundle (Biber et al.1999: 988-999) *the fact that*. According to Biber et al. (1999: 650, 1016), this bundle is a stylistic index of academic prose, implying a locative/logical relation and providing the basis for some finding or assertion.

Another lexical bundle which was found more frequently in the male corpus is *one of the*; it was noted that it occurs often –as part of a larger extraposition structure (Biber et al. 1999: 1022) - within the pattern *one of the* (+ negative superlative adjective: *worst, most difficult*, etc.) + *experiences, things/reasons/causes/side effects* (+ *that*-clause), with a negative semantic prosody. The higher frequency of this lexical bundle in male interviews may be explained if we consider it as an item of a hyperbolic style typical of traditional masculinity (cf. the analysis of the cluster *one of the problems* in Charteris-Black and Seale 2010: 56-57), in that men following traditional styles of masculinity experience the disruption of illness as a linear sequence of reasons/problems/issues/experiences which undermines the way they are accustomed to dealing with life. Moreover, this bundle can

also be considered as another expression of reification (cf. Charteris-Black & Seale 2010: 56) by means of which men can distance themselves from the emotional implications of illness.

5.2.2. Pragmatic devices

In the comparative keyword analysis it was highlighted that the male KW list does not contain interactive/pragmatic devices. Comparatively, the female list presents not only technical keywords related to the gynaecological/oncological domain, and more KW related to the semantic field of family, but also words which are strictly related to the pragmatic/interactional nature of conversation, such as *know* (mostly in the form of the pragmatic particle *you know*), *because, just* and *really*. Such keywords fall within the wider category of discourse markers, which in this case can be conceived as "hedges" and "boosters" (Holmes 1995: 72), used to weaken or intensify the strength of an utterance (cf. Biber et al. 1999: 555, 1045-1047, Holmes 1995).

A feature which was only found in women's files was the use of *because* as a boundary marker or as an "add-on" device, typical of conversation, with an aim to extend the body of the utterance through an "add-on" strategy (other conjunctions used with a similar purpose are *and*, *so* and *but;* cf. Biber et al. 1999: 1078-1079). It should be added, however, that in the corpus analysis it was not always a straightforward task to ascertain whether *because* was used as a causal conjunction, as a boundary marker or as an "add-on" discursive device.

The keyword comparison raises the issue of the different use of pragmatic particles in male vs. female conversation and is consistent with Holmes' (1995: 87-88) statement that women tend to use pragmatic particles to express positive politeness more often than men do. This finding may be linked to women's higher sensitivity to the fact that what they are saying may threaten the interlocutor's face or to their higher attention to context when considering norms of politeness (Holmes 1995: 109).

Moreover, as Ochs (1992: 343) says, studies of women's speech in several societies indicate that women tend to be more polite than men and that they use linguistic structures that show support, approval of another - what Brown and Levinson (1987) have called "positive politeness", whereas men tend to use linguistic forms that indicate a sensitivity to the other's need not to be intruded upon - what Brown and Levinson have called "negative politeness".

As regards the pragmatic marker *you know*, according to Holmes (1995: 87-90), it conveys both referential and affective meaning, but women tend to use it with a primarily affective meaning and with an interactional function of other-oriented positive politeness, whereas men seem to focus more on its referential meaning.

As regards this doctoral thesis, it should be noted that *know* is a top ranking keyword in the female cancer corpus, whereas it is not a keyword in the male cancer corpus.

The higher frequency of *you know* in female conversations can be linked to their communicative style, which is allegedly more tentative, indirect, non-committal, and collaborative, if compared to men's competitive style (Lakoff 1975). It is noteworthy that most of these nuances can be covered by *you know*, which is therefore very versatile in conversation. Due to its versatility, speakers can employ *you know* to express high modality, as a hedge within a mitigating strategy, as a hesitancy filler, or as an expression prompting a sympathetic circularity sequence between speaker's statement and addressee's agreement/feedback.

Previous research in the language of illness underlined that *you know* as a pragmatic marker was more frequently found among women than men (Charteris-Black and Seale 2010: 106-107).

