SSOAR

Open Access Repository
www.ssoar.info

Identity ambivalence and embodiment in women's accounts of the gynaecological examination

Galasiński, Dariusz; Ziółkowska, Justyna

Postprint / Postprint
Zeitschriftenartikel / journal article

Zur Verfügung gestellt in Kooperation mit / provided in cooperation with:
www.peerproject.eu

Empfohlene Zitierung / Suggested Citation:
Galasiński, D., & Ziółkowska, J. (2007). Identity ambivalence and embodiment in women's accounts of the gynaecological examination. *Health*, *11*(4), 455-474. https://doi.org/10.1177/1363459307080864

Nutzungsbedingungen:
Dieser Text wird unter dem "PEER Licence Agreement zur Verfügung" gestellt. Nähere Auskünfte zum PEER-Projekt finden Sie hier: http://www.peerproject.eu Gewährt wird ein nicht exklusives, nicht übertragbares, persönliches und beschränktes Recht auf Nutzung dieses Dokuments. Dieses Dokument ist ausschließlich für den persönlichen, nicht-kommerziellen Gebrauch bestimmt. Auf sämtlichen Kopien dieses Dokuments müssen alle Urheberrechtshinweise und sonstigen Hinweise auf gesetzlichen Schutz beibehalten werden. Sie dürfen dieses Dokument nicht in irgendeiner Weise abändern, noch dürfen Sie dieses Dokument für öffentliche oder kommerzielle Zwecke vervielfältigen, öffentlich ausstellen, aufführen, vertreiben oder anderweitig nutzen.
Mit der Verwendung dieses Dokuments erkennen Sie die Nutzungsbedingungen an.

Terms of use:
This document is made available under the "PEER Licence Agreement ". For more Information regarding the PEER-project see: http://www.peerproject.eu This document is solely intended for your personal, non-commercial use.All of the copies of this documents must retain all copyright information and other information regarding legal protection. You are not allowed to alter this document in any way, to copy it for public or commercial purposes, to exhibit the document in public, to perform, distribute or otherwise use the document in public.
By using this particular document, you accept the above-stated conditions of use.

gesis
Leibniz-Institut
für Sozialwissenschaften

Mitglied der
Leibniz-Gemeinschaft

Diese Version ist zitierbar unter / This version is citable under:
https://nbn-resolving.org/urn:nbn:de:0168-ssoar-226146

health: An Interdisciplinary Journal
for the Social Study of Health,
Illness and Medicine
Copyright © 2007 SAGE Publications
(Los Angeles, London, New Delhi and Singapore)
DOI: 10.1177/1363459307080864
Vol 11(4): 455–474

Identity ambivalence and embodiment in women's accounts of the gynaecological examination

Dariusz Galasiński and Justyna Ziółkowska
University of Wolverhampton, UK and Warsaw School of Social Psychology, Poland

ABSTRACT In this article we are interested in the negotiation of identities in women's narratives of their gynaecological examination and more particularly, the shifts of identity positions that permeate their stories.

Taking a constructionist view of discourse and identity, we make two arguments in the article. First, we demonstrate that women talking about their gynaecological examinations constructed their selves ambiguously. The identity spaces that they discursively opened in the narratives were not inhabited. Second, we show that the embodiment of their identities – the inclusion of the body into the construction of self – fluctuates depending on the stage of the narrative of the examination.

KEYWORDS *embodiment; gynaecological examination; identity; narrative*

ADDRESS Dariusz Galasiński, Humanities, Languages, and Social Sciences, University of Wolverhampton, Wulfruna Street, Wolverhampton WV1 1SB, UK. [Tel: +44 01902 3423408; fax: +44 1902 322739; e-mail: d.galasinski@wlv.ac.uk]

Introduction

In the social sciences, studies of the gynaecological examination, described as the most intimate of examinations (Royal College of Obstetricians and Gynaecologists, 1997), primarily focus on the experience of the procedure. Thus patients are said to associate the examination with vulnerability (Oscarsson and Benzein, 2002), discomfort (Hilden et al., 2003) and relief from it (Ragan, 1990), anxiety, humiliation and dehumanization (Weiss and Meadow, 1979) or degradation (Areskog-Wijma, 1987). Research focusing upon the examined women explores preferences of the gynaecologist's gender (Delago et al., 1993; Elstad, 1994; Ekeroma and Harillal, 2003), various aspects of doctor–patient communication (van Dulmen, 1999; Hall and

Roter, 2002; Uskul and Ahmad, 2003) or gender differences in the workforce and careers (Pearse et al., 2001; Gjerberg, 2002; Benedetti et al., 2004).

