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“What he hasn’t told you ...”: Investigating the micro politics of gendered support in heterosexual couples’ co-constructed accounts of illness

Sarah Seymour-Smith and Margaret Wetherell

Abstract

Research has demonstrated that heterosexual men receive enhanced health benefits from their relationships with women. Explanations for this gendered pattern often focus on women’s role as the main caregivers and arrangers of health care. However, what remains unclear is how these benefits are mediated. In this paper we describe the micro-politics evident in negotiations between twelve heterosexual couples as they discuss the serious illness of one of the pair with an interviewer. The interviews were transcribed and subsequently analysed using a synthetic approach to discursive psychology. We argue that in these co-constructed stories women potentially trouble men’s identity performances. For instance, by interjecting emotional assessments women supporters allow men the opportunity to discuss aspects of the illness experience that might be otherwise viewed as at odds with hegemonic masculinity. We suggest that women’s positioning of men is a form of complicity with hegemonic masculinity and urge that further research should follow this line of enquiry.

Key words: gendered support, discursive psychology, complicity with hegemonic masculinity

Introduction

For some time now researchers have been exploring the relationship between gender and variations in health and illness (Hayes and Prior, 2003). Particular attention has been paid to the differential effects of heterosexual relationships on men and women's health and well-being. From the 1970s onwards, for example, studies have consistently demonstrated that men receive enhanced physical and mental health benefits from their relationships with women (House, Landis, and Umberson, 1988; Gove, 1973; Mullen, 1996; Norcross, Ramirez and Palkinkas, 1996; Schumaker and Hill, 1991; Umberson, 1992; Waldron, Hughes and Brooks, 1996). Widowhood, for instance, is more detrimental to the health of men than women (Umberson, 1992). Unmarried individuals, especially men, have higher mortality rates than individuals who are married (Shye, Mullooly and Pope, 1995). It seems that social support is likely to be a vital factor in everybody's health status. But why do heterosexual men gain so much additional benefit from their relationships with women? And, from a feminist perspective, why is this benefit not more reciprocally shared?

One explanation is that women tend to be the main caregivers and arrangers of health care for both their male partners and children (Lewis and Lewis, 1977; Norcross et al, 1996). Norcross et al (1996) note that women are more likely to seek medical help and possess greater knowledge about health matters. Heterosexual women encourage their male partners to seek health care and to monitor their health. According to Umberson (1992), marriage gives women an opportunity to exert more social control over men's health care. The greater health benefits associated with marital status for men could be

due therefore to this practical and material support. But is health supervision the only benefit men receive? What else might be entailed and how are these practical benefits mediated? The body of work we have discussed above typically takes a traditional perspective to empirical research, treating findings as being able to offer some generalized ‘truths’ about patterns of health care. In contrast to this, the stance that we take switches the focus in an attempt to understand the social practices heterosexual couples engage in. From this position we begin to consider how the variable of social support, identified by traditional psychological research as significant, is constituted. We can thus unpack what ‘social control’ looks like in practice and attempt to explicate what kind of power might women ‘enjoy’.

Research on heterosexual relationships more generally (Crawford, 2004; Fisherman, 1983) has demonstrated that women perform a disproportionate amount of the emotional work required to sustain a relationship. It seems likely that some of the health benefits men receive from their relationships with women are due to this emotional labour in addition to the physical effects of increased health supervision. Women’s greater level of emotional work has been variably interpreted as reflecting differences in men and women’s emotional cultures (Tannen, 1991) and/or as an indication of men’s greater social power (Cameron, 1992). The persistent inequalities in the relational benefits women and men seem to receive suggest that if this is a simple cultural difference then it is one with regular asymmetric effects which need investigating. How do couples deal with the emotions associated with health and illness and what might be the consequences of their preferred styles and performances of emotionality?

This paper describes the micro-politics evident in negotiations between heterosexual couples as they discuss the serious illness of one of the pair with an interviewer. In contrast to the large-scale questionnaires and self-report surveys usually conducted in this area our study involves the intensive analysis of the discourse of a small sample. Our focus is on the identity spaces or discursive climates of support women and men set up for their ill partners. We explore the ways in which female partners protect men's identity positions and men's investments in what Connell (1995) has described as 'hegemonic masculinity'. We trace regularities in the identity positioning of the couples in relation to emotionality and look more closely at what is entailed in women's health supervision of men.

We chose to explore these issues through the close analysis of discourse because in common with other work in discursive psychology (Edwards, 1997; Potter and Wetherell, 1987; Wetherell, Yates and Taylor, 2002) we assume that everyday discourse is not ephemeral but is a key site for psychological and relational business. In conversation and interaction, people formulate their mental states, construct themselves and present accounts of their actions and motives to others. Participants 'do' emotions and organize their versions and representations of their lives in efficacious ways. Discourse and narrative are where we perform embodiment and 'come to terms' with the body's possibilities and limitations, perhaps especially so in relation to the huge disruption of serious illness (Frank, 1993). Relationships are enacted, too, through the flow of discourse and in an important sense they are defined through the prevalent and patterned organization of interaction over time.

The research interview, even when organized as an informal conversation, is, of course, not everyday discourse. It is a specific discursive genre with its own rituals and procedures (Baker, 2003; Holstein and Gubrium, 2003). Nonetheless, interviews with couples are sites where familiar routines can be rehearsed. They are particularly illuminating because they require the management of ‘coupleness’ and are usually interpreted by participants as a display of the nature and quality of the couple’s relationship (Dryden, 1999). Interviews with couples highlight methods of co-construction. In comparison, the individual interview highlights and tends to require the performance of self as an independent psychological actor with a personal history.