According to Lakoff's (1975) model of women's language (WL), women rely on hedges of all kinds more than men. However, some scholars (O'Barr and Atkins 1980, cit. in Cameron & Kulick 2003: 57) have questioned Lakoff's concept of WL: in their opinion, the linguistic devices that Lakoff considered typical of WL were rather to be interpreted as indices of (lack of) power rather than gender.

However, as Holmes (1995: 111) cleverly notes, the interpretation of the function and effect of such devices depends largely on the subjective assessment of the interpreters. One (female) person's hedge may be another (male) person's perspicacious qualification. Moreover, she adds, it is interesting to note that the association of linguistic markers of tentativeness and epistemic modal devices with insecurity, powerlessness, lack of confidence and subordination is restricted to studies of "women's language". For instance, epistemic devices are not interpreted in this way when used in scientific discourse (dominated by men), where they are regarded as evidence of judicious accuracy (Holmes 1995: 111). This suggests that women's subordinate societal status may account not so much for the way they talk, as for the way their talk is perceived and interpreted.

5.3. "Tumour humour"

Another feature which seems interestingly more attributable to male interviewees is the way they use self-irony in their accounts of illness, especially in the context of testicular cancer. This result was also highlighted by Chapple & Ziebland (2004).

Irony, boastful talk and bantering are typical features of male socialisation (Eckert & McConnell-Ginet 2003, Cameron & Kulick 2003); however, in this case the use of irony is polyvalent: men use irony (with a deflecting/avoiding function) to show to an ideal circle of male peers that they do not fear their difficult situation and that they can cope with it; moreover, humour seems also aimed at avoiding male peers' embarrassment in dealing with life-threatening issues. In this sense, it can be considered another expression of traditional masculinity, because it helps respondents to conform to the gender norm according to which heterosexual men are not supposed to make emotional disclosures with male peers, which might be perceived as indulging in homosexual/feminine behaviour.

Women were also shown to sometimes use self-irony (mainly when speaking of mastectomy). However, it was suggested that their use of humour was different from men's, in that they seem to use irony with a focus on the self and as an interactional strategy aimed at being accepted by an ideal circle of female friends.

5.4. Women and screening: Community of Practice

In the analysis chapter it was observed that the HT website promotes a discourse of cancer prevention, by stressing the need for screening (breast screening, cervical screening, PSA, bowel screening sections); this seems particularly evident in the women's sections, where a discourse of reassurance and solidarity is created and virtually addressed to other women. More precisely, in the HT comments, the word *screening* was often found in a semantically positive environment (positive semantic prosody).

Another cluster which was almost exclusively found in the introductory comments of the website is *to other women*. This cluster is not paralleled by **to other men* in the corpus. One possible explanation is that the website editors explicitly decided to create a discourse of female solidarity to support screening practices, in compliance with the NHS directives which provide for compulsory screening for women, but not for men. In that

regard, in the edited comments, the cluster *to other women* is often used with verbs of suggestion.

Similarly, corpus analysis also retrieved the following pattern (which was not found as frequently in the men's files):

Name of woman respondent/she + urge/advise/encourage/recommend + (other) women+ to + [expressions indicating screening or medical practices]

as in <c>Jane advises women to go for their smears regularly</c>

It can be suggested that the way the interviews are edited indicate the web editors' choice in favour of screening practices. If women seem to accept more eagerly screening procedures (which are also part of a UK national screening programme), the same does not hold for men; in the PSA screening interviews, several hints were found implying that men are discriminated against for not being involved in wider prevention programmes.

It is also possible to interpret the findings assuming that the website aims to create a *community of practice* (CoP; Lave & Wenger 1991, Eckert & McConnell-Ginet 1992, 2003). Since CoPs emerge as groups of people respond to a mutual situation, it could be that the website backs the idea that women are more apt to create bonds, and are consequently a more suitable target for successful awareness raising campaigns. However, it should be added that there is no evidence to ascertain whether this is done purposely, as a way of conforming to medical/governmental guidelines - another explanation being that this result is achieved unintentionally.