Yet, apart from the classic study of Henslin and Biggs (1978) on patients' desexualization during the gynaecological encounter, we did not find any research that explicitly undertakes the issue of the patient's or doctor's subject positions in the situation of the gynaecological examination/visit. Implicitly, the patient's depersonalization/personalization is also discussed in Emerson's work on shifting definitions of the gynaecological encounter (Emerson, 1970). Emerson argues that doctors must sustain a shifting balance between the patient as an object and the patient as a co-operative impersonal being. However, both Henslin and Biggs' and Emerson's studies are based on the authors' observations. Indeed, the analysis of the doctors' narratives of the gynaecological visit problematizes their findings – we have shown elsewhere that male gynaecologists do construct their female patients, and themselves, in terms of gender (Galasinski and Ziółkowska, 2007).

Aims and assumptions

Our aim in this article is twofold. First, we would like to examine the identities and subject positions which women take, while talking about their gynaecological examinations. Moreover, we shall demonstrate that gender identities are not 'superior' to others and that they are not omnirelevant in such stories. Rather, we shall show that gender was part of the ambiguity which dominated the subject positions and identities assumed by the informants. Second, we shall argue that in the context of the gynaecological examination women's identities are necessarily embodied, and, importantly, that such embodiment changes depending on the stage of the medical encounter narrated by the woman.

Thus, we are interested in questioning the prevalent assumptions in the literature that gender is the dominant identity category assumed in interactions, one 'superior' to others, constructed as the most important aspect of the person permeating 'the way we think and talk about ourselves and others' (Siann, 1994: 1; also Connell, 1999; Kitzinger, 1999; Weatherall, 2002).

Furthermore, we are interested in the apparent tension surrounding gender identities. While the exclamation after the child's delivery 'It's a girl!' has the power to assign gender (Butler, 1990; McIlvenny, 2002a, 2002b), it is made after the child's genitals are inspected and acknowledged (also McKenna and Kessler, 2000). But crucial as they are in ascribing and inhabiting gender identities, they are also constructed as the category of disgust and shame (Miller, 1997), represented as the most private (intimate, personal) part of the body, not to be displayed publicly, if at all, nor talked about (Braun and Wilkinson, 2001). Yet, during the procedure of the gynaecological examination they are the subject of attention and scrutiny, as they are displayed and discussed.

We do realize therefore that the narratives we examine are not 'any' narratives, of 'any' medical encounter. As we have noted above, researchers have long noted the extraordinary character of the gynaecological examination, one in which the woman can be seen at her most vulnerable, and the doctor, particularly the male doctor, at his most powerful (see Kapsalis, 1997; also Fox, 1993). Thus, we are interested in identity work in an extreme circumstance – both in terms of telling the story of the examination in the situation of the interview, and represented *past* identity work within the procedure.

We understand the notion of narrative very broadly and see it not so much in terms of the linguistic form (notoriously difficult to identify for narratives, for a review see Toolan, 1988; Georgakopoulou and Goutsos, 2000), but in the concept of the 'narrative contract' (Barthes, 1974), that is, an understanding between the narrator and the narratee that the former is expected to 'tell a story' – whatever that story might be – and the other is expected to listen. We follow Johnstone in understanding narratives as 'a way of constructing "events" and giving them meaning' (2001: 644).

Furthermore, we see the informants' narratives as stories of an event that is a site for 'identity work', a space in which one's own identity as well as the Other's is constructed and positioned. Also, the act of telling the story is one in which identity is continually (re-)constructed. We think of identity as a discourse of (not) belonging, similarity and difference, which is continually negotiated and renegotiated within a localized social context (Barker and Galasiński, 2001; also Wodak et al., 1999; Galasiński, 2004). A continual process of becoming, it involves mutual (re-)construction of self and Other, with the Other understood as the self's 'constitutive outside' (Hall, 1996). But, as we said, we are also interested in representations of identities, in how they are told and re-told with the benefit of the hindsight. Also here, however, we assume that those identities are 'fixed' for the purpose of the narrative, and they are also subject to narrative re-construction.

