Gender
and
Language

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Article

Men and emotion talk:
Evidence from the experience of illness

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Abstract

Evidence is presented supporting the view that serious illness is often interpreted by men as an opportunity for emotional expressivity, contrasting with language and gender ideologies that stress men's deficiencies in this realm. Comparative analysis of a large matched corpus of male and female interviews concerning the experience of a wide range of illnesses is reported. Illness experience prompts a process of biographical disruption for men resulting in a highly varied verbal repertoire. Compared with women discussing the same kind of experience, some men employ direct 'on the record' styles such as swearing, while others employ indirect 'off the record' distancing strategies, such as metaphor and generalisation that reify illness experience by externalising it as a problem. Some men express high levels of frustration, while others use a more self-conscious 'women's language' of feelings that enables them to construct new identities. Such men associate this with the capacity for new and, paradoxically, more powerful performances of masculine identity.

KEYWORDS: GENDER, MEN, EMOTION, FEELING, ILLNESS EXPERIENCE

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Introduction

A belief that was previously widespread in the ideology of gender was that men – as compared with women – are deficient in the communication of their feelings and emotions. For example:

> Femininity and female roles are associated with the ability to experience, express, and communicate emotions to others, and to empathize with others' feelings, whereas masculinity and male roles are defined as the ability to suppress and control one's emotions. (Fischer and Manstead 2000: 91)

However, a growing body of contemporary theory has proposed that the performance of masculinity is heterogeneous and influenced by more local contextual factors (e.g. Bergvall 1999; Brod and Kaufman 1994; Connell and Messerschmidt 2005; Emslie et al. 2006; Galasiński 2004; Hearn and Morgan 1990; O'Brien et al. 2005; Whitehead and Barrett 2001). According to these perspectives, men are best regarded as agents in creating their own gendered identity and draw on a range of culturally available discursive repertoires according to their communicative purposes within specific contexts of interaction. This entails the construction of a varied range of locally produced masculinities rather than a single context-independent 'hegemonic' one. As Galasiński (2004: 144) summarises:

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

The purpose of the research described here is to investigate how the biographical disruption of illness may reflect in men's language use. Health sociologists have sought to contribute to an understanding of the impact of serious illness on gendered performance, usually following popular language ideology in identifying a lack of emotional expressiveness as a particular problem in relation to male health issues. The nurturing characteristics of 'feminine' styles, so this argument goes, are likely to be especially appropriate in the case of sickness, where people may benefit from expressing their feelings about their situation. Indeed illness has been identified by health sociologists as an area of experience in which 'women's' style predominates:

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

There is a large body of empirical research in health sociology identifying men's reluctance to seek help from health professionals (Addis and Mahalik 2003; Sabo and Gordon 1995). A typical example of such a study is that of O'Brien, Hunt and Hart (2005: 514) who suggest men are reluctant to talk about health concerns and health behaviour:

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

Health sociologists, concerned to improve men's help-seeking behaviour when ill, have at times argued that challenging 'hegemonic' masculine formats may benefit men's health by, for example, enabling them to seek medical help at the first sign of symptoms (O'Brien et al. 2005). Yet these, and many other studies in the field of health sociology, rely on a reading of an account of events and experiences occurring outside the particular context of the interview or focus group setting in which the account is produced. The performative element of the interview or focus group setting itself is thereby often neglected. It is, it seems to us, quite possible that men may tell stories about their performance of stereotypically masculine identities, but may do so in ways that are in themselves revealing of different kinds of masculine performance. We will address the question of whether men who give accounts of their illness in interview settings conform to 'hegemonic masculinity' (Connell 1995; Connell and Messerschmidt 2005) by suppressing emotional expressivity – or perform more varied versions of masculinity.

Illness experience potentially provides a rich source of insight into how gender identities are reinforced, performed or contested. This is because illness produces biographical disruption (Bury 1982), interfering with the 'normal' performance of social roles and often requiring a concomitant narrative reconstruction of the self (Riessman 1990; Williams 1984). As Butler (1990: 33) has observed:

> Gender is the repeated stylisation of the body, a set of repeated acts within a highly rigid regulatory frame that congeal over time to produce the appearance of substance, of a 'natural' kind of being.

However, in the context of illness the question arises of whether the experience of an ailing body that may no longer be able to engage in 'a set of repeated acts' influences the gendered performance of identity. In this paper

we investigate some linguistic evidence for emotion expression in a large collection of interviews with men and women who have experienced illness with a particular focus on how contemporary masculine identities are verbalised. We find evidence supporting the proposition that the experience of illness elicits a varied verbal repertoire by men that includes direct 'hegemonic' styles such as swearing and the direct expression of feelings as well as indirect distancing strategies such as metaphor, generalisation and externalisation. The experience of undergoing often life-threatening illness leads some men to explore the potential of new identities, while others retain direct expressive styles such as swearing or other indirect styles for the expression of emotion.

Gender, emotion, feeling and language

Characterising both the 'dominance' and the 'difference' paradigms in sociolinguistic accounts of gender has been the belief that there are binary differences in gender styles. Within these paradigms, which have themselves been implicated in the support and promotion of language ideologies – for example in health sociology – the female style is described as one of rapport, sympathy, intimacy and cooperation while the male style is one of reporting, problem-solving, independence and competition (Talbot 2003: 475). As Lakoff (2003: 163) summarises:

> Until very recently, men were not supposed to cry or express sadness; women were not permitted to express anger, including the use of swear words.

The application of the label 'hegemonic masculinity' to explain this has, for some researchers, become almost axiomatic:

> The absence of talk about feelings is perhaps the most notable consequence of 'the constraining hand of hegemonic masculinity' in the conversations I've collected. The imperative to avoid vulnerability means that men have to put a lot of effort into keeping up a front (or wearing a mask) ….. although it is acknowledged that men and boys have a lot of fun together, at the same time there is a sense 'of something missing emotionally'. This sense of something missing in men's talk is the strongest evidence of some kind of crisis of contemporary masculinity. (Coates 2003: 197–199)

The main argument here is that men conceal their emotions and avoid revealing themselves as vulnerable in their quest to maintain a self-presentation of themselves as masculine: 'men's stories are characterized by emotional constraint, whereas personal self-disclosure is typical of women's stories' (Coates

2003: 137). The emotional restraint of men is traced to their dominant role in public life which requires indirectness since exposure of emotions could be potentially face-threatening. Women are perceived to dominate the private sphere of the home where self-disclosure is less face threatening. Emotions may readily be revealed in a domestic setting in a way that would be prohibited or socially disapproved in an 'onstage' or public setting. From this perspective – one that is by no means unique to Coates (e.g. Tannen 1992) – men become silent in the presence of the emotionally private in the same way that women become silenced in the traditional style of public discourse. However, it is questionable how far hegemonic notions apply to all men; for example, Emslie et al. (2006) propose that the concept conceals forms of masculinity in which some men construct themselves as different from dominant norms, while others might not have been strongly influenced by hegemony in the first place. This leads us – along with researchers such as Cameron (1997) and Hewitt (1997) – to take a more critical view on the claimed deficiency of 'men' in emotional expression and argue that men's language has evidence of hegemony, resistance to hegemony and an absence of characteristics that are explained by gender altogether.