5.5. Ways forward: suggestions for future research

Other issues which, due to time restrictions, I could not elaborate on are the following:

1. Aspects related to social stigma in pathologies such as AIDS, mental illness, lung cancer, cervical cancer, bowel cancer. The focus might be on how stigmatised features (race, poverty, cultural differences, disability) are reflected in patients' illness narratives. I have noticed, for instance, that patients with a minority ethnic background tend to distrust the UK health system, along with the education system. Moreover, in the corpus several respondents from ethnic minorities reported that in their communities the stigma attached to mental illness was so strong that they preferred not to search for medical advice, or that it was a cause of reduced compliance with (or refusal of) the therapy. As for mental health patients, some of them interpret hospitalisation as an alienating and de-

humanising experience. The distrust in institutions is also voiced by respondents (or relatives of respondents) affected by autism, who seem to distrust specifically the education system (both school and university), in that they reported experiences of bullying and general incomprehension of their conditions.

2. Study of paralinguistic features (in particular laughters), hesitations and backchannel devices in men's and women's interviews. Impressionistically, there seems to be a different distribution of laughter in women's and men's interviews, which may be studied within the framework of conversation analysis. It seems that the backchannel cues between interviewer and interviewee are higher in the women's files. Considering that the interviewer is always a woman, this could raise questions about the kind of interaction which is established between the participants in the setting. It could be worthwhile expanding on whether the backchannel cues have a collaborative function in women's interviews (as reported in the literature, cf. Lakoff 1975 and Holmes 1995), and if there are differences with men's files. Such a study could also consider features like overlaps, interruptions, repetitions, pitch, hesitations and pauses in men's and women's speech.

References

Adler, A. (1938) *Social interest: A challenge to mankind.* London: Faber and Faber.

Adler, H. M.(1997) “The history of the present illness as treatment: who's listening, and why does it matter?” *Journal of the Board of Family Physicians, 10(1)*, pp. 28-35.

Althusser, L. (1971) *Lenin and Philosophy and other Essays.* New York & London: Monthly Review Press.

Badinter, E. (1992) *XY: de l'identite' masculine.* Paris: Odile Jacob.

Baker, P. (2008) *Sexed Texts: Language, Gender and Sexuality.* London: Equinox.

—. *Sociolinguistics and Corpus Linguistics.* Edinburgh: Edinburgh University Press, 2010.

Bamberg, M.(2011) “Narrative practice and identity navigation.” In *Varieties of narrative analysis*, by J.A. Holstein & J.F. Gubrium (Eds.), pp. 99-124. London: Sage.

Bamberg, M., De Fina, A. & D. Schiffrin (2006) *Discourse and Identity.* Cambridge: Cambridge University Press.

Barrett, F.J. & S.M. Whitehead (2001)*The Masculinities Reader.* Oxford & Malden, MA: Polity.

Bell, S. E. (2006) “Becoming a mother after DES: Intensive mothering in spite of all.” In *Discourse and Identity*, by Bamberg M., De Fina, A. & D. Schiffrin (eds.), pp. 232-252. Cambridge: Cambridge University Press.

Bem, S. (1993)*The Lenses of Gender: Transforming the Debate on Sexual Inequality.* New Haven: Yale University Press.

Biber, D. & E. Finegan (eds.) (1994) *Sociolinguistics Perspectives on Register.* Oxford: Oxford University Press.

Biber, D., Conrad, S. & R. Reppen (1998) *Corpus Linguistics: Investigating Language Structure and Use.* Cambridge: Cambridge University Press.

Biber, D., Conrad, S., Finegan, E., Johansson, S. & G. Leech. *Longman Grammar of Spoken and Written English.* London & New York: Longman, 1999.

Biber, D., Johansson, S., Leech, G., Conrad, S. & E. Finnegan (1999) *Longman Grammar of Spoken and Written English.* London: Longman.

Bing, J.M. & V.L. Bergvall (1998) “The Questions of Questions: Beyond Bynary Thinking.” In *Language and Gender: a Reader*, by Coates J. (ed.), pp. 495-510. Oxford & Malden, MA: Blackwell.

Bourdieu, P. (2001 [1998]) *Masculine Domination.* Oxford & Malden, MA: Polity.

Brigham Young University. *BYU-BNC (British National Corpus).* URL http://corpus.byu.edu/bnc/ (accessed 2011).

Brown, P. & S. Levinson (1987) *Politeness. Some universals in language use.* Cambridge: Cambridge University Press.

Butler, J. (1990) *Gender Trouble.* London: Routledge.