We take the notion of subject positions to be broader than that of identity. For while the latter necessarily involves positioning oneself in terms of belonging, a position with regard to those 'like me', as well as the Other, the subject position does not. It is a construction of the self as self. It locates the self within a space available to it, giving it at the same time certain rights and duties. Also subject positions are discursive and subject to immediate change (see Davies and Harré, 1990; Harré and van Langenhove, 1999).

The Study

We report on a qualitative study on constructions of the gynaecological in the narratives of women seeing male doctors, and of the doctors carrying out the examination. The research aimed to explore the gynaecological examination as experienced both by the actors and objects of the procedure (Ziółkowska, 2005). The research was conducted between January and June

2004 in a city in the south of Poland. The informants were recruited from women seeing male gynaecologists with the use of the snowballing strategy. Twelve self-reportedly healthy women, married and not pregnant took part in the study. The data were obtained through semi-structured interviews (later fully transcribed), which were conducted in the informants' flats and included questions concerning characteristics of doctors, patients' preparations for the examination, the examination itself, touch and gaze during the procedure as well as issues of comfort. In this article we focus solely upon the narratives of the female informants.

In Poland, gynaecological care is performed almost exclusively by specialist gynaecologists, and GPs do not deal with that aspect of woman's heath. In every health care centre there is at least one gynaecologist who conducts routine check-ups (including taking smear tests) and performs minor treatments. In the case of the gynaecologist's absence in her health centre (as might be the case in some rural areas), the woman would be referred to a specialist in a different centre. In addition there is a well-established network of private gynaecologists' surgeries. The institution of the chaperone is practically unused in Poland and it is normally up to the woman to wear such clothing in which she will feel comfortable after undressing.

Identities to pick from

When we approached the corpus of our data, we expected that the identity positions assumed by the speaking women would be predominantly gendered. We assumed that we would hear *women* speaking and that gendering of their identities would be the dominant trait of their narratives. We were mistaken in this assumption. Our female informants did speak as women, but more often than not they did not – their femininity was either implicit or completely removed from their constructed identities. Alternatively, when they did speak as women, their gender was juxtaposed with and at the same level as other identities they constructed and, often, distanced from.

What we shall show is that the subject positions the informants took did not translate into clear inhabited identities. The narratives of the gynaecological examination, an event that seems to be an ultimately feminine one, did not produce unambiguous identity categories. And it is this ambiguity that dominated the informants' discourses.

Let us start by showing two extracts in which the speaking women explicitly speak of themselves, yet do not take a clear identity position.

Extract 1

I: na początku chciałabym żeby pani mi powiedziała co jest dla pani ważne jak pani idzie do ginekologa (.) co jest ważne jak się idzie do ginekologa?

US: dla mnie jest przede wszystkim ważny kontakt z lekarzem żeby po prostu móc mu zaufać

I: At the beginning I would like you to tell me what is important for you when you go to see a gynaecologist? What is important when one goes to see a gynaecologist?

US: First of all, for me the contact with the physician is important. So you can simply trust him.[1]

Extract 2

I: Co jest ważne dla pani podczas wizyty u ginekologa?

AS: (..) wydaje mi się ze komfort jaki lekarz stwarza to jest spokój jakaś delikatna cicha muzyka (.) Oczywiście i rozmowa (.) z lekarzem

I: A cicha muzyka w gabinecie?

AS: Tak tak (.) Bo przede wszystkim krepuje mnie to ze za drzwiami zawsze słyszy się to co mówią (.) To takie krępujące jest trochę ten odgłos tych narzędzi (.) Rękawiczek zakładanych to się wszystko słyszy na zewnątrz to takie jest wiesz? No dla mnie bynajmniej (.) Ale widzę ze każdy to odczuwa tak jakoę słucha i udaje że cos robi coś coś takiego, no.

I: What is important for you during the gynaecological visit?

AS: I think it is the comfort that the physician creates. The calm, some delicate quiet music (.) And of course the conversation with the physician.

I: Quiet music in the surgery?

AS: Yes yes (.) Because above all I am embarrassed that behind the door one can hear what they talk about. It is a little embarrassing. this noise of instruments, gloves put on. You can hear it all outside the surgery and it is you know? At least for me. But I can see that everyone feels it, listens to it and pretends that they do something else.

Both informants explicitly refer to themselves; they stress their subject positions, inserting their perspective in speaking explicitly into what they say: US speaks of what is important *for her* when she sees a gynaecologist; AS, alternatively, says what *she thinks*, what is important *for her*. Let us consider the issue in some detail.