Scientific research into the emotions is characterised by a distinction between 'naturalistic' and 'social constructionist' views on emotion. Naturalistic views of the emotions associated with Ekman (1972) propose a set of physiologically based modular affects including facial expression and nervous system arousal that characterise emotional responses and occur in all cultures. Emphasis on the evolutionary roots of these affective responses implies that they are universal dispositions to respond in a predictable way; for example, fear of the dark may be a natural way to respond in all cultures. Conversely, the social constructionist view emphasises more complex, culture-specific emotional phenomena that vary across cultures, and may vary between genders. As Griffiths (1997: 10) summarises:

> The most interesting insights of constructionism are embodied in the view that there are emotional responses whose existence depends on the existence of cultural models of normal emotional response. These responses are interpreted by the subject and their society as natural and involuntary when they are in fact produced in conformity to local cultural models.

Social constructionists such as Harré (1986) focus on the *causes* of emotion, rather than on their physiological characteristics and emphasise the considerable variation between the causes of an apparently similar emotion in different cultures; the claim is that there is very little in common between these causes to permit the emotion to be categorised as the same. Other researchers such

as Damasio (2003) integrate these views by drawing a distinction between innate, primary emotions located in the limbic system and acquired secondary emotions that are mediated by higher brain centres. Therefore unlike the social constructionists he still incorporates a role for the underlying biological basis for the emotions.

In relation to gender and illness experience, we might anticipate that many types of illness are likely to be characterised by physiological changes; however, we might also expect that how men and women respond to traumatic events may be influenced by social constructions as to how men and women should deal with such trauma. It may well depend on the previous experience of particular individuals as to how far they have a pre-existent cultural model for how to 'do' illness; factors that could influence this might include age, social class, and family composition. In this respect, while emotions may at least be partially socially constructed, it is not easy to identify *which* cultural models might apply in the complex social interactions entailed by increased mobility and the growth in global networks. Nor is language itself the only semiotic mode for 'doing' emotion; Goodwin and Goodwin (2001) locate emotion in activity systems that include the lexicon, embodied action and other sign systems that are available to actors. A study of leadership communication emphasises the effects that symbolic actions such as handshaking, crying in public, fasting, marathon swims, forced departures, magical reappearances and other dramatic performances may have on the feelings of followers (Charteris-Black 2007). It is therefore one thing to claim that emotions are socially constructed – a claim that we would not disagree with – and another to know what cultural models may influence them and through what modes they are expressed. How individuals respond emotionally to illness is therefore likely to be influenced by an interaction between the nature of the illness itself, the range of socially constructed cultural models that are available and the individual's personal resources for responding to the challenges it presents.

Since this study focuses on language alone, and in particular because it focuses on keywords, we briefly consider studies that have been undertaken of the emotional lexicon of English (and other languages) to identify how emotions are verbalised. A major issue has been the extent to which there is linguistic evidence for conceptualisations that correspond with the physiological effects of emotion. For example, is there linguistic evidence that an emotion such as anger is always conceptualised as the build up of pressure within a container (Lakoff 1987)? Cross-linguistic enquiry has led cognitive linguists to face the same type of issues regarding whether emotions are socially constructed or universal as we have considered above in relation to theories of emotion. Kövecses (2000 and 2005) takes a similarly integrationist perspective to that of

Damasio, arguing that general schemas based on universal physiological bases for emotion concepts are filled out with culturally specific content. For example, there is linguistic evidence in Hungarian; Chinese and English for the underlying conceptualisations HAPPY IS UP and HAPPINESS IS LIGHT; however, in Chinese there is also linguistic evidence for HAPPINESS IS FLOWERS IN THE HEART. This reveals the possibility that different cultures may express the same emotion of happiness in quite different ways. The focus on the lexicon alone has been a problematic issue for linguistic anthropologists who point out the pervasiveness of emotion throughout *all* language structure and use (e.g. Ochs and Schieffelin 1989). Nonetheless, the keyword approach employed in this paper has the advantage of drawing inferences from large amounts of authentic language without any initial intrusion by the researcher as to which individuals to select for investigation of the emotions.

As regards evidence from English and other European languages concerning the verbalisation of emotion, Kövecses (2000) summarises various expert theories of the emotions as follows:

> Emotion as physical agitation or bodily disturbance. (Young 1943)
> Emotion as a kind of force or drive that impels the person to respond. (Plutchik 1980)
> Emotion as subjective physical sensations. (Schacter 1971)

All these western models for emotion represent it as something that is experienced by individuals in the same way everywhere, whereas other cultural models taking a more social constructionist perspective represent emotion as arising from the interaction between the individual and her society and culture (see Lutz and White 1986). Expert models for emotion imply bodily disturbances that force people to be aware of their physical sensations but in no way predict how they may be linguistically expressed. Since an illness diagnosis suddenly changes the normal state of the body, the resulting loss of control is likely to have an effect on the emotions. Emotions, like illnesses, are characterised by physiological changes and Ekman (2000) provides empirical evidence that bodily activity precedes feelings. Cognitive linguists of a more universalist orientation find evidence for the embodied nature of cognition in the verbalisation of emotion with verbs and nouns that express the motion of liquids within a container – in the case of English this is evident in words such as 'waves', 'surges', 'swells' and 'undercurrents', or of pressures on the container – as in 'floods', 'outbursts', 'pouring out', 'gushing' etc. (Goatly 2007: 197ff.). Such expressions entail that the body is experienced as a container and the inherent instability of emotions may be conceptually traced to the association of emotion with changed states and loss of control as the forces that build up in a container pressurise its boundaries.