In this analysis we focus on the fine-grain detail of the couples’ constructions of self and other. Following feminist conversation analysis (Kitzinger and Frith, 2002; Stokoe, 2000) we try to place priority on evidence, internal to the discourse, of participants’ orientations. In doing so we focus on what appears to be important for the participants in the interaction rather than imposing our own analytic framework. Our starting point is patterns across our corpus. Unlike conversation analysis, however, neither sequential organization nor categorization practices are our main target and we range beyond the proximal context to draw conclusions about broader gender relations, and then use our knowledge of that broader context to make sense of the patterning of the interaction. In line with standard procedures in discursive psychology (Antaki and Widdicombe, 1998, Wetherell and Edley, 1999), we pay most attention to the identity positioning work evident in couple’s discourse and discuss its implications, often through unpacking singular illustrative extracts. We draw on Wetherell’s (1998) discussion of troubled and

untroubled subject positions as a way of charting the formative influence of the broad social and cultural context on the detail of interaction. We also utilise, where relevant, sociolinguistic analyses (Coates, 1996; Tannen, 1984) of the discursive devices in heterosexual couple talk.

Participants and Materials

The data for this study consisted of the transcripts of audio-taped interviews conducted with twelve heterosexual couples where one member of the couple had cancer. In four of the couples, the woman was the cancer sufferer (all with breast cancer) and in eight couples the man was the cancer sufferer (four with testicular cancer and four with prostate cancer). This imbalance (twice as many couples where the man was the patient compared to couples where the woman was the patient) reflected our initial interest in masculinity and health (Seymour-Smith, 2003), with women cancer sufferers included to sharpen our sense, through difference, of commonalities in men's identity projects and illness trajectories. As a result, in this paper we focus mostly on the climates of support women construct for ill men and make less confident claims about the climates men construct for ill women, although some conclusions are possible.

Some (four) of the couples were recruited through hospitals in the Midlands area of the UK (after gaining ethical approval from two hospital ethics committees). Some (eight) were recruited through newspaper advertisements and self-help groups in the same geographical area (following approval from the relevant university ethics committee). Eight of the ill participants had already been interviewed on a one-to-one basis. All

participants were given the opportunity to discuss the details of their involvement in the study by telephone. Participants also read a detailed outline of the project before they consented to take part in the study. Confidentiality was assured and anonymity provided through the use of pseudonyms; all doctor, hospital and place names have been changed. Each interview lasted between forty-five minutes to two hours. Participants were informed that they had the right to withdraw their consent at any point and were advised that they were at liberty to stop answering questions if they became uncomfortable with the level of disclosure. They were informed that if they found the interview distressing they could be put in touch with a suitable counsellor.

The interviews were informal and were conducted in the participants' own homes by the first author. The interview opened with a first question to the ill partner usually phrased as follows: 'can you tell me in our own words something about what it has been like for you both since finding out about the illness?'. In all interviews this resulted in a jointly told account. The interviewer then prompted until the narrative seemed complete. Subsequent questions then focused on the couple's emotional reactions, the hospital experience, friends and family, the role of the supporting partner, relationship issues and life changes. The interviews were transcribed using a simplified version of the scheme developed by Gail Jefferson (Potter and Wetherell, 1987, see Appendix A for transcription notation).

Analysis and discussion

The discourse of the sample displayed a great many interesting and important patterns. In this article we follow only the threads noted in the introduction – the gender differences in positioning around the emotions raised by serious illness and the positioning underlying women’s ‘social control’ of men’s health. We begin first, however, with gender similarity rather than difference, describing the mutually supportive ways in which couples developed their narratives of one partner’s illness.

The Co-Construction of Cancer Stories

As noted, when couples are interviewed, it creates a situation where the couple’s relationship is on display to the researcher. It is perhaps not surprising that the heterosexual couples in our sample worked hard to accomplish a unified front and constructed the cancer suffered by one partner as a shared event. This joint construction was something in which both male and female partners engaged using a variety of discursive devices, notably through features associated with the ‘conversational duet’ (Coates, 1996) and through the strategic use of ‘tag questions’ (Lakoff, 1975). Conversational duets were first identified by Coates as a distinguishing feature of women’s talk but have also been found to characterize the discourse of heterosexual couples (Johnson, 1990) as they collaborate on shared narratives. Extract One below in which Frances and Rupert collaborate in telling the interviewer (Sarah) a narrative about Frances’ hair loss demonstrates the core discursive features which were evident across the sample as a whole. These features include talking simultaneously (e.g. Lines 7 and 8), repetition of phrases (e.g. Lines 30 and 31), completing each other’s turns (e.g. Lines 28

and 29), passing the narrative line from one to the other (e.g. Lines 12 and 13) and developing shared assessments (e.g. Lines 38 and 39).