One could of course assume that both women, because they are biological women, speak as women. The argument, however, is problematic to say the least. As gender is social rather than biological, an inference of gender identity cannot be made on the basis of the speaker's body. One could also assume that the woman's identity is 'implied' – after all the narrative is on the gynaecological examination and the questions concern the informants as women. The interaction requires the informants to access and/or produce the stories of their (feminine) bodies, thus they cannot speak but as women. Acknowledging them, we think that such argument lines are also problematic, as they are based on assumptions (and not arguments) of gender as the omnirelevant aspect of interaction. We do not think that the analyst's interpretation – her or his claim that in a given context gender was relevant as

a category of 'accounting' for what happened (see, for example, Cameron, 1998) – can or, indeed, should be seen as an argument that gender was relevant for the participants; that they, in one way or another, oriented themselves towards it. The two issues, we think, should not be presented as one, or as 'displaced' by one another (for a detailed discussion see Galasiński, 2004).

We take the view that gender identities cannot be simply 'read' off' what people say, with the assumption that women talk as women and men talk as men, on the decision of the analyst. We are particularly uneasy with regard to the notions of constructing contexts, which go beyond the control and intention of the participant (as Wetherell (1998) seems to suggest). While we assume that identities can be imposed in the course of interaction, they should not be in the process of the analysis. We are concerned with Stokoe and Smithson's (2001) proposal that the analyst use his or her background knowledge or common sense in the analysis. If identities are locally negotiated, it is not for the analyst to impose identity categories upon the participants whose interaction he or she is analysing (see also Coleman, 1990).

In contrast to the points made by Swann (2002), who offered a list of 'clues' how the analyst might decide on whether gender is relevant in an interaction, we agree with Ochs (1992), who says that there are few such linguistic resources which index gender, exclusively and directly. The point was taken up by Cameron (1997) and Johnson (1997), who point out that the complexity of gender identities does not allow an assumption that they might be performed in some patterned ways. Thus, in line with our earlier work (Galasiński, 2004), we assume that there are no systematic discursive markers of gender identities. It is only possible to have insight into the context-bound 'discourse of belonging', one which might change from one situation to another, with speakers drawing upon different resources, often contradictory, to construct themselves as 'being something' or 'belonging' (for narratives with contradictory constructions of identity, see Barker and Galasiński, 2001). Crucially, the informants above did not construct such belonging. Their subject positions referred to 'them', rather than 'them as something or someone', constructing subjectivity without belonging.

As much as the informants do not take a gendered identity when speaking to the interviewer, gendered identity does not arise when they speak from the perspective of the doctor–patient interaction. Witness the following extract.

Extract 3

OG: =tak. ja po prostu jak wchodzę do niego do gabinetu to się czuję bardzo (.) spokojnie rozluźniona nie jestem spięta potrafię mu o wszystkich swoich problemach tego typu powiedzieć (.) i i no a: mam zaufanie po prostu do niego po prostu mam do niego zaufanie.

OG: when I go into his surgery, I feel very calm and relaxed, I am not tense. I can tell him about all problems of that kind. I simply trust him.

It is hard to say that OG is speaking of herself as a woman or, indeed, as a patient. She constructs herself as 'herself' – whatever that might actually mean. That of course does not mean that she takes a gendered or patient (or both!) position during the medical encounter (and we have no doubt that the powerful medical context is capable of imposing such an identity upon a person), but in the narrative at hand we find little evidence of that.

Thus, in contrast to such commentators as Fox (1993), our argument is that the three extracts cannot be analysed as made from the positions of women. Their 'selves' are uninterpellated, not spoken for. The subjectivity the women occupy is neither gendered nor anything else. The subjects perform 'themselves', we could say, rather than a belonging.

We see this as the informants' attempts to keep their 'identity options' open. The informants, for one reason or another, chose to remain ambivalent with regard to their identity positions. What is particularly interesting for us here is that the maintenance of the identity ambivalence can be observed throughout our data corpus; also when our informants took up explicit identity positions. In such cases they chose to do it in a distanced way, never fully inhabiting the identities they performed. In other words, they constructed their identities only by implying belonging to the categories flagged up in their discourse.