However, universalist cognitively-orientated accounts of the emotions tend towards perspectives which may not be entirely appropriate when considering the influence of socially constructed categories such as gender on emotional expressivity. In a study of fraternity culture, Kiesling (2005) shows that when 'doing friendship' individual men express feelings indirectly rather than through explicit verbalisation. Homosocial desire is expressed through a variety of indirect language activities, including talk about sporting events. Kiesling reinforces the important point that masculinity is not unitary or necessarily 'hegemonic' but is composed of 'multiple, sometimes conflicting cultural discourses' (Kiesling 2005: 722). A view of 'men' (or 'men's language') as emotionally constrained or expressively inhibited is therefore problematic in so far as it overlooks variation in the performance of masculinity. Effectively, such treatments of male language essentialise men in the same way that descriptions of women's language as 'over-emotional' essentialise women – that is, they fall into the trap of more 'naturalist' thinking by treating all men, everywhere, as if they were the same. Some support for the view that men perform a range of identities in interview settings is provided by Emslie et al. (2006), who found variation from stereotypes in their analysis of 38 interviews with men with depression that form a component of the data we analyse here. These authors argue that while some men did indeed reconstruct their identity around hegemonic masculinity by being 'one of the boys' and seeking to re-establish control, others emphasised their difference from and sometimes superiority to this version of masculinity by creating performances that displayed themselves as emotionally sensitive. They support Warren's (1983) claim that depression is incompatible with conventional masculine identities. However, these studies seem still to make assumptions about what constitutes the norms of masculine behaviour by creating polarities between men who perform conventional masculine identities and those who don't – rather than challenging the basis for such presuppositions.

This paper extends this work by Emslie et al. (2006) by considering men suffering from a much wider range of illness experiences and therefore has social implications for men who are more generally affected by illness. If illness is indeed to be considered a 'feminine' domain in popular language ideology the question arises of whether this disables men in their development of new narratives of self. In our research we identify linguistic evidence of both conformity and resistance to such gender stereotypes, including several men who attempt a redefinition of gender identity that neither fits with outright reinforcement or rejection of gender stereotypes.

Methods

The data for this study were drawn from a large sample of 1,036 qualitative interviews with people who had experienced a health or illness condition (either as a patient or as a carer) held by DIPEx at Oxford University (www.DIPEx.org.uk). The purpose of the interviews was to provide publicly available information via a web site for the use of those wanting to know more about illness experience from the perspective of those influenced by it. Interviewees were aware that their accounts of a very private experience would be made publicly available in this way. Awareness of this context is important in understanding our study as an investigation of a particular 'community of practice' (Eckert and McConnell-Ginet 1992, 2003, Eckert 1992). Our investigation is not one of a face-to-face community of the sort which a traditional ethnographer might study, but one in which participants can be thought of as participating in a 'virtual' community (Hine 2000) in which adjustments of performance will have taken place in response both to knowledge of research interview dynamics and of the eventual public use to which the interaction would be put. The participants in the interviews examined here were able to view the narratives of other participants on the DIPEx web site and were informed that they were contributing to education about health issues through providing information on their own experience.

In order to make valid comparisons between male and female interviewees, matched sub samples of male and female interviewees were drawn up, ensuring that gender comparisons controlled for age, socio-economic status, type of illness and the gender of the interviewer.[1] This matching procedure has been used in other investigations of gender arising from this project (Seale and Charteris-Black 2008a, 2008b). Socio-economic status was categorised into three levels according to the scheme used by the UK Office for National Statistics to categorise occupations (Rose and Pevalin 2005; see also www.statistics.gov.uk). We therefore identified 99 pairs of male and female interviewees (198 interviewees in all). A 'pair' is where there is a man and a woman who share the same characteristics on the variables (age etc) listed above. The total size of the sub corpus for the 99 interviews with men was 983,085 words and for the 99 interviews with women was 1,094,912 words (respondents' speech only). A profile of the matched sub samples is given in Appendix one.

Once interviews from these matched samples had been matched according to illness type, social class and age, interviewer speech and male and female respondent speech were separated into different files using Word macros in preparation for quantitative comparisons of word usage.

Analysis involved both quantitative and qualitative techniques, supported by computer software. Initially, comparative keyword analysis was employed to identify 'keywords'. The notion of a keyword originated in Firth (1935: 41) as

'sociologically important words' and was later developed by Williams (1976) into words of social and cultural importance. Scott (2005) has developed a statistically-based method of identifying keywords that warrants a redefinition of the concept as words that occur *significantly more frequently in the vocabulary choices of one group as compared with the other* (Seale, Charteris-Black and Ziebland 2006). From these keywords it was possible to identify adjectives that were used significantly more by one gender than the other. We focus primarily (though not exclusively) on adjectives in our analysis because they are one means for the verbalisation of feelings. This is part of a larger project that will eventually report on a wide range of linguistic features; an initial examination of keywords showed that adjectives looked relevant to the expression of feelings because they are concerned with communicating evaluations of experience; however, this does not preclude later analysis of other word categories which might be equally, if not more revealing. We examined the verbal contexts of these adjectives in the matched interviews for all men and all women (respondents' speech only – i.e. excluding interviewer speech); we also examined the quantitative findings for higher social and economic class (SEC) men and higher SEC women; lower SEC men and lower SEC women; older men and older women and younger men and younger women. While the primary focus was on gender it was also relevant to interpret these findings with reference to their interaction with the variables of social class and age.

A separate software programme WMatrix (www.comp.lancs.ac.uk/ucrel/wmatrix/) that tags text automatically and then presents the distribution of groups of words with related meanings (semantic fields) was also used to make a preliminary scan of the texts. For example, the semantic field that is used most differently by men and women in this study is coded as A 12 and labelled 'Difficult'; Table 1 shows words that were classified in this semantic field and that occurred more than 20 times in the male sub corpus:

Table 1: Semantic field A12 'Difficulty'

Word	Uses by men	Uses by women
problem	878	578
difficult	672	605
problems	540	431
difficulty	51	24
difficulties	40	27
burden	28	31
awkward	21	27
complications	20	6

This shows us that there is a group of words that are semantically related to the notion of 'Difficulty' that are used differently when considered as a field rather than individually. This semantic field contains words corresponding with indirect emotional responses to illness since viewing a situation as a 'problem' or as 'difficult' might cause an emotional response. A qualitative analysis was also undertaken of other adjectives that related to emotions such as 'emotional', 'frustrated' and 'vulnerable' that directly express emotion – even though these were not relatively more frequent in either the male or female corpus and therefore not 'key' – and their verbal contexts. Thus quantitative distributions of word usages were a helpful preliminary to more detailed qualitative analysis that allowed exploration of variation within the data, so that individual variations within genders that might not have been visible with an overall gender comparison could be brought out.