Extract One: Interview with Frances and Rupert (a woman who had breast cancer and her male partner)

1. Sarah you said that that didn't bother you that much=
2. Frances =not as much as (.) it seems to have bothered [other people where they say
3. Sarah [other people yeah
4. Frances that losing their hair was the (.) the worst thing to have happened to them
5. throughout the treatment I wouldn't have said that
6. Sarah n[o
7. Rupert [and the important thing was we had a strategy
8. Frances [at all
9. Rupert so we went to the top (.) hair stylist in Bir oh you know about this do
10. you ?
11. Sarah no no
12. Rupert we went to the top hair stylist in Birmingham who[was at
13. Frances [well we went to we went to House of
14. Fraser' [s I don't know whether that is the best the best one
15. Sarah [(LAUGHING)
16. Frances but we were in the shopping centre and I went and we went there before I had the
17. chemo=
18. Sarah =right
19. Frances and talked to their top stylist who was very nice she has gone off to do
20. training in hai train hairdressers now
21. Sarah mm
22. Frances she's very good we said what the problem was and what (.) what could she do
23. Sarah yeah=
24. Frances = because I had long straight rather (.) droopy hair=
25. Sarah =yeah I remember you [said
26. Frances [and they said it would fall out quicker if it was (.) long
27. Sarah right
28. Frances [so
29. Rupert [so she cut the hair to a new style and looked what she knew what weeks
30. were available roughly to match the transitional wig
31. Frances so we got a [wig that was
32. Sarah [oh wow
33. Rupert [so that worked=
34. Frances =it was very exciting it was nice to go and be pampered
35. Sarah yeah yeah
36. Frances it all fell out a fortnight afterwards thoug[h (laughs)
37. Rupert [so that worked well the wig was actually very
38. very good wasn't it?
39. Frances it was very nice

Note that routinely in these joint narratives ‘I’ became ‘we’ in the discourse of the male and female partners who were supporting the ill partner (e.g. Rupert in Line 7 – ‘we had a strategy’). This needs to be sensitively done so that the ill person also remains the main ‘owner’ and protagonist of the story. Most of the ill partners, however, supported this construction of a joint ‘we’ subject and joint authorship of the narrative, alternating between ‘I’ and ‘we’ as appropriate. Note, for example, Frances’ self-correction in Line 16 from ‘I’ to ‘we’. Tag questions proved a useful device for managing ownership and ‘joining in’, also accomplishing the easy handover of parts of the narrative from one to the other. See, for example, Rupert’s tag question in Line 38 (‘wasn’t it’) which among other things reinforces Frances’ status as the final authority on knowing what might have worked for her. We suggest that in these ways the couples performed mutuality and a positive and a harmonious relationship.

Extract One gives some indication of what relational support might look like as social interaction and suggests that men and women use similar devices to present this support. We now describe some striking differences in the discourse of heterosexual male and female participants which we speculate may provide part of the answer as to why men seem to obtain more support and health benefits from their relationships with women.

Emotion, Identity and Support

There was a regular difference in the ways in which the men and women with an ill partner constructed their identity as a supporter. Before considering these gendered differences in support, it is important to acknowledge that social support is itself a

contested notion. We don't pick up on other contradictory meanings of social support as, following our conversation analytic focus, this did not appear to be an issue for the participants. Consider first responses from three of the four male supporters interviewed.

Extract Two: Interview with Joyce and Derek (a woman who had breast cancer and her husband)

1. Derek erm (1) I think in terms (.) of coping er:rm (2) I suppose I was the er I
2. was the one that felt I had to be the strong one
3. Sarah ye:eah=
4. Derek =nd always you know be there supportive and er
5. Sarah yeah
6. Derek and hopefully yeah sort of er with the optimistic (.) approach all
7. the time
8. Sarah yeah
9. Derek so how did I (.) fare on that? =
10. Sarah =(laughs)
11. Joyce =very well
12. Derek very well
13. Sarah (laughing)
14. Joyce yeah you did yeah
15. Sarah do you think you're the type of person that copes well with
16. sort of stressful events? or
17. Derek (1) I think so yeah
18. Sarah yeah
19. Derek yeah yeah I tend to be a very sort of calm relaxed (1) person er (.)
20. not overly emotional
21. Sarah no (.) no
22. Derek erm so yeah I think erm probably well built to cope
23. Sarah yeah
- [.....]
24. Sarah what would you say has been your kind of major
25. role throughout the illness then? (.) you said a bit before about being
26. the sort of strong one?=
27. Derek =yeah I I suppose I just try and keep things as normal as (.) they
28. possibly could be
29. Sarah yeah
30. Derek erm (1) you know and obviously sort of make sure that Joyce got
31. everything that she (.) should have got in the way of erm support from
32. the medical (.) people and er well there was no trouble with support
33. from family and friends [I mean everyone was being brilliant erm but
34. Sarah [yeah
35. I suppose it was just really just trying to keep things as normal
36. [and
37. Sarah [yeah
38. Derek er everyday (.) as they always have been

Extract Three: Interview with May and Tim (a woman who had breast cancer and her husband)

1. Sarah um so can you tell me in your own words something about what it's
2. been like for you both since finding out about the illness? (1) I know
3. I've spoken (.) to you quite a bit about it but you know what about as a
4. couple what's it been like (.) and what about you?
5. Tim well it's difficult from time to time
6. Sarah yeah (.) yeah it must have been like extremely difficult at first
7. kind of devastating news
8. Tim (.) well I had to [support
9. May [(laughs) everybody else (laughs)
10. Tim everybody else
11. Sarah yeah
12. Tim for a time
13. Sarah yeah
14. Tim but that's what I'm here for
15. Sarah yeah
16. Tim so we do it
17. Sarah yeah and kind of cope with that illness yeah
18. Tim yeah