The ambiguous self

Let us now discuss a few examples in which the informants distance themselves from taking up the categories they lay out in their narratives, but, most importantly for the argument here, construct a number of equivalent subject positions in their narratives. In other words, we would like to show how our informants laid out a certain 'identity potential', never inhabiting any of the possible positions. We understand distancing as dissolution of the 'ownership' relationship (Bavelas et al., 1990) between the category and the subject. For example, linguistically it includes situations when the social actor is not rendered as the linguistic one, socially, when, say, an ill person is using strategies allowing them to avoid making a direct attribution of illness to their self (see Galasiński, forthcoming). This is exactly how the informants position themselves with regard to their identities – the relationship of 'ownership' is never complete or fulfilled. Moreover, we found that the informants alternated between a number of positions: the undifferentiated 'me' position, what we call the 'person' position, the position of a patient, as well as their gendered identity.

We realize of course that it is difficult to describe a 'canonical' way in which people take an identity, and exploring it comprehensively is beyond the scope of this article. However, if we assume that identity is a 'discourse

of belonging', we must assume that in one way or another the person taking an identity must speak of her/himself being something, or pertaining to a group of people (for a detailed discussion on distancing in discourse see Galasiński, 2004).

The subject positions laid out were not only those available to the speaker, but they were also interchangeable. We begin with an extract that in part we quoted earlier (1). This time we show it with the additional two turns which followed.

Extract 4

I: Na początku chciałabym żeby pani mi powiedziała co jest dla pani ważne jak pani idzie do ginekologa (.)Co jest ważne jak się idzie do ginekologa?

US: Dla mnie jest przede wszystkim ważny kontakt z lekarzem żeby po prostu móc mu zaufać

I: Yhm

US: To jest najważniejsze po prostu żeby być y: pewnym tego no że on ma odpowiednie kwalifikacje ale jednocześnie że (.) Ma dobry kontakt z pacjentem bo to jest ważne dla kobiety wtedy kiedy może powiedzieć *wszystko* temu lekarzowi prawda (.) To jest dla mnie bardzo ważne

I: At the beginning I would like you to tell me what is important for you when you go to see a gynaecologist? What is important when one goes to see a gynaecologist?

US: First of all, for me the contact with the physician is important. So you can simply trust him.

I: Yhm

US: That's the most important, to be sure that he has appropriate qualifications, but simultaneously that he has good contact with the patient because it is important for the woman that she can tell the physician everything right? It is very important for me.

There is a shift from a subject position that does not occupy an identity space, to one that is clearly gendered, except that it is constructed in generic terms. The argument of distancing from a gendered identity space is stronger here, as the informant oscillates between the 'me' position, via the generic 'woman' position, switching back to the 'me' position. There is no evidence that could suggest that the 'woman' position, even though it is in the third person singular with the speaker taking a narrator-like voice (Hodge and Kress, 1993), does not refer to US. Admittedly, the gendered space US opens has an additional function of re-repositioning her experience onto a more general level – it is unlikely to be important only for her, but also for other women. Still, we would argue that its primary function is self-reference, constructing an available identity category for the speaker.

Moreover, being a patient and a woman seem to be interchangeable for the informant. The difference, it seems, is the perspective from which one tells the story. If the informant takes the point of view of the doctor, then she constructs a potential for being a patient; otherwise, she chooses the woman position. Importantly for our argument here, the opening of a number of potential spaces for herself, but not taking any of them, only adds to the constructed ambiguity of self. In such a way the speaker blurs further what kind of identity she might take up.

The repair action shifting the generic form to the 'me' in the next extract suggests again that the informant switches between two equally weighted options.

Extract 5

I: A podczas badania lekarz też dotyka pacjentkę jak można byłoby opisać ten dotyk? jaki ten dotyk jest?

OG: (6sec.) Czasami ma za zimne ręce. [laughs] To się momentalnie kobieta de/ ja na przykład momentalnie po tego ale na przykład ten lekarz do którego chodzę on na przykład y: bo zanim założy rękawiczki bo to w rękawiczkach więc często y: nawet mówi mówi mam y: zimne ręce (.) zagrzeje sobie trochę na przykład czy o kaloryfer czy pod ciepłĄ wodę mówi żeby mimo tego przez rękawiczki mówi żeby to nie było y: nieprzyjemne dla pani(.) no a to jest takie y(....) takie zawodowe. taki dotyk zawodowy. po prostu musi i: i ja się tak do tego nastawiam (.) no.

I: During the examination the physician touches the patient. how can one describe that touch? what is that touch like?