Qualitative analysis was supported by the concordancing and 'keyword-in-context' displays of these software packages, generating a more detailed understanding of how particular adjectives were being used in context. The original interview transcripts, including interventions by the interviewer, were inspected for further details of context. This has facilitated a context-sensitive, targeted and systematic comparative analysis of the use of adjectives in male and female interview texts. Throughout, the comparative analysis was informed both by what the computer outputs and readings of the interviews told us were key features relevant to an understanding of gender and the expression of emotions.

Since we are working with transcripts of interviews – rather than with the original recordings – we are not able to examine other aspects of the expression of emotions and feelings that would be revealed by other approaches. Conversation analysis would explore the interactive dimension of the interview and accounts of the gendered performance such as Goodwin's include an account of pitch variation and other prosodic features as well as expressive modes such as bodily stance (Goodwin and Goodwin 2001). However, since keyword analysis has not previously been applied to analyse gender in relation to the experience of illness, we consider that the patterns revealed by words and expressions that occur with high frequency may provide insights that might not be revealed by other approaches. We have sought to undertake a fine-grained analysis by examining the verbal context in which keywords occur in order to identify the function of these keywords in emotional expression.

We think that comparative keyword analysis has enabled us to examine a very large quantity of text for promising features that could be investigated

further, identifying interesting and somewhat unusual phenomena located in small parts of the larger corpus that could then be read and analysed conventionally. Contrary to expectations that an emphasis on 'difference' would result in a stereotyped and 'essentialised' picture of gender, it in fact led to a discovery of people 'doing gender' in a variety of ways – including, but not restricted to, the conventional and non-conventional – in response to biographical circumstances and social context. Additionally, because the method is backed up by counts of keywords, the classic problem of anecdotalism that affects much qualitative research (only showing quotations that support the writer's argument at the expense of negative or deviant cases) is avoided. In this respect, comparative keyword analysis fulfils the benefits of counting in qualitative research perceived by Silverman (2006) and the advantages of mixed method research outlined by Bryman (1988). (See also Seale 1999, for a discussion of counting in qualitative research and its potential for improving the quality of reporting.)

Because comparative keyword analysis can manage very large quantities of text it is possible to construct samples, as we have done, that are more representative of a broad variety of experiences than in small-scale wholly qualitative studies. This then enhances the capacity for empirical generalisation, something which has traditionally been a problem in qualitative research, albeit mitigated by the capacity for theoretical generalisation (Seale 1999). Reliability and replicability is enhanced by the fact that inference is relatively more delayed than in conventional qualitative work, which relies from the start on interpretive identification of phenomena by the analyst. Validity, in the sense of the capacity for sensitivity to nuances of meaning and context, is then provided by the qualitative element of keyword analysis whereby individual keywords are examined in their context. However, the method is limited in its capacity to examine interaction, which is more appropriately investigated by methods such as conversation analysis.

Overview of findings

The first comparison identified 187 comparative keywords that were used significantly more by one gender than by another; of these nine were adjectives used significantly more frequently by women; Table 2 and Table 3 show these adjectival keywords for women and for men, respectively.

Table 2: Female 'key' adjectives (ranked by keyness)

Adjective	Females 1,094,912 words		Males 983,085 words		Significance level
	uses	Frequency per 10,000 words	uses	Frequency per 10,000 words	
sure	795	7.23	525	5.34	p<0.0001
fine	631	5.77	339	3.45	p<0.0001
ill	519	4.74	315	3.20	p<0.0001
hard	498	4.55	285	2.89	p<0.0001
awful	289	2.64	145	1.47	p<0.0001
lovely	199	1.82	68	0.69	p<0.0001
frightened	194	1.77	65	0.66	p<0.0001
poorly	87	0.79	17	0.17	p<0.0001
terrified	56	0.51	12	0.12	p<0.0001

Table 3: Male 'key' adjectives (> 50 occurrences, ranked by keyness)

Adjective	Male 983,085 words		Female 1,094,912 words		*
	uses	use per 10,000 words	Uses	use per 10,000 words	Significance level
important	446	4.54	345	3.15	p<0.0001
depressed	289	2.94	201	1.75	p<0.0001
local	285	2.89	192	1.84	p<0.0001
easy	206	2.09	132	1.21	p<0.0001
major	196	1.99	111	1.01	p<0.0001
serious	181	1.84	102	0.93	p<0.0001
wee	92	0.09	41	0.34	p<0.0001
gay	84	0.85	2	0.02	p<0.0001
successful	70	0.71	27	0.25	p<0.0001
tremendous	66	0.67	24	0.22	p<0.0001
bloody	53	0.54	10	0.09	p<0.0001
multiple	34	0.35	3	0.03	p<0.0001
fucking	18	0.18	0	-	p<0.0001

We found that adjectives identified by keyword analysis such as 'frightened', 'terrified', 'hard' and 'lovely' were direct strategies for the expression of emo-

tion. Analysis of the contexts in which some of the other adjectives occurred indicated that they were employed to describe states of health rather than feelings. For example, uses of 'fine' and 'poorly' generally referred to positive and negative evaluations of physical rather than emotional health. In addition, it is questionable how far these adjectives in fact convey emotion; analysis of the phrasal contexts of 'awful' indicated that 33% of the total uses were in the phrase 'an awful lot' in which 'awful' has the same intensifying function as 'very' and is hyperbolic rather than emotive: [2]

> ….. I know money's short in the National Health, I know everything's difficult but *an awful lot of money* would be saved if people were diagnosed earlier and didn't have to have all the expensive chemotherapy that we have now. (CRC25, female, colorectal cancer)

Initially, 'kind' appeared to be a keyword adjective; however analysis showed that 95% of its uses were to communicate vagueness in the expression 'kind of'. There was also evidence of other variables interacting with gender in the use of adjectives that referred directly to emotional states. For example, 'Frightened' was a keyword for younger women as compared with younger men[3], but not for older women and 'lovely' was a keyword for lower SEC women[4], but not for higher SEC women. There is, therefore, evidence that we need to qualify claims about how *all* women express their feelings by considering the intervening variables of age and social class.