Extract Four: Interview with Frances (a woman who had breast cancer and her husband)

1. Sarah what would you say (.) has been your kind of like major role then throughout
2. the illness?
3. Rupert (blows out breath) (.) I suppose supports there (.) driver (.) when you've not felt
4. like going there
5. Sarah mm
6. Frances well he always came with me to the chemo=
7. Rupert =oh yes
8. Frances because I wouldn't really have wanted to [drive back from Newark
9. Rupert [no it wouldn't have been right
10. Sarah no
11. Frances besides I shouldn't really have been let to drive back from Newark afterwards
12. Sarah mm
13. Rupert well you know you do what is necessary [there's nothing else you can say about it
14. Sarah [yeah

In these three extracts men position themselves as doing what is 'normal and necessary'.

In Extract Two, for example, in lines 28 and 36, Derek talks about keeping things as

“normal” as possible. Derek also constructs himself as the “strong one” (line 2) to “be

there supportive” (line 4) and “optimistic” (line 6). These qualities are reminiscent of Pleck’s (1987) discussion of the ‘sturdy oak’ theme in ideologies of masculinity. This construction seems to be echoed by Tim (in Extract Three) who says “but that’s what I’m here for” (line 14). Perhaps this response is implicitly marked out as distinctive (and superior?) to the type of support women might provide, through the binary possibilities gender categories offer. For example, in Extract Two, Derek constructs himself as “not overly emotional” (line 20) and “well built to cope” (line 22). In Extract Four, Rupert also draws on the generalized description “you do what is necessary” (line 13). In line 9 he describes the possibility of not driving Frances to the chemotherapy as “not being right” which sets up support as a moral duty. In general in these accounts there is a distancing of personal involvement and the universalisation of the experience. These men construct themselves as simply doing what ‘everyman’ would do in the circumstances.

Compare this pattern, however, with the constructions women supporters developed of themselves at similar points in the interview. Eight heterosexual couples were interviewed where the woman was supporting an ill male partner. Two examples are given but the patterns in the unfolding interactions below were found across the sample.

Extract Five: Interview with Alf and Claudia (a man who had testicular cancer and his female partner)

1. Sarah so (.) what was it like when the consultant told you (.) the news then
2. what was it like when they told you? was it did you feel really
3. scared?
4. Claudia well yeah
5. Alf when they told me
6. Sarah yeah
7. Claudia not really did you well

8. Alf it didn't frighten me too much
 9. Sarah no
 10. Claudia no
 11. Alf I took it pretty calmly
 12. Claudia (laughs) yeah I did well (inaudible)
 13. Sarah (1) 'cos it's quite a big thing isn't it?
 [.....]
 14. Sarah did you you were frightened? (1) yea:ah
 15. Claudia emotional (Claudia begins to cry)
 16. Sarah (1) yeah it's very scary isn't it
 17. Alf she's very touchy now (laughs)
 18. Sarah yeah
 19. Claudia (inaudible)
 20. Sarah yeah (1) I know
 21. Claudia [sorry
 22. Sarah [no that's fine I know I mean when Oliver my partner found out
 23. we both we were both very scared and
 24. Claudia he was more brave than me
 25. Sarah yeah (laughs) yeah
 26. Claudia and I think I would have been brave if it had been me
 27. Sarah do you think so yeah

In contrast to the male supporters, female supporters (encouraged by the interviewer) both described and performed emotions, crying, for example (e.g. Line 16 of Extract Five).

Extract Six: Interview with Ivan and Stella (a man who had prostate cancer and his female partner)

1. Sarah um (1) so the first question is can you tell me in your words
 2. something about what it's been like for you both since finding out
 3. about your illness? (.) the illness
 4. Stella um frightening to start with=
 5. Sarah =yeah
 6. Stella until you got to know a bit more (.) frustrating for me because (.) I
 7. can't actually help him
 8. Sarah no
 9. Stella except be there
 10. Sarah yeah
 11. Stella um and he's got to make the decision on his own I can't tell him
 12. what to do
 13. Sarah is that difficult
 14. Stella that's quite difficult
 15. Sarah yeah
 16. Stella 'cos I have got angry once haven't I? [(laughter) for goodness
 17. Sarah [(laughter)
 18. Stella sake have something done but you can't I realise I can't say that

19. because it's not right
20. Sarah yeah
21. Stella and we don't know well we do know a bit more now don't we?
22. Ivan mm
23. Stella since he last saw you
[.....]
24. Sarah yeah yeah um (1) what would you say that your major role has been
25. throughout the illness then?
26. Stella (1) just a support I suppose
27. Sarah yeah
28. Stella yeah
29. Sarah yeah
30. Stella he's been calling me his rock at the moment
31. Sarah ah that's nice
32. Stella oh don't you'll make me cry (laughter)
33. Sarah sorry
34. Stella no it's alright but you did that in my Christmas card
35. Sarah ah
36. Stella it was that as well wasn't it
37. Ivan mm
38. Sarah yeah
39. Stella yeah
40. Ivan it's true

In Extract Six, similarly, Stella suggests that Ivan has been calling her “his rock” (Line 31). The interviewer responds with “ah that’s nice” (line 32), and Stella asks her to desist or it will make her cry. Female supporters’ accounts of emotion such as panic, anger, frustration and grief were prevalent and appear to be expressed in a relatively untroubled fashion as normative and appropriate responses.