Cameron, D. & D. Kulick (2003) *Language and Sexuality.* Cambridge: Cambridge University Press.

Cameron, D. (1997) "Performing Gender Identity." In *Language and Masculinity*, by Johnson, S. & U. H. Meinhof (eds.), pp. 47-64. Oxford & Cambridge, MA: Blackwell.

Caron, A.M. (2001) "That's another story: narrative methods and ethical practice." *Journal of Medical Ethics, 27*, pp.198-202.

Chapple, A. & S. Ziebland (2004) "The Role of Humour for Men with Testicular Cancer." *Qualitative Health Research vol. 14 n. 8*, pp. 1123-1139.

Charon, R. (2000) "Literature and Medicine: Origins and Destinies." *Academic Medicine, 75(1)*, pp. 23-27.

Charon, R. (2001) "Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust." *Journal of the American Medical Association (286)*, pp.1897-1902.

—. *Narrative Medicine: Honoring the Stories of Illness.* Oxford: Oxford University Press, 2006.

Charon, R. (1986) "To render the lives of patients." *Literature and Medicine (5)*, pp. 58-74.

Charteris-Black, J. & C. Seale (2010) *Gender and the Language of Illness.* London & New York: Palgrave MacMillan.

Cheshire, J. & S. Ziebland (2005) "Narrative as a resource in accounts of the experience of illness." In *The Sociolinguistics of Narrative*, by Thornborrow J. & J. Coates (eds.), pp. 17-40. Amsterdam: John Benjamins.

Chodorow, N. (1978)*The Reproduction of Mothering. Psychoanalysis and the Sociology of Gender.* Berkeley: University of California Press.

Chouliaraki, L. & N. Fairclough (1999) *Discourse in Late Modernity: Rethinking Critical Discourse Analysis.* Edinburgh: Edinburgh University Press.

Cicourel, A. V. (1985) "Doctor-Patient Discourse." In *Handbook of Discourse Analysis, vol.4*, by Van Dijk, T. (ed.), pp. 193-215. London: Academic Press.

Coates, J. (ed.) (1998) *Language and Gender: a Reader.* Oxford & Malden, MA: Blackwell.

Coates, J. (2003) *Men talk.* Oxford & Malden, MA: Blackwell.

—. (1986) *Women, Men and Language.* London: Longman.

Connel, R. W.(1995) *Masculinities.* Berkeley: University of California Press.

Coupland, N. (2001) “Age in social and sociolinguistic theory.” In *Sociolinguistics and Social Theory*, by Coupland N., Sarangi S. & C. N. Candlin (eds.), pp.185-211. Harlow: Pearson Education.

Couser, G. T. (1997) *Recovering Bodies: Illness, Disability and Life Writing.* Madison: The University of Wisconsin Press.

Das, V., Kleinman, A. & M. Lock (eds.) (1997) *Social suffering.* Oxford: Oxford University Press.

Davis, K., Evans, M. & J. Lorber (2006) *Handbook of Gender and Women's Studies.* London: Sage.

De Beauvoir, S. (1949) *Le deuxième sexe.* Paris: Gallimard.

Duranti, A. & C. Goodwin (eds.) (1992) *Rethinking Context: Language as an interactive phenomenon.* Cambridge: Cambridge University Press.

Eckert, P. & S. McConnell-Ginet (2003) *Language and Gender.* Cambridge: Cambridge University Press.

Eckert, P. & S. McConnell-Ginet (1992) “Think practically and act locally: language and gender as community-based practice.” *Annual Review of Anthropology 21*, pp. 461-490.

Eckert, P. (1997) “Age as a Sociolinguistic Variable.” In *The Handbook of Sociolinguistics*, by Coulmas F. (ed.), pp.151-167. Oxford & Cambridge, MA: Blackwell.

Elliott, A. & C. Lemert (2006)*The new individualism: the emotional costs of globalization.* London: Routledge.

Elwyn, G. & R. Gwyn (1999) “Narrative based medicine: Stories we hear and stories we tell: analysing talk in clinical practice.” *British Medical Journal (318)*, pp. 186-188.

Eriksson, K. & L. Fredriksson (2001) “The patient’s narrative of suffering: a path to health?” *Scandinavian Journal of Caring Sciences, 15*, pp. 3-11.