We found that the majority of these adjectives revealed something about men's emotionality; for example 'tremendous' indicated expression of positive emotion, while 'depressed', 'bloody' and 'fucking' indicated expression of negative emotion. However, others such as 'important' indicated assertiveness rather than emotional expression, as in the following:

> ….but I'm the patient, I'm the most important patient as far as I'm concerned, and if I need something doing and it doesn't happen I don't hesitate to ask why. Speak up for yourself, you have to do that. (PC21, male, 77, prostate cancer)

Such words were dropped from further analysis because they were not especially revealing about men's expression of feelings and emotions. Examination of 'local' showed it was used in relation to a medical facility such as a hospital, doctor, anaesthetic or GP, and 'multiple' was mainly used to refer to 'multiple sclerosis'. However, analysis showed that other words such as 'major', 'serious' – although not directly related to the expression of emotions – were found to be an indirect means by which some men with illness talk about their emotions. By 'indirect means' we mean one that distances the speaker from the person who is experiencing the emotion as if it were happening to someone other than the speaker, as in the following:

> Well I used to go to a lot of dinner dances. That's definitely out. [er] Golf. Played a lot of golf. [er] Played a lot of snooker as well, been playing that since I was about 12 or 13. [er] Bending over the table is a major problem. [er] Being on my feet for any length of time [er] is a major problem. [er] So, you know, two things right away that had to go. (CP32, male, 57, chronic pain)

Here when 'major problem' is used, the first person subject pronoun 'I' is avoided by use of the present participles 'bending' and 'being'; this externalises the experience of physical discomfort and men who speak like this are doing illness by sustaining an emotional distance from the experience. 'Tremendous' and 'gay' were keywords used more by older men (as compared with older women); 'serious', 'important', 'local', 'depressed' and 'kind' were keywords when comparing lower SEC men with lower SEC women.

Table 4 shows the semantic fields that were used most differently by men and women in this study:

Table 4: Key semantic fields compared by gender

Semantic field	Male 983,085 words	Female 1,094,912 words
Difficult	2484	1955
People: Male	778	464
Numbers	9473	9121
Important	1422	1086
Sports	826	595
Mental object: Means, method	1592	1318
Success	610	412
Business: Generally	364	209

These semantic fields appear to confirm ideologies of male deficiency in emotional expression: men talk more about other men, sports, business, success, numbers etc. and avoid talking about emotions. However, as we will see in the discussion of expressions such as 'major problem and serious problem', the semantic field 'difficult' can be related to a tendency by some men to reify their experience of illness. Because words such as 'depressed', 'bloody', and 'tremendous' imply evaluation or expression of an emotional state we decided to use WMatrix to search for the semantic field that appeared most closely related to the expression of positive emotion: ' Happy'. This semantic field was used significantly less by men and we therefore decided to search the corpus for adjectives expressing negative emotion. These are shown in Table 5 below.

If the 'deficit model' of male language which designates men as unwilling or unable to discuss feelings (particularly those involving vulnerability or weakness) had applied one might have expected to see a significant difference in favour of women on these adjectives. We do find evidence in the contexts of use of these words that some men adopt strategies that distance themselves from emotional experience and that they discuss their feelings in a way that is different from women.

Table 5: Other negative emotion adjectives compared by gender

Adjective	**Male 983,085 words**		**Female 1,094,912 words**		
	Uses	Uses per 10,000 words	Uses	Uses per 10,000 words	
emotional	93	0.95	90	0.82	not significant
frustrating	45	0.46	36	0.33	not significant
frustrated	25	0.25	31	0.28	not significant
embarrassing	32	0.33	35	0.32	not significant
embarrassed	24	0.24	29	0.26	not significant
lonely	20	0.20	17	0.16	not significant
vulnerable	20	0.20	22	0.20	not significant

Analysis and interpretation of men's language

On first impressions, the quantitative data confirm established views of gendered language: among men experiencing illness there is a preoccupation with maintaining gender identity through swear words. Men who swear are both performing emotion directly and indexing masculine identification. Adjectives such as 'bloody' and 'fucking' have a dual indexing function in men's expression of feelings and emotion: they perform the identity of a person who is experiencing negative feelings arising from illness *and* index a conventional masculine identification (Kulick 2003 explains the distinction between identity and identification). In Brown and Levinson's (1987) terms men who swear are going 'on the record' as men who are doing illness. Other men employ indirect or 'off the record' strategies – such as the use of figurative language and adopting an external perspective on their illness experience. Such men are performing in a conventionally masculine 'objective' style that – although concealing their own intimate feelings and protecting the hearer's

face through avoiding upsetting detail – covertly indexes their masculinity. Both direct strategies that overtly index masculinity and indirect strategies that covertly index masculinity are conventional ways that men express their feelings about illness experience.

Such variation indicates that in interpreting the findings we should consider how far particular words show statistically as 'key' only because they are used frequently by particular interviewees; for example, all the uses of 'gay' occurred in only three of the 99 interviews and 67 of the 92 occurrences of 'wee' were in a single interview with a Scotsman. One of the difficulties in small scale corpus research is that a small number of texts may have a skewing effect and this has been taken into account in the following analysis by only including discussion of adjectives that occurred in five or more separate interviews. However, we recognise that this procedure may overlook more individualised ways of doing illness.

In the following analysis we analyse male 'key' adjectives first in relation to performance of gender by direct strategies such as swearing, then other performances of gender by indirect strategies such as the use of negative emotion adjectives and the adjectives 'major' and 'serious' – arguing that such strategies serve to create a distance between the actual, or felt, feelings of the person experiencing illness and his expression of such feelings.

Male swearing as a direct strategy

Coates (2003: 196) argues that 'men's use of taboo language in telling their stories also performs toughness'. Yet in our interview data we found that, rather than performing toughness, the use of swear words expressed feelings of frustration felt by some men with the limited potential of language to express the strength of their emotions. Swearing can be considered as a style for doing illness that implies a stereotypical and possibly (though not necessarily) hegemonic masculine identity. 'Bloody' occurred 53 times, and 'shit' occurred 27 times in the male interviews. Other swear words were 'bugger' (8); 'blimey' (3); 'bollocks' (3) and 'bastard' (2). There were also particular expressions such as 'bloody hell' (10) and 'fucking awful' (5). In the female interviews 'bloody' occurred only 10 times, 'shit' three times and 'bollocks' once.