So far this difference confirms usual gender patterns. Male supporters ‘do what is necessary’ and female supporters ‘do emotions’. We now look, however, at how this difference pans out in a further regular form of interaction apparent between the heterosexual couples and how it intersects with the co-construction discussed in the previous section.

The Flow of Trouble

We noted earlier the striking degree of harmonious co-ordination in the heterosexual couples' shared narratives of the illness. This sharing was not entirely equivalent and matched, however. Particular parts of the story tended to be carried much more frequently by the female supporter of the ill man. The nature of this asymmetry is already intimated in Extract Five above. Alf describes himself as responding to the news of his cancer in a fairly calm manner (see Line 11). Arguably, his performance of calm is aided by Claudia's adoption of the other side of the binary – she is emotional while he is calm. We found that women tended in this way to carry the more 'troubled' (Wetherell, 1998) parts of the illness narrative. By trouble in this context we mean two things. First, those narrative elements of any illness story which evoke pain, trauma, disruption and mourning and difficult human experiences. Second, we mean trouble in a more technical sense. Women's interventions troubled men's preferred or normative identities and seemed to create interactional difficulty for them leading to what could be read as identity repair work.

Extracts Seven and Eight below give examples of this pattern where the woman partner contributes trouble to the developing narrative through her emotion assessments.

Extract Seven: Interview with Frank and Cindy (a man who had prostate cancer and his wife)

1. Frank by the Friday that was the Tuesday by the Friday I was
2. all okay (.) to come home
3. Sarah mm
4. Frank (1) but I was working at the time=

5. Sarah =right
6. Frank because obviously
7. Sarah yeah
8. Frank I still carried on once I got better but I must have been away
9. for what a couple of months
10. Cindy oh yeah easy
11. Frank yeah mainly sitting in the armchair watching the telly for a
12. couple of months
13. Sarah yeah
14. Cindy but he did have a lot of pain
15. Sarah yeah
16. Frank well yeah you do (.) and also I had lots of trouble I mean I had a
17. lot of help from a local doctor and the local district nurse

In Extract Seven Frank is talking about coming home after his operation. He is careful to point out that he “carried on” working once he recovered from his illness (Lines 4 to 8). In Lines 8 and 9 he states that he was off work for a couple of months and Cindy agrees (Line 10). However, Frank constructs a picture of his recuperation as “mainly sitting in the armchair watching telly”. In Line 14 Cindy takes over the narrative role and says “but he did have a lot of pain”. Interestingly, Frank then first minimizes the pain “well you do” (Line 16) but this topic shift also allows him to comment on the more difficult aspects of his experience and the help he received.

Extract Eight: Interview with Ivan and Stella (a man who had prostate cancer and his wife)

1. Sarah so do you think you’ll have it now then?
2. Ivan well (1) what’s happened is I had this blood test I came back (.) and it had shot 3.
3. up my blood=
4. Sarah =oh
4. Ian the cancer had shot up
5. Sarah right
6. Ivan from point 5 to 2 point (.) 07 =
7. Stella =so we panicked didn’t we? [for three or four hours=
8. Ivan [well
9. Sarah =mm
11. Ivan well (.) my own GP said oh it’s fine it’s within tolerance levels and I said well
12. that’s the highest it’s ever been (mobile phone rings)
- [pause while phone is answered]
13. Ian yeah so my GP said oh it’s within the tolerance level if it’s (.) 4 er between 4 and 10 then

14. got to look at it then (.) I said but it's the highest it's ever been I said it's a 300% increase
 15. Sarah yeah
 16. Ivan he said that's okay and I came out and I said I'm not happy so I rang the help line
 17. again (.) and she said well (1) if it goes up 10% within three months then you've got a
 18. problem I said well it's gone up 300% what in three months I said no six weeks well you
 19. know what I'm going to say you've got to talk to your consultant now (deep in breath)
 20. Sarah mm
 21. Ivan you've got to deal with it you can't leave it
 22. Sarah mm
 23. Ivan because (.) she said the other thing is at your age if it does starts to grow it will grow
 24. quickly because of your age and if you're an older man it grows more slowly
 25. Sarah that's yeah
 26. Ivan so (exhales) ahh devastating

In Extract Eight Ivan is discussing how his cancer levels had “shot up”. In Line 7 Stella takes over the story line with “so we panicked didn’t we?”. Here, as in the earlier extracts, co-construction is achieved through discursive devices such as tag questions. Stella’s contribution to the story adds a display of emotion previously missing in Ivan’s talk. At this point then Ivan is given the opportunity to agree with Stella, which he does *eventually* in line 26. At first he hesitates with the overlapped “well” in Line 8. In Line 11 Ivan again starts with “well” possibly suggesting a dispreferred response to Stella’s construction of panic. He continues by describing how his cancer levels had dramatically increased (Lines 6 to 24). Into this account he incorporates the reported voice of a cancer advice worker, “you know what I’m going to say you’ve got to talk to your consultant now” (Lines 18 and 19). And finally in Line 26, he concurs with Stella’s initial assessment. It appears that Stella has opened up the discursive space for Ivan to discuss his emotional response but it seems that, first, Ivan has to justify this response before admitting that it was “devastating”. Perhaps the inclusion of the cancer advice worker’s ‘words’ is similarly useful in permitting a display of devastation.