Erman, B. (2001) “Pragmatic markers revisited with a focus on you know in adult and adolescent talk.” *Journal of Pragmatics 33*, pp. 1337-1359.

Ervin-Tripp, S. and A. Kyratzis (1999) “The Development of Discourse Markers in Peer Interaction.” *Journal of Pragmatics 31*, pp.1321-1338.

Ezzy, D. (2000) “Illness narratives: time, hope and HIV.” *Social Science & Medicine, 50*, pp. 605-617.

Fairclough, N. (1989) *Language and power.* London & New York: Longman.

Fielder, L.A. (1996)*Tyranny of the normal: essays on bioethics, theology & myth.* Boston: Godine.

Fleischmann, S.(1999) "*I am..., I have..., I suffer from...*: A Linguist Reflects on the Language of Illness and Disease." *Journal of Medical Humanities, 20(1)*, pp. 1-32.

Foucault, M. (1991[1975]) *Discipline and Punish: The Birth of the Prison.* London: Penguin.

—. (1976) *La Volonté de Savoir: Histoire de la Sexualité 1.* Paris: Gallimard.

—. (1963) *Naissance de la Clinique.* Paris: PUF.

Foucault, M. (1980) "The eye of power." In *Power/knowledge: selected interviews and other writings 1972-1977* , by Gordon C. (ed.), pp.146-165. New York: Pantheon Press, 1980.

Frank, A. W. (1995)*The Wounded Storyteller: Body, Illness and Ethics.* Chicago: University of Chicago Press .

Freud, S. *Totem and Taboo, 23rd edition.* London: Routledge, 1999 [1912-1913].

Galimberti, U. (1987) *Gli equivoci dell'anima.* Milano: Feltrinelli.

—. (1992) *Idee: il catalogo è questo.* Milano: Feltrinelli.

—. (1983) *Il Corpo: Antropologia, Psicoanalisi, Fenomenologia.* Milano: Feltrinelli.

—. (2009) *Psiche e techne: L'uomo nell'età della tecnica, Opere Vol. XII.* Milano : Feltrinelli.

Gee, J. P. (2004) *An Introduction to discourse analysis: Theory and method.* London: Routledge.

Ghadessy, M. (ed.) (1993) *Register Analysis: Theory and Practice.* London & New York: Pinter Publishers.

Giarrelli, G. & E. Venneri (2009) *Sociologia della salute e della medicina. Manuale per le professioni mediche, sanitarie e sociali.* Milano: FrancoAngeli.

Giddens, A. (1991) *Modernity and Self-Identity: Self and Society in the Late Modern Age.* Cambridge: Polity.

Gilmore, D. (1990) *Manhood in the Making: Cultural Concepts of Masculinity.* New Haven & London: Yale University Press.

Goffman, E. (1961) *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates.* New York: Doubleday.

—. (1981) *Forms of Talk.* Oxford & Malden, MA: Blackwell.

—. (1968) *Stigma: Notes on the Management of Spoiled Identity.* Harmondsworth: Pelican Books.

—. (1959)*The Presentation of Self in Everyday Life.* New York: Doubleday Anchor.

Good, B. J. (1994) *Medicine, rationality and experience: an anthropological perspective.* Cambridge: Cambridge University Press.

Gotti, M. (1991) *I linguaggi specialistici.* Firenze: La Nuova Italia.

Gramsci, A. (2001[1947]) *Quaderni dal Carcere.* Torino: Einaudi.

Greenhalgh, T. & B. Hurwitz (1998) *Narrative Based Medicine.* London: BMJ Books.

Greenhalgh, T. & B. Hurwitz. (1999) "Narrative based medicine: why study narrative." *British Medical Journal, 318*, pp. 48-50.

Greenhalgh, T. (1999) "Narrative based medicine: Narrative based medicine in an evidence based world." *British Medical Journal, 318*, pp. 323-325.

Greenhalgh, T., Hurwitz, B. & V. Skultans (eds.) (2004) *Narrative Research in Health and Illness.* London: BMJ books.

Grice, H. P. (1989) *Studies in the Way of Words.* Cambridge, MA: Harvard University Press.