OG: Sometimes he has too cold hands; then immediately the woman, me for example immediately, but the doctor I see for example before he puts on gloves because it is with gloves, he often says. My hands are cold; I'll warm them up, or on the radiator or under warm water he says that despite it is through gloves, so it's not unpleasant for you. And that is that is so professional. Such a professional touch. He simply he has to, and that's how I approach it.

The extract suggests that the informant takes the two voices – that of the 'woman' and that of the 'me' – as equivalent in the sense that they can be interchanged depending upon the context of the narrative. As we suggested, we see speaking in the auctorial voice, linguistically manifesting itself in the generic third-person form, as one of the ways in which an identity space can be opened but not inhabited at the moment of constructing it. But as much as our informants used gender identity potential to situate themselves next to, they used other positions that can also be seen as equivalent to the 'woman' position we described earlier. This is precisely why we cannot interpret the 'me' as gendered: it was on a par with other categories.

The most important such category was that of the 'human being' (Polish *człowiek*, often translated as a generic 'man' or 'one'), which could be translated into English as 'person'. In the next two extracts the speaking women construct 'personhood' as the potential identity category for them – the

references to 'człowiek' (human being, person) are in generic third-person singular terms. Consider:

Extract 6

I: [...] jak się pani przygotowuje do wizyty u ginekologa?

AA: to znaczy się no wiadomo że że trzeba być i umytym i bielizna musi być czysta specjalnie na to przebrana i po prostu (.) przygotowanym to znaczy być odświeżonym czystym bo: ten i i: (.) jak tam się wchodzi czy coś to też jeszcze tam człowiek idzie z jakimś jakimś troszeczkę się umyć czy coś i tak w ten sposób idzie się później do już do samego gabinetu przed samym wyjściem wiadomo że jest napięcie że się tam i sikać chce i ten zawsze coś sobie z sobą biorę żeby się troszeczkę umyć iść żeby i czystym (.) no.

I: How do you prepare yourself for a visit with a gynaecologist?

AA: I mean, obviously one must be washed and the underwear must be clean, specially changed for that. And simply prepared. It means to be freshened up, clean because when you go in there, you go in in such a way, and later into the surgery, just before leaving, obviously there is tension that and you want to pee and I always take something with me to wash up a little and to go clean. There.

Extract 7

AS: Tak tak (.) Bo przede wszystkim krepuje mnie to ze za drzwiami zawsze słyszy się to co mówią (.) To takie krępujące jest trochę ten odgłos tych narzędzi (.) Rękawiczek zakładanych to się wszystko słyszy na zewnątrz to takie jest wiesz? No dla mnie bynajmniej (.) Ale widzę ze każdy to odczuwa tak jakoś słucha i udaje ze cos robi coś coś takiego, no

I: A gdzie muzyka leci?

AS: W gabinecie cichutko ściszona jest taka delikatna bardzo ewentualnie nawet na zewnątrz tak samo jest ten telewizorek tam zawsze puszczony w korytarzu i cichutko i człowiek tak inaczej się czuje przez te chwile chociaż.

AS: […] because above all I am embarrassed that behind the door one can hear what they talk about. It is a little embarrassing. this noise of instruments, gloves put on. You can hear it all outside the surgery and it is you know? At least for me. But I can see that everyone feels it, listens to it and pretends that they do something else.

I: And where is the music?

AS: In the surgery. Quietly. Turned right down, it is very soft. possibly also outside, also there is the little television, always on in the corridor so a you feel differently at least for a moment.

The most significant point we would like to make here is that our informants constructed the 'person' positions in linguistically the same way they constructed 'woman' positions as identity resources. Once again, there is little doubt that the introduction of 'człowiek' is also designed to construct the activities as a general rule. Still, we would argue, it is an identity re-

source, exactly in the same way as 'woman' was above. To make the point in general terms, there is no evidence that the identity positions the speaking women constructed for themselves were differentiated in any way. Our informants showed a number of identity categories as equivalent to each other, identity spaces they could occupy, but at the moment of speaking, did not. The equivalence was only undermined by opening the patient identities that were linked to taking the perspective of the physician in the narrative.

The argument that underpins this discussion is that the women who spoke to us wanted to leave their identity positions ambiguous. This manifested itself in two main ways. On the one hand in speaking they were taking up the 'me' position, the position in which the self was not interpellated. On the other hand, it manifested itself in strategies of distancing from the identity categories that the women constructed for themselves, implied partaking in them, but never performing them. They were laying out identity resources, rather than using them in the local construction of identity. This ambiguity was underscored by their constructed equivalence. Being a woman was constructed at the same level as being a person or being a patient.