In the interviews part of women supporters' contribution to the joint construction of illness narratives seemed to be to introduce emotional and other dimensions (such as pain and panic), which the discursive evidence suggests troubled male identity. This introduction of trouble, however, also seemed to facilitate men talking about the more difficult aspects of their illness. If a female partner instigated such discussions then the man was able to confirm this information and even expand on it whilst distancing himself at the same time from dwelling on pain, fear and grief.

Women's contribution thus seems to have mixed effects. On the one hand, as the extracts above demonstrate, it requires men to do some work to deal with the identity trouble potentially introduced. Having reasserted or established a normative identity in line with hegemonic masculinity, however, it also allows men to discuss the difficult aspects of illness and have these heard and recognised in ways which protect their identity. The fact that women carry these parts of the story-line allows men to maintain what seem to be preferred and normative 'unemotional' identity positions. Women's emotional assessments seem to offer men the opportunity to preserve a positive identity and deal with some of the trauma of illness. Could this interactional pattern and the identity spaces which women's emotional assessments construct for men explain part of the health benefits men gain from relationships with women? Is this an interactional gift that women give to men – the handling and acknowledgement of vulnerability in an acceptable way? We assume that although social support is multi-faceted, one important ingredient is the opportunity to come to terms with and develop a stabilising narrative for

disruptive events along with the validation and confirmation of one's actions and reactions.

What about the reverse situation though? Do male supporters construct a similarly mixed but potentially positive and beneficial identity space for their female partners? Although our sample of men with female partners suffering from cancer is small, we can speculate. We note that none of the male supporters in the data set took over the difficult or painful parts of their partner's story in this way. It seems possible that the 'normal and necessary' and 'sturdy oak' aspects of men's supporter discourse described above might actively close down women's rehearsal of the traumatic aspects of illness. But this requires further investigation. Perhaps, like female supporters, male supporters are taking up positions which are dispreferred (non-normative) for women, thus troubling women's identity but 'liberating' them to engage with what is dispreferred?

In our view the positioning dynamics evident in these couple interviews suggest this is unlikely. The assessments men offer based on constructions of 'normal and necessary' and 'sturdy oak' do not set up identity positions which are dispreferred, non-normative or undesirable for women and these positions of 'everyday coping' are, we suggest, available in women's identity repertoires in a way that emotional assessments seem not to be for some men. In other words, there could be a disparity in the kind of identity spaces couples create for each other which might mesh with the disparities in the health benefits of relationships for men and women in intriguing ways.

Women's Health Supervision

The claim that the benefits of relationships for men are due to women's health supervision was noted in the introduction (Umberson, 1992). But what are the positioning dynamics that accompany this 'social control' attributed to women? We have argued elsewhere (Seymour-Smith, Wetherell and Phoenix, 2002) that the discourse of male and female health professionals constructs a position for the male patient as 'hapless and helpless' but where men's inability to take care of themselves is seen benignly and their supposed failings are both protected and indulged. Similar patterns were evident in the discourse of this sample of heterosexual couples. Frequently, this positioning of the ill male partner was achieved through humour as in Extracts Nine and Ten below.

Extract Nine: Interview with Tony and Jane (a man who had testicular cancer and his female partner)

1. Sarah yeah yeah um would you say that you were the kind of person
2. that took care of your health?
3. Tony (5) yeah yeah I guess so [I mean I didn't
4. Sarah [yeah
5. Tony I did there was nothing that I did not do to look after my health=
6. Sarah =no
7. Tony um (.)
8. Sarah you went to the doctors if you were ill?
9. Tony yeah (.) yeah
10. Sarah OH there's some funny faces being pulled in the corner over
11. there (laughs)
12. Jane (laughing) men don't go to the doctor when they're ill [(laughter)
13. Sarah [(laughter)
14. Tony they do eventually
15. Jane eventually yes [after a lot of nagging
16. Tony [(inaudible)
17. Sarah (laughs) so would you say that's true now as well then? =
18. Jane =yes he
19. Sarah yeah (laughs)
20. Jane I mean he'll sit and suffer a headache (.) for hours before he'll
21. take any pills
22. Sarah mm
23. Jane whereas er I'll take them before the headache starts
24. (laughter)
25. Sarah (laughter) (1) um so would you say that (.) men are good at taking care of their

26. health in general or do you think there is a difference between
 27. [men and women?
 28. Jane [no I'm sure there is a difference I'm sure men
 29. Sarah yeah
 30. Jane men from my perception from Tony from my father from my two
 31. brothers
 32. Sarah mm
 33. Jane will not go to the doctor unless they absolutely have to
 34. Sarah yeah (.) why do you think that is then=
 35. Jane =I don't know maybe [it's
 36. Tony [they're they're busy people aren't they (lau[gher) no but I mean
 37. Sarah [(laughter)
 38. Jane [(laughter)
 39. Tony these places are full of germs you don't want to catch anything
 40. Sarah (laughter)
 41. Jane (laughter)