Gumperz, J.J. & D. Hymes (eds.) (1972) *Directions in Sociolinguistics: The Ethnography of Communication.* New York & London: Holt, Rinehart and Winston.

Halliday, M.A.K. & R. Hasan (1989) *Language, Context, and Text: Aspects of Language in a Social-Semiotic Perspective.* Oxford: Oxford University Press.

Hamilton, H. E., Schiffrin, D. & D. Tannen (eds.) (2001) *The Handbook of Discourse Analysis.* Oxford & Malden, MA: Blackwell.

Hays, S. (1996) *The cultural contradictions of motherhood.* New Haven: Yale University Press.

Hoey, M. (2007) "Lexical priming and literary creativity." In *Text, Discourse and Corpora: Theory and Analysis*, by Hoey M., Mahlberg, M., Stubbs, M. & W. Teubert (eds.), pp. 7-30. London & New York: Continuum.

Hoey, M., Malberg, M., Stubbs, M. & W. Teubert (eds.) (2007) *Text, Discourse and Corpora: Theory and Analysis.* London & New York: Continuum.

Hudson Jones, A. (1999) "Narrative in medical ethics." *British Medical Journal, 318*, pp. 253-256.

Hurwitz, B. (2000) "Narrative and the practice of medicine." *Lancet, 356*, pp.2086-2089.

Hydén, L.-C. "Illness and narrative." *Sociology of Health & Illness, 19*, 1997: 48–69.

Illich, I. (1976) *Medical Nemesis: the Expropriation of Health.* New York: Pantheon.

Jakobson, R. (1960) "Closing statement: Linguistics and poetics." In *Style in lauguage*, by Sebeok T. A. (ed.), pp. 350-377. Cambridge, MA: MIT Press.

—. (1963) *Essais de linguistique générale.* Paris: Minuit.

Johnson, S. & U. H. Meinhof (eds.) (1997) *Language and Masculinity.* Oxford & Malden, MA: Blackwell.

Johnson, S. (1997) “Theorizing Language and Masculinity.” In *Language and Masculinity*, by Johnson S. & U. H. Meinhof (eds.), pp. 8-26. Oxford & Cambridge, MA: Blackwell.

Kiesling, S.F. (2006) “Hegemonic identity-making in narrative.” In *Discourse and Identity*, by Bamberg M., De Fina, A. & D. Schriffin (eds.), pp. 261-287. Cambridge: Cambridge University Press.

Kitzinger, C. (2000) “How to resist an idiom.” *Research on Language and Social Interactionm, vol. 33(2)*, pp.121-154.

Kleinman, A. (1980) *Patients and healers in the context of culture : an exploration of the borderland between anthropology, medicine, and psychiatry.* Berkeley: University of California Press.

—. (1988)*The Illness Narratives: Suffering, Healing and the Human Condition.* New York: Basic Books.

—. (2006) *What really matters: living a moral life amidst uncertainty and dange.* Oxford: Oxford University Press.

Kyratzis, A. & S. Ervin-Tripp (1999) “The development of discourse markers in peer interaction.” *Journal of Pragmatics 31* , pp.1321-1338.

Labov, W. & J. Waletzky (1967) “Narrative analysis.” In *Essays on the Verbal and Visual Arts*, by Helm J. (ed.), pp.12-44. Seattle: University of Washington Press.

Labov, W. (2001) *Uncovering the event structure of narrative-Georgetown University Round Table 2001.* URL http://www.ling.upenn.edu/~wlabov/uesn.pdf (accessed 9-10-2009).

Lakoff, G. & M. Johnson (1980) *Metaphors We Live By.* Chicago: University of Chicago Press.

Lakoff, R. (1975) *Language and Woman's Place.* New York: Harper & Row.

Langellier, K.M. (2001) “Personal narrative.” In *Encyclopedia of Life Writing: Autobiographical and Biographical Forms, Vol. 2*, by Jolly M. (ed.), pp. 699-701. London: Fitzroy Dearborn.

Lasch, C. (1979)*The Culture of Narcissism: American Life in an Age of Diminishing Expectations.* New York: Norton.

Lave, J. & E. Wenger (1991) *Situated Learning: Legitimate Peripheral Participation.* Cambridge: Cambridge University Press.