Now, we see this ambivalence as a very important aspect of the interviewee's identity and face management in the situation of the interview, one that touched upon a sensitive and potentially very threatening subject. Let us explore it in some detail. Our research explored the narratives of women who see male gynaecologists for their routine gynaecological checkups. It explicitly explored the women's choices of the male physician, their comfort during the pelvic examination, as well as the issue of touch during the procedure. Admittedly, these themes are potentially difficult and embarrassing for the informants, a few of whom commented on the 'unusual' nature of the topic of the conversation.

Moreover, the potential of 'misunderstanding' the relationship between the male gynaecologist and the female patient was not lost on the informants. In such a situation, it is probably only the 'me' and, perhaps, the 'person' positions that provided the informants with the safety of not acknowledging this tension and the certainty that no sexual innuendos would be inferred from what they said. Moreover, it is particularly the gendered 'woman' position that is particularly risky in this respect. If a 'biological woman' is a woman during the gynaecological examination (and the physician, explicitly or implicitly, a man), it raises the possibility of projecting what is an asexual relationship onto a sphere that is not. De-gendering of the relationship as well as the informant itself seems an important strategy with which to cope with and tame the potentially embarrassing experience of gynaecological examination. It is much better and safer for the woman not to be a woman in such a situation.

In such a way the patient position can be used to offset the possibility of gender and enables the telling of the story from the physician's perspective. But the patient identity is not inhabited, because it is not the informants' identity – it is one that is imposed by the relationship between the doctor and

the person who sees her/him. Our data show that the identity of the patient, or, shall we say, labelled 'patient', is much more complex and context-ridden than is often assumed in the literature. To put it very briefly – the person who is sitting in front of the doctor might be a patient because that is what we or the institution call such people, but it does not mean that the person has constructed and inhabited a patient identity.

Also, the distinction between the real 'me' as opposed to the 'me in illness' suggested in the literature (e.g. Bury, 1982; Charmaz, 1999; Cheshire and Ziebland, 2005) is not constructed by our informants, although it must be remembered that our informants were self-reportedly healthy and their stories were of examination rather than illness. The 'self' constructed in the stories of gynaecological examination consists of a number of complementary positions, with the uninterpellated 'me' being actually the object of medical examination.

Now, it seems that only the 'person' position is 'safe' in this regard. It provides a neutral ground on which to construct oneself. But the informants are distancing themselves also from that position, for the identity options constructed by the speaking women serve another purpose. As we mentioned, the linguistic form of the identity positions in the stories in our corpus is invariably that of third-person, generic statements about a certain group of people. In such a way, our informants co-opt the support of other women, or other people in their statements. Their experience of the gynaecological examination is not just theirs, it is also others'. Given the potential threat posed by the conversation about events like a genital examination, putting it in a wider context might also serve as a mitigating device.

The self floating in the body

But the ambiguity of identity positions constructed by the speakers is only one aspect of the constructions of the self in the women's stories of the gynaecological examination. The other is the construction of the self as embodied. What we found in the data is that the bodily self floated and changed its bodily anchor depending on which part of the encounter with the gynaecologist the informants focused upon. There were two locations for the embodied self – the entire body and, alternatively, the face, with the rest of the body 'disenfranchised' from subjectivity.

The change in the construction of the embodied self is engendered by the two crucial events during the gynaecological encounter: undressing and the actual genital examination. Thus, when the informants were undressing, their selves were located in the entire body; when they were undergoing the examination, their selves moved to their faces or eyes. These constructions are, incidentally, mirrored by the narratives of the gynaecologists in which undressing was the only moment when the patient's identity was gendered

and this not only limited their medical power, but also disenabled the medical (and other) gaze. On the other hand, when physicians talked about the examination, their stories were almost entirely deprived of human agency – it was their hands that examined, genitals (see Galasiński and Ziółkowska, 2007).