'Bloody' was most commonly used by higher SEC men who used it more than twice as frequently as lower SEC men. Around 25% of the instances of 'bloody' occurred in reported speech following verbs such as 'thought' or 'think' – suggesting that some men construct their gender identity through an imagined internal dialogue as in the following:

> I bought one of these mountain bikes and [er] I got on there, I thought, at first, you're thinking '*Bloody hell*' you know, it tires your legs out but then you get a sore bum. ….and I thought '*Bloody hell*, I need to do these like I like another pair of ear holes' (CP46, male, 49, chronic pain)

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

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

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

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

with physical pain:

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

and with emotional pain:

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

'Fucking' was used in seven different interviews with men and occurred in collocation with 'feel' and in expressions such as 'fucking awful'. Interestingly, 'fucking' only occurred in the higher SEC interviews and was used much more by younger than by older men. However, it only occurred as an expression of

frustration in relation to the recollection of an extreme state of mental suffering – typically depression – as in the following:

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

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

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

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

> …..for a long time I couldn't face her during this illness because I thought well, I don't know what I thought, sorry I don't know what she thought, but I thought that she would think 'God', you know, '*look at this bloody wimp* playing around doing nothing'. (CP27, male, 54, chronic pain)

Here a man describes his beliefs about his partner's views concerning him as a man experiencing illness. This suggests that engendered beliefs about illness experience are at least partly socially constructed. As Ochs (1992: 338) (citing Bakhtin 1981 and Voloshinov 1973) makes the point:

> … that utterances have several 'voices' – the speaker's or writer's voice, the voice of a someone referred to within the utterance, the voice of another for whom the message is conveyed etc. The voices of speaker/writer and others

may be blended in the course of the message and become part of the social meanings indexed within the message.

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

The findings for swearing should lead us to be cautious in assuming that it always enforces a single 'hegemonic' masculinity. Swearing shows the effect of social stereotypes on men, and the way that stereotypical hegemonic masculinity, though performed by men, is at least partly socially constructed. Swearing is also often employed by younger, higher SEC men to express concerns about their toughness. In this collection of interviews swearing has the dual role for men of directly indexing feelings of emotional frustration with their lack of a language for feelings *and* indexing socially constructed masculine identification. It contrasts with the use of 'whatever' which young men use twice as frequently as younger women; this indirectly indexes feelings of frustration with their inability to articulate feelings but without directly indexing masculine identity – it is an example of the social meaning created through the blending of voices referred to in the quotation above. Swearing is emotionally expressive and performs a range of interpersonal and communicative functions for men experiencing illness including – but not restricted to – the indexing of a stereotyped performance of masculine identification.

Indirect strategy (1): non-specific terms and metaphor

We will now consider adjectives related to the expression of feelings and emotions that were used with similar frequency by men and women and also other parts of speech with which they collocate. The men involved in these interviews used the word 'emotional' as much as women (see Table 5). This was often used with first person pronouns as in the following:

> I've becu, *I've become more emotional*, I think I've become more emotional, more [um], I [pause 4 secs] I get upset, *I get more emotional easier* than before. And that is not just getting upset, but [um] if I'm really happy then I'll remember that, you know, yeah I am really happy and that, you know, life is still good [um] and I'll, you know, I feel myself *welling-up* then. (EAP35, male, 38, ending a pregnancy)

Use of a word such as 'emotional' indicates a rather self-conscious performance of emotion and the use of a superordinate term 'emotion', rather than specific emotion terms such as 'frightened' or 'terrified', could be seen as an indirect

way of expressing emotion. Similarly, the use of a metaphoric expression such as 'welling up' that implies experience of the body as a deep container we would also describe as an indirect strategy. In seven instances in the male sample an expression of emotion was transcribed indicating that the interviewee had ceased talking because he was overwhelmed by emotions causing him to cry:

> And I always remember saying to him 'Why, why don't you do them when' [*emotional*] Sorry I've gone again [*emotional*]. [um] I'll explain in a minute why, when I talk about family [*sniffs*] it cuts me up. [um] I said to him 'Why don't you get your family involved in your exercises so they understand what's going on'. (CP45, male, 54, chronic pain)

While crying itself is a direct way of communicating emotion, the use of the metaphor 'it cuts me up' is an indirect strategy and the indirectness is reinforced by an apology ('Sorry') and attributing agency to something *unspecified*. Some men showed apparent difficulties in expressing their feelings directly by employing metaphoric expressions based on the concept of a liquid under pressure within a container:

> The frustration of [um] the system *building up against you,* because that's what it does, [um] *boils over* and then this impression that people think there's something wrong with you it destroys you it set, sets you back and [um] when I first saw the clinical psychologist I went in and I was very angry because I realised well I'm not round the twist, I've just had enough. [Emotional] [Sorry]. (CP45, male, 54, chronic pain).

> ….. this feeling comes over me of the stupidity of the Christian religion and a hatred of the other people in the pews with me because they, they're sort of buying it. But I'm... but I'm aware of that happening. What I do is I turn the... the *anger that I feel sort of boiling up* inside me against the concept about life which I think is partly a religious one which I don't believe in. (DP13DR, male, 39, depression)

> And inwardly your thinking 'Sod it, I wish I could get up there' but you can't. And that's the way you adjust. You do adjust and *your frustration boils over* sometimes yourself, you know and you think 'Oh blooming heck'… (CP45, male, 54, chronic pain).

Expressions such as 'boil over' comply with cognitive linguistic accounts of the BODY IS A CONTAINER and the choice of these expressions implies that these men experience their emotion as something that should be controlled within a container. However, this is hardly a discourse of tough, 'hegemonic' masculinity in the same way that swearing is; this is a discourse of fragility, emotional weakness and powerlessness involving personal feelings of alienation

from society. Similarly, when feelings are expressed it is like a liquid being released from a container:

> Instead we had a brief discussion down the phone, I think. And again, *I just pour out* my life history and try and have somebody to make sense of it, really [um]. (DP09 male, 35, depression)

There is evidence that women find the direct verbal expression of feelings through metaphor easier; in the following extract emotions are described as 'building up' prior to 'pouring out':

> Sometimes you feel things in your body that you can't express. So I would encourage anybody to do whatever they feel comfortable doing, whatever their means are to express themselves, whether it be through music, dancing, or something, or screaming or getting in the.... getting in the car and having a good shout is a good thing because nobody can hear you when you are driving along in your car. Let it out because if it doesn't come out, it gets stuck, I think. And *it builds up* and *it builds up* and *it builds up* and *you get full* and *you get full of all these feelings* that have never been expressed. And [um] for me at the moment in therapy *they are pouring out of me, all sorts of feelings, thoughts and feelings and are coming out through all sorts of different means as well.* (DP08DR, female, 24, depression)

Here the woman expresses the embodied nature of emotional experience through metaphor. It seems highly possible – from the wealth of evidence in adjective use – that men involved with an illness condition (especially young males) were overwhelmed by a conflict between social constructions for the performance of masculinity and a health situation which made them singularly ill-equipped to deal with the intense physiology of their emotions. This was particularly the case when men were dealing with especially debilitating illness conditions such as chronic pain. There is evidence for this in adjectives such as 'frustrating' and 'frustrated':

> I am a stubborn so and so, and [er] I wouldn't want a job as a civilian in something that I once had a career in, in support in aspects that I once I had a career and *I would find that particularly frustrating*. [um] And I, I don't think I would stand it for long, so. (CP39, male 38, chronic pain)