Lemert, C. & A. Elliott (2006) *Deadly worlds: the emotional costs of globalization.* Lanham (Maryland): Rowman & Littlefield.

Luce, A. (1966) “Berkeley's New Principle Completed.” In *New Studies in Berkeley's Philosophy*, by Steinkraus W. E. (ed.), pp. 1-12. New York: Holt, Rinehart & Winston.

Maci, S. M. (2008). The Research Letter: an emerging medical genre. In *Identity and Culture in English Domain-specific Discourse,* by Di Martino, G., Polese, V. & M. Solly (eds.) *,* pp. 367-390. Napoli: Edizioni Scientifiche Italiane.

Maci, S. M. (2009). The Migration of Scientific Knowledge into Alternative Forms of Research Articles: The Case of Medical Research Letters. In *Forms of Migration. Migration of Forms,* by Torretta, D., Dossena, M. & A. Sportelli (eds.), pp. 479-495. Bari: Progedit.

Maci, S. M. (2011). Genre variation in medical discourse: the case of medical posters. In *Genre(s) on the Move: Hybridization and Discourse Change in Specialized Communication,* by Sarangi, S., Polese, V. & G. Caliendo (eds.), pp. 169-190. Napoli: Edizioni Scientifiche Italiane.

Mailer, N. (1968) *The Armies of the Night: History as a Novel / the Novel as History.* London : Penguin.

Mancini, M. & R. Rogers (2007) "Narratives of Recovery from Serious Psychiatric Disabilities: A Critical Discorse Analysis." *Critical Approaches to Discourse Analysis across Disciplines, 1(2)*, pp. 35-50.

Maturo, A. (2007) *Sociologia della malattia: un'introduzione.* Milano: FrancoAngeli.

Mc Enery, T., Xiao, R. & Y. Tono (2006) *Corpus-based language studies.* London & New York: Longman.

McElhinny, B. (2003) "Theorizing Gender in Sociolinguistics and Linguistic Anthropology." In *The Handook of Language and Gender*, by Holmes J. & M. Meyerhoff (eds.), pp. 21-42. Oxford & Malden, MA: Blackwell.

McEnery, T. & A. Wilson (1996) *Corpus Linguistics.* Edinburgh: Edinburgh University Press.

McLellan, M.F. (1997) "Literature and medicine: narratives of physical illness." *Lancet, 349*, pp. 1618-1620.

Merleau-Ponty, M. (2005[1962]) *Phenomenology of perception.* London: Routledge.

Miller, T. (2009) "Masculinity." In *A Companion to Gender Studies*, by Essed P., Goldberg D.T.& A. Kobayashi, pp. 114-131. Oxford & Malden, MA: Wiley-Blackwell.

Mishler, E.G. (1999) *Storylines: craftartists' narratives of identity.* Cambridge, MA: Harvard University Press.

Monod, J. (2001[1970]) *Il Caso e la Necessita'.* Milano: Mondadori.

Monti, C., Bendazzoli, C., Sandrelli A. & M. Russo (2005) "Studying Directionality in Simultaneous Interpreting through an Electronic Corpus: EPIC (European Parliament Interpreting Corpus)" *Meta: Translators' Journal*, 50(4).

Moore, L.J.& M. Kosut (eds) (2010) *The Body Reader: Essential Social and Cultural Readings.* New York & London: New York University Press, 2010.

Nicholson, L.(1994) “Interpreting gender.” *Signs: Journal of Women in Culture and Society, 20(1)*, pp. 79-105.

Ochs, E. (1992) “Indexing gender.” In *Rethinking Context: Language as an interactive phenomenon*, by Duranti A. & C. Goodwin (eds), 335-358. Cambridge: Cambridge University Press.

Ong, W.J. (1982) *Orality and literacy: the technologizing of the world.* London & New York: Methuen.

Orgad, S. (2006) “The cultural dimensions of online communication: a study of breast cancer patients’ internet spaces.” *New Media & Society, 8(6)*, pp. 877-899.

Overcash, J.A. (2003) “Narrative research: a review of methodology and relevance to clinical practice.” *Critical Revues in Oncology/Hematology, 48*, pp.179-184.