We would like to present the data demonstrating the floating embodiment by showing the change in the interviewee's construction of self, depending on the stage of her narrative. Thus, when speaking about their preparations for the examination, two informants say the following:

Extract 8

LG: [...] na przykład ja jak idę tam do tego [name of the gynaecologist] to on ma fajny parawan mówi proszę niech pani się przygotuje teraz on nie patrzy na to jak się rozbierasz czy coś tylko on też tam przygotowywuje różne rękawiczki a tam miały być wszystkie rozebrane na przykład wyobraź sobie że ty poszłaś jak poszłaś w spódnicy to chwała Bogu (.) bo rozebrałaś sobie rajstopy buty potem musiałaś gołe nogi włożyć no bo oni się śpieszą. (.) no chwileczkę no przecież my nie jesteśmy jakieś y: co ja mam nago iść a jak nie daj boże poszłaś w spodniach. no to jak ty miałaś się rozebrać co miałaś NAGA stać a tam stoi piętnaście pań (..) no bo będzie szybko. I każda siup na fotel i badanie cytologiczne. bo to było badanie cytologiczne. szybko wymaz pobrać.

LG: for example when I go to see this [name of the gynaecologist], he has a nice screen and he says please get ready. he doesn't look at how you get undressed but he also prepares various gloves or something, and there [referring to a different surgery] all [women] had to be undressed already. imagine, you had a skirt on, thank God, because you got the tights off, the shoes then you had to put naked feet in, because they [the doctors] are in a hurry. But wait a minute, we are not some, why do I have to go naked? and if you, God forbid, wore trousers, how were you supposed to undress and wait naked and there were 15 ladies, because it's going to be quick. And each one bang on the examination chair and the smear test, because it was the smear test. Quickly take the smear.

Extract 9

AS: [...] tak jak mówiłam staram się ubrać tak żeby nie świecić pewnymi częściami ciała tylko sobie ubiorę dłuższy sweterek czy coś i droga która/ bo jest specjalnie oczywiście oddzielony gabinet do rozbierania się jest tak że jestem zakryta odpowiednio i a później to wiadome

AS: as I said I try to dress in such a way that I do not shine with certain parts of the body. I wear a longer sweater or something and the distance which, because there is of course a separate room for undressing, I am properly covered and later it's obvious.

Then, later, when talking about the actual procedure they say the following:

Extract 10

LG: = Nie nie raczej tak na mnie żeby patrzył to może nie (.) To znaczy nie to jest chyba niemożliwe bo przecież jak on mnie bada tam i ma zobaczyć szyjkę no to nie może na mnie się patrzeć wtedy (.) A później jak on mnie bada tutaj tak po brzuchu (..) Nie on chyba (.) On mów/ a tutaj panią boli tutaj czuje pani coś tu jest ucisk tu tu (.) Nie. Chyba nie patrzy na mnie (.) Ale a później ale później jak rozmawia ze mną to patrzy oczywiście (.) Tak myślę że tak tylko jak ja tam leżałam to ja nie zauważyłam tak dokładnie [...]

LG: = No no he rather doesn't look at me. no. (..) I mean, no, I think it's impossible because when he examines me there and he has to see the cervix, then he can't look at me at that time. later when he examines me on the belly (..) no. I think he says, here do you feel pain? do you feel anything? there is pressure here. no. I don't think he looks at me. but later when he talks to me then obviously he looks at me. That's what I think, but when I lay there I didn't notice exactly.

Extract 11

I: A teraz niech mi pani powie coś więcej już o samym badaniu ginekologicznym. lekarz patrzy na panią?

AS: To znaczy tak tak jeżeli coś do mnie mówi to patrzy jeżeli mnie bada to wiadomo że na mnie nie patrzy (..) w oczy [laughs] [whispers] ty mnie pytasz a ja już jestem cała mokra morkrusieńka

I: And now please tell me something more about the gynaecological examination. does the doctor look at you?

AS: I mean yes if he is telling me something then he is looking at me, if he is examining me, then obviously that he doesn't look at me, in the eye. you ask me and I am completely wet.

The selves in Extracts 8 and 9 are located in the entire body; they are also, importantly, created by the (potential) gaze of the doctor. There are two aspects of such location. First, the moment of undressing, of potential nakedness of the body and the potential of embarrassment situates the self in the entire body of the person. Undressing, as we argued earlier, a rite of passage between the status of the patient, through the status of the woman, to the status of the body part (Galasiński and Ziółkowska, 2007), results in exposing the female body, an act which is socially inappropriate between a woman and a man who do not know each other intimately. The protection of modesty, protection against exposing the body results in locating the self in its entirety. Looking at the body means looking at the self. The other aspect of the location is the potential gaze of the physician, which, as a man's gaze, can be threatening; after all undressing belongs to the 'back stage' (Goffman, 1959) of the medical encounter. Implicitly