> *Frustrated I think really. Frustrated* because I can't do anything. The garden needs doing for example. I was going to paint the outside of the house this year but of course I can't do that. But I did, I'm, normally marking [school work] I've been marking for years, English. (IC22, male, 71, intensive care)

As Table 5 shows, there was also very little difference between men and women in the use of 'vulnerable'. Typically it was used by men in relation to situations such as bereavement:

> It was partly also because *I was feeling very vulnerable* because my mother had just died aged 69 of her third heart attack and so I was feeling very like 'oh I have lost my mother' to start with which is always a blow you know when you lose a parent. (HYP14, male, 51, high blood pressure)

Here the man describes his situation in quite an objective way giving both a reason *why* he is feeling vulnerable and then making a general statement about what are likely to be universal ways of feeling regarding parental bereavement. Another man used the term to summarise the changes brought about by the entire illness experience he had undergone:

> I feel a better person for it. Not necessarily stronger, I think I, in some ways *I feel more vulnerable* because I, I have been through quite a lot but I do, its made me think a lot about what is important in life. (CRC17, male, 54, colorectal cancer)

Rather than experiencing themselves as heroic achievers, it seems that these men at least initially underwent feelings of inadequacy and lowered self-esteem. This is because their role as 'doers' – performing socially constructed, traditional versions of manhood by doing physical jobs such as the garden, manual jobs or serving in uniform – was no longer available to them. The experience of illness necessitated a significant change in their self-perception, as well as in their definition of masculinity, which now included emotional expressiveness – albeit through indirect strategies such as metaphor. This contrasts markedly with some language and gender ideologies, as well as the findings of those who seek for context-free generalisations about gender and language.

Indirect strategy (2): externalisation of perspective

Analysis of the verbal contexts of the intensifiers 'major' and 'serious' showed that they were relevant to emotive expressivity and were generally used as synonyms because they were both most frequently used to modify 'problem' or 'problems'. Either the singular or plural forms were keywords for lower SEC men as compared with lower SEC women and for younger men as compared with younger women. The collocation 'major problem/s' occurred 35 times and 'serious problem/s' occurred 14 times in the male sub-corpus compared with only five and three times respectively in the female sub-corpus. We will

also recall that the semantic field 'Difficulty' was the one used most differently between genders. This indicates that men – and in particular lower SEC men – externalise their experience of illness by thinking of it as a 'problem' that needs to be 'solved' – rather than as an experience that needs to be lived. Table 6 presents an analysis of the entities referred to as 'major' or 'serious' 'problem/s':

Table 6: Entities referred to as 'major problem/s' and 'serious problem/s'

	Male	Female
general physical condition	24	5
performing a physical task	6	0
negative 'no major problem'	6	0
psychological state (e.g. depression)	6	0
financial	2	0
relationship related	2	0
other	3	3
TOTAL	49	8

Men evaluated their physical condition as 'major problems' and described the physical and mental effects of illness on their ability to perform physical tasks. The following give an example of each of these:

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

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

These findings provide empirical evidence that men experiencing illness perceive their situation as being 'problematic' or potentially problematic (since this is implied even when the existence of a 'problem' is denied). This suggests that men – especially lower SEC men – may view themselves from an external perspective, treating themselves as problems to be forensically examined from the outside, in much the same way as they might face the problem of fixing a faulty tap or leaking roof. Such indirect or 'off the record' strategies are ways of doing illness by keeping an emotional distance and concealing their own intimate feelings. An 'objective' performance of illness may be another covert way of indexing masculinity by protecting the hearer's face through avoiding details about illness experience that might upset their interlocutor.

By viewing their identities as problematic men communicate their emotion states by reifying their experience of illness. However, it is also a way of viewing their ill selves that may lower their self esteem:

> You know, [er] or any of the enjoyable things that I used to do. They're way beyond my reach now. So I've really got to put them out of my mind and start afresh. *And that was a major problem* at the beginning with me. It took me two years, at least two years, to come to terms with that. … *I must admit. [er] I was getting angry with myself* for not being able to do simple things. (CP32 male, 57, chronic pain)

For some men illness creates feelings of frustration because it is conceptualised as a problem for which a solution may not immediately be apparent. Tannen may be right that 'Trying to solve or fix a trouble focuses on the message level of talk' (1992: 52); however, her analysis does not consider how the use of reified language is one way that men also communicate emotion indirectly by distancing themselves from it. For some of the men in this study, particularly those from lower SEC backgrounds, states of illness are objectified as 'problems' with the implication that if their health cannot be 'fixed', their masculine identity as problem-solvers becomes endangered and they communicate their feelings about this in language that social constructions of masculinity have made available to them.

The tendency to classify a wide range of different entities as 'problems' is also indicative of another indirect 'off the record' strategy employed by some men for the expression of feelings and that is generalisation; consider the following examples:

> Um, and I dis, I believe that your mind can control your health to a certain extent uh, I don't know how you do it consciously but I believe it does do it to a certain extent and the positive attitude is very important in life. (CRC26, male, 57, colorectal cancer)

> I feel that it is very important that even in the midst of great depression one realises that there can be something at the end of the rainbow, something very different. And my message is don't despair, there may be something round the corner, very different from what you anticipate. (EP04SP04, male, 51)

There is an element of distance created from the experience by the use of impersonal pronouns such as 'you', 'one' and 'it' and the general nature of the advice that is given. These men appear to be addressing their virtual community with advice framed in general and clichéd language – 'the end of the rainbow' and 'round the corner'- that is indicative of an externalised experience of illness but not one that explicitly reinforces or rejects conventional ways of performing masculinity.

Discussion

Our analysis has shown that health sociologists may have over-simplified the way that men do illness; we have identified a variety of ways in which men perform in accounts of their illness experience; some reinforce and some reject conventional notions of masculinity, while others do neither of these and may be better explained with reference to age or social class. Compared with women discussing the same kind of experience, some men employ direct 'on the record' styles such as swearing, while others employ indirect 'off the record' strategies, such as metaphor and generalisation, and reify illness experience by externalising it as a problem. Though they may represent their situation objectively, it may be experienced subjectively. Some men are no less prepared than women to express feelings of vulnerability especially when they are faced with particularly serious and debilitating illnesses. Feelings of frustration arise from the difficulties they experience with an unfamiliar idiom for the elaboration of feelings which popular language and gender ideology have associated with women. There is, therefore, as much evidence of variation in *how* men express their emotions as there is of men's claimed deficiency in expressing them. It may not therefore be beneficial to treat men as a special case but rather to treat illness as something that is a human experience rather than one that is gendered.