Owen, W.F. (1984) “Interpretative Themes in Relational Communication.” *The Quarterly Journal of Speech, 70*, pp. 274–287.

Partington, A. (2006)*The Linguistics of Laughter: A Corpus Assisted Study of Laughter Talk.* London: Routledge.

Quaranta, I. (ed)(2006) *Antropologia medica.* Milano: Raffaello Cortina.

Riley, T. & P. Hawe. (2005) “Researching practice: the methodological case for narrative enquiry.” *Health Education Research, 20(2)*, pp. 226-236.

Sacks, O. (1991) *A Leg to Stand On.* London: Picador.

—. (1973) *Awakenings.* New York: E.P. Dutton.

—. (1986) *Migraine: understanding a common disorder.* Berkeley : University of California Press.

—. (1985)*The man who mistook his wife for a hat and other clinical tales.* New York: Summit Book.

Sarangi, S.& M. Coulthard (eds) (2000) *Discourse and social life.* London & New York: Longman.

Schiffrin, D. (1987) *Discourse Markers.* Cambridge: Cambridge University Press.

Schiffrin, D. (2006) “From linguistic reference to social reality.” In *Discourse and Identity*, by Bamberg M., De Fina, A. & D. Schiffrin (eds.), pp.103-131. Cambridge: Cambridge University Press.

Scott, M. (2008) *Wordsmith Tools version 5.* Liverpool.

Seidler, V. J. (1989) *Rediscovering masculinity: reason, language, and sexuality.* London: Routledge.

Sontag, S. (1991) *Illness as Metaphor & AIDS and its Metaphors.* London: Penguin Books.

Stoller, R. (1985) *Presentations of Gender.* New Haven, MA: Yale University Press.

Stubbs, M. (2007) “On texts, corpora and models of language.” In *Text, Discourse and Corpora: Theory and Analysis*, by Hoey M., Mahlberg, M., Stubbs, M. & W. Teubert (eds.), pp.127-162. London & New York: Continuum.

—. (2001) *Words and phrases: corpus studies of lexical semantics.* Oxford & Malden, MA: Blackwell.

Tagliamonte, S. & Hudson, R. (1999) “Be like et al. beyond America: The quotative system in British and Canadian youth.” *Journal of Sociolinguistics 3/2*, pp.147-172.

Tannen, D. (1991) *You just don't understand: Women and Men in Conversation.* London: Virago.

Tannini, L. (2008) *Medicina narrativa e medical humanities.* Milano: Raffaello Cortina.

Teubert, W. (2007) “Parole-linguistics and the diachronic dimension of discourse.” In *Text, Discourse and Corpora: Theory and Analysis*, by Hoey M., Mahlberg, M., Stubbs, M. & W. Teubert (eds.), pp. 57-88. London & New York: Continuum.

Tognini-Bonelli, E. (2001) *Corpus Linguistics at Work: Studies in Corpus Linguistics.* Amsterdam: John Benjamins.

Waitzkin, H. (1989) “A Critical Theory of Medical Discourse: Ideology, Social Control, and the Processing of Social Context in Medical Encounters.” *Journal of Health and Social Behavior Vol. 30 (June)*, pp. 220-239.

Weiss, G. & R. Wodak (eds) (2003) *Critical Discourse Analysis: Theory and Interdisciplinarity.* London & New York: Palgrave Macmillan.

Whitehead, S. M. (2002) *Men and masculinites.* Malden, MA: Blackwell.

Wittgenstein, L. (2006[1953]) *Philosophical Investigations.* Oxford & Malden, MA: Blackwell.

Wodak, R. (ed.) (1997) *Gender and Discourse.* London: Sage.

Woodward, K. (1997) *Identity and Difference.* London: Sage.

Zaner, R. M. (2004) *Conversations on the Edge: Narratives of Ethics and Illness.* Washington: Georgetown University Press.

Zannini, L. (2008) *Medical humanities e medicina narrativa: Nuove prospettive nella formazione dei professionisti della cura.* Milano: Raffaello Cortina.

Ziebland, S. & A. McPherson (2006) “Making sense of qualitative data analysis: an introduction with illustrations from DIPEx (personal experiences of health and illness).” *Medical Education 40(5)*, pp. 405-414.

Contents

Tables