Laughter is a crucial part of the mechanics of everyday conversation oiling the smooth flow. Laughter by recipients demonstrates that tellers' narratives are culturally understood as funny and also it can ease troubled interactions (this is evidenced by the awkward laughter by the interviewer at different points in the interviews). In the case of Extracts Nine and Ten both these uses are apparent. In Extract Nine Tony has responded that he would go to the doctor if he were ill. In Line 10 the interviewer notes that Jane is nonverbally challenging Tony's construction of himself. However, rather than singling out Tony, Jane constructs *all men* as not going to the doctor until after 'a lot of nagging' (Lines 12 to 15). In the midst of this Tony simply says that "they do eventually" (Line 14). The interviewer then returns to the topic in Line 17 asking what Tony is like now after the testicular cancer? There is possibly a hearable implication here that his practice should have changed as a consequence of his cancer. Jane eases this by joking about how men and women treat headaches differently (Lines 20 to 24). Again the interviewer draws the conversation back to a more serious discussion of gender and health differences and Jane constructs a three-part list (Line 30) and extreme case formulation "absolutely"(Line

33) to persuade the interviewer that men *in general* do not go to the doctor unless it is compulsory. When the interviewer asks Jane to account for this, Jane starts to reply but Tony interrupts with “they’re busy people aren’t they” (Line 36) which leads both Jane and the interviewer to laugh. By means of this joke the potential ‘trouble’ of Tony’s reluctance to visit a doctor is smoothed over. Jane, Tony and the interviewer become complicit with a particular positioning of men linked to hegemonic masculinity as independent, tough and self-reliant. We suggest that women’s health supervision in practice involves this delicate collusion and respect for their partner’s investment in hegemonic masculine positions. Men are criticised, supervised and celebrated.

Extract Ten: Interview with Phillip and Elizabeth (a man who had prostate cancer and his wife)

- | | |
|--------------|---|
| 1. Elizabeth | but <u>anyway</u> I said you <u>must</u> go and mention to Doctor Samir and Phillip was |
| 2. | seeing Doctor Samir virtually every month from then onwards= |
| 3. Sarah | =right [because of |
| 4. Elizabeth | [because of his blood pressure |
| 5. Sarah | yeah |
| 6. Elizabeth | but did you mention it to him? |
| 7. Phillip | not at that point no [(laughter) |
| 8. Sarah | [(laughter) |
| 9. Elizabeth | [(laughter) he doesn’t do everything that (.) <u>I say</u> okay |
| 10. | [(laughter) |
| 11. Sarah | [(LAUGHTER) |
| 12. Phillip | of course not |
| 13. Sarah | that’s the way it goes is it? (laughter) |

In Extract Ten, Phillip and Elizabeth are jointly constructing their illness narrative. In the course of this Elizabeth positions herself as the health supervisor and reports telling Phillip to go to the doctor. In Line 6 she requests verification from Phillip about whether he then went to see the doctor but she does so in a way which allows an apparently

familiar ‘positioning dance’ to take place. Phillip has the opportunity to take over the story. He says “not at that point no” and laughs (Line 7). Instead of taking a longer turn to explain this, he simply answers the question without offering a reason. Why does this evoke so much laughter on the part of the recipients? Again what seems at stake, economically presented and mutually understood, is a canonical construction of the ‘hapless and helpless’ (and resistant) male. Phillip’s response also positions him as the ‘regular guy’, able to laugh at himself. Interestingly in Line 9, Elizabeth orientates to the basis on which women are ‘allowed’ to be men’s health supervisors. Women can control and order men’s behaviour but men remain autonomous agents and indeed their recalcitrance and show of resistance protects and preserves their identity. Once again, one could argue that women are delivering an interactional ‘gift’ here – men’s preferred and positive identities are maintained and women carry for men the parts of the positional dance involving vulnerability, dependence and need of medical services.

Women’s duties as health supervisors extend quite far, as the next two extracts demonstrate, to the extent of making special knowledge claims about their male partner’s bodies.

Extract Eleven: Interview with Phillip and Elizabeth (a man who had prostate cancer and his female partner)

1. Phillip um so she took my blood pressure um and I rang the clinic to
2. tell them what it was and it was high still
3. Elizabeth well but it wasn’t sky high
4. Phillip it wasn’t sky high
5. Elizabeth I mean it was Phillip high (laughter)

As noted earlier, displays of knowledge about one's partner and the co-construction of one partner's illness story as a joint narrative demonstrate a close and harmonious relationship. With the simple phrase "it was Phillip high" (Line 5) Elizabeth actively achieves a construction of herself as intimately knowledgeable about Phillip's blood pressure. She owns special knowledge about his body.

Extract Twelve: Interview with Frank and Cindy (a man who had prostate cancer and his wife)

1. Frank yeah 'cos you've got a choice of operation or a laser
2. and all these things these days
3. Sarah yeah (.) yeah
4. Frank but no I was quite well quite pleased about
5. Sarah yeah
6. Frank the laser one because touch wood I've never had an operation
7. in me life
8. Sarah oh right yeah
9. Frank so I wouldn't have you know [wouldn't have been sure what to do
10. Sarah [don't want to start now (laughs)
11. Cindy no
12. Frank no
13. Cindy I mean beforehand he had lost a lot of weight
14. Sarah mm
15. Cindy he's made up for it since
16. Frank well yeah I've packed up work now haven't I (laughter) yeah
17. Cindy yeah he eats very well anyway hasn't stopped him eating has it
18. Frank oh no no
19. Sarah (laughs)

In Line 13 of Extract Twelve Cindy makes a similar special knowledge claim. The narrative switches at this point from Frank as the main narrator of his illness to Cindy who constructs the embodied details of his health. Like Elizabeth, she positions herself as having some higher command of the physical symptoms of ill health. Interestingly she refers to Frank at this point using the third person 'he'. Aronsson and Cederborg (1998) have described how child patients in medical consultations are often devoiced and constructed as 'non-persons' by their mothers. Here Phillip and Frank both have a voice

but Elizabeth and Cindy have a certain authority over the embodied details. The men are positioned by their female partners in an almost child like way. Indeed at one point in the interview Cindy exclaims, “never had him ill”- an intriguing way of talking about a mature man.