There are perhaps two possible explanations of why our findings depart from those of researchers such as Coates (2003). First, our corpus is based on men experiencing illness – and in many cases of highly debilitating types of illnesses that are likely to enhance feelings of vulnerability – when compared with Coates' informants who were healthy males. Second, a research interview that is explicitly set up as an opportunity to talk about personal experience differs significantly from the kind of setting studied by Coates since it requires a degree of personal disclosure that may be unusual in most types of male experience; in addition, in interview situations men are detached from the influence of peer group pressure to which Coates attributes the heroic element in men's style. Given social constructions of gender, though, we might have expected men experiencing illness to present themselves as heroic survivors or fighters against life-threatening conditions, and to conceal their feelings from the interviewer in order to sustain such a 'masculine' presentation of self. Components of these interviews (not presented here) do indeed contain such motifs. However, the overall effect of the sense of the context and purpose of the interviews (the development of a health support web site) may have been to reduce heroic display.

It is always possible that men who disliked the idea of an interview about personal experience did not take part, leaving us with a sample of men

unusually willing to display their feelings and emotions. This aside, it is clear that not all of the men in this sample of interviews represent themselves as engaged in manly or heroic contests with an illness condition. Indeed as Galasiński (2004: 15–17) points out, one of Coates supposedly heroic stories is more a story of male helplessness. Many men tend to express negative emotions more than women, who were presumably subject to the same selection processes, and this does not fit with the patterns one might have expected from ideological depictions of 'hegemonic' tough masculinity. Could it be, then, that such men concealed their vulnerability prior to their experience of illness, and that this experience has led them to rediscover a part of themselves concealed by later socialisation? If so, our findings provide some evidence in support of Seidler's view that:

> In concealing our [male] vulnerability to ourselves and others, we learn to present a certain image of ourselves. We become strangers to aspects of ourselves. This reflects in our relationship to language as we distance and disown parts of ourselves. We refuse to experience parts of ourselves that would bring us into contact with our hurt, need, pain and vulnerability since these threaten our inherited sense of masculinity. (Seidler 1989: 153)

This seems especially relevant in studying a virtual community of practice that forms around the experience of serious illness. By rediscovering those aspects of themselves, men can be perceived as accommodating to a more favoured self-reflexive and contemporary identity and finding a style of discourse appropriate to this identity.

Illness may challenge the 'masculine' identity of some men more than it challenges an equivalent 'feminine' identity. Women use more 'on the record' strategies to express feelings such as the use of the powerful negative adjectives: 'frightened', 'awful' and 'terrified'; however, men express their emotions through a wide range of strategies that include on the record ones such as swearing, and off the record distancing strategies such as metaphors, external perspectives and generalisation. Our evidence indicates that many men with illness undergo a degree of identity transformation as illness forces them to discover more about themselves and accept their vulnerability. Cameron (1997, 2000, 2003, 2005) argues that in late modernity the stereotype of masculine emotional reticence is part of a wider male deficit model. Many contemporary situations require talk about feelings, as she summarises: '…skills such as emotional expressiveness and empathetic listening are … idealized in many present-day representations of language' (Cameron 2003: 459). The language associated with women's style is perceived to be desirable as we move into a primarily service economy where interpersonal functions of communication are at a premium:

> …the conditions obtaining in late modern societies have given rise to a new linguistic ideal: the skilled interpersonal communicatory who excels in such verbal activities as cooperative problem-solving, rapport-building, emotional self-reflexivity and self-disclosure… (Cameron 2003: 459)

According to Cameron (2003), modern public discourse operates as if there were no men around because this permits greater emotional expression. She refers to the 'gendered logic that has prevailed in the West for several centuries, these changes are bound to be perceived as feminizing the values and the language of public discourse…' (Cameron 2003: 461). The new ideal is for men who combine conventional 'masculine' qualities with a command of a more 'feminine' language of emotional expressiveness; our findings show when experiencing illness some men – especially those from higher SEC backgrounds – have accommodated to this ideal by feminising their emotional expression while others are constrained by less contemporary ways for performing emotionally.

We conclude, then, that there is a highly varied verbal repertoire among men experiencing illness: some men find that 'hegemonic masculinity' has not prepared them well for illness and undergo tensions between their beliefs about a 'masculine' gender role and an experience that requires them to perform according to what they might perceive as a 'feminine' one. Higher SEC, younger men who do not want to appear weak rely on conventional strategies for expressing emotion directly through swearing, whereas other men express emotion indirectly through distancing strategies. Others are less gender bound in their performance of illness and resist dominant norms by using a more self-consciously 'feminine' language of feelings that enables them to construct new identities. Such men are experimenting with an identity in which frustration is replaced by self-knowledge and emotional understanding. They appear to be striving towards a new construction of identity that, we speculate, may enable a redefinition of what it means to be powerful. They may be contributing to breaking down the dualism that underlies cultural constructs such as 'masculine' and 'feminine' by redistributing the stylistic resources of gender. Ultimately an acknowledgement of feelings of powerlessness in the face of illness is something that is human, rather than being specifically male or female.

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Notes

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

2 Please note that the use of italics in excerpts from the data indicate the authors' emphasis rather than that of the speaker.

3 Other keyword adjectives for younger women were 'strange' and 'terrible'.

4 Other keyword adjectives for lower SEC women were 'fine' and 'upset'.

Appendix 1: Characteristics of matched sub samples for gender comparison

	Men	**Women**	**All**
Type of health/ illness experience			
Carers of people with dementia	3	3	6
Cancer			
Breast	1	1	2
Colorectal	10	10	20
Lung	13	13	26
Teenage	6	6	12
Rheumatoid arthritis	3	3	6
Chronic pain	9	9	18
Depression	11	11	22

	Men	Women	All
Pregnancy	1	1	2
Ending a pregnancy	4	4	8
Epilepsy	8	8	16
Heart attack	3	3	6
Heart failure	7	7	14
High blood pressure	1	1	2
Intensive care	4	4	8
Immunisation of children	2	2	4
Terminal illness	10	10	20
Sexual health of young people	3	3	6
Age			
16–25	13	13	26
26–35	11	11	22
36–45	15	15	30
46–55	25	25	50
56–65	18	18	36
66–75	12	12	24
76–87	5	5	10
Mean age	48.8	48.7	48.75
Socio-economic status			
Managerial/professional	66	66	132
Intermediate	14	14	28
Routine and manual	19	19	38
ALL	99	99	198

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