Conclusion

In this paper, we have tried to unpack the fine detail of the identity positioning work evident in the illness narratives of heterosexual couples. It is plausible that these discursive patterns explain some of the global disparities evident in the health benefits men and women receive from relationships. Since our material was most extensive for heterosexual couples where the man was ill and the woman was the supporter, we have focused particularly on the kind of ‘identity spaces’ and ‘positioning dances’ the interactions in this situation construct. We used our smaller corpus of data from couples where the man was the supporter of an ill female partner to clarify commonalities and differences.

We began by showing how couples jointly construct illness narratives. This usefully furthers our understanding of the similarities of relational support in heterosexual couples’ narratives. Then, focusing on gender differences we examine how male supporters ‘do what is necessary’ whilst female supporters ‘do emotions’. This, of course, confirms the typical gender order. However, we then focused on how in these co-constructed stories women’s emotional assessments create identity trouble for men. But this is not trouble which overwhelms the interaction or disrupts the general impression of

a harmonious couple. Rather, men typically reassert or maintain their preferred identity positions consonant with typical cultural forms of hegemonic masculinity. We argued that heterosexual men probably benefit from women's rehearsal of the more emotional dimensions of the experience of serious illness. In the introduction we outlined how women influence the health behaviour of men (Norcross, et al, 1996), perhaps our analysis offers one step further in puzzling out how the type of emotion work that women perform for men actually gets translated into something practical. We have already discussed elsewhere how men have to carefully negotiate talk about health (Seymour-Smith, Wetherell & Phoenix, 2002) and here we can view the emotion work that women perform as an interactional gift, allowing men the space to talk more candidly about their illnesses.

We then looked in more detail at women's health supervision of men. A similar pattern was noted there. In many respects, female partners potentially seriously trouble men's identity performances as competent and autonomous individuals capable of looking after themselves. Yet, again, this trouble does not overwhelm the interaction or disrupt heterosexual coupleness. Rather, done humorously, it further reinforces co-construction and mutuality. Women seem to be engaged in delicate work here – taking on a supervisory role and 'owning' others' bodies in a way not dissimilar to the maternal stance in relation to children but simultaneously celebrating and indulging those they 'control'. Men - what are they like! This seems to be the up-shot.

Women's positioning work is, we suggest, a form of complicity with hegemonic masculinity. It is a strange kind of power and social control therefore which women exert over men's health. It could be argued that it is a power which benefits the 'victim' or the target much more obviously than the one who is notionally assigned the control. This is what health supervision looks like, we suggest, within a broader gender regime of male power.

Further research is needed particularly on the identity spaces male supporters create for their ill female partners. From a feminist perspective, it would be interesting to unpack why this benefit is not more reciprocally shared. However, based on the wider data corpus (which this sample was taken from) we can suggest that women may be receiving more emotional support from attending breast cancer support groups. Perhaps this may explain the discrepancy in relational care. Heterosexual women may not need relational support in the same way as their male counterparts because they are more able to confide in each other.

In this paper we have been able to unpack what social support looks like in practice. The interviews with heterosexual couples are useful in demonstrating the mundane ways that relationships are performed. We suggest that tracking the flow of trouble through an interaction and developing forms of discursive psychology which combine fine-grain analysis and attention to the broader social and cultural context are productive ways of exploring these questions further.

8, 179 words

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Appendix A: Transcription notation

The form of notation used in the thesis is a simplified version of the transcription notation developed by Gail Jefferson. A more detailed description is found in Atkinson and Heritage (1984).

Extended square brackets mark overlap between utterances, e.g.:

A: [men overlapping utterances
B: [yeah

Square brackets with a line of dots indicate that some lines of the interview have been omitted, e.g.:

[.....] lines omitted

An equals sign at the end of a speaker's utterance and at the start of the next utterance indicates the absence of a discernable gap, e.g.:

A: like I said before=
B: =when you mentioned

Numbers in brackets indicate pause times to the nearest second. A full stop in brackets indicates a pause which is noticeable but too short to measure, e.g.:

A: he meant (2) that he felt (.) ill

One or more colons indicate an extension of the preceding vowel sound, e.g.:

B: I was very anxious:s about it

Underlining indicates that words are uttered with added emphasis and words in capitals are uttered louder than the surrounding text, e.g.:

A: I sent him to see a doctor but he **WOULD NOT** go

Rounded brackets indicate material in the brackets is either inaudible or there is doubt about its accuracy. 'Unclear' is written in brackets if no guess has been made at the utterance, otherwise the words in brackets are an attempt at discerning what was heard, e.g.:

B: when I went (unclear) to see him he was (sat) down on the floor

Laughing is indicated by the word 'laughter' in bracket, e.g.:

B: I can't say why (laughing)

A question mark is used to indicate rising intonation, often when there is a question, e.g.:

A: what did he say that for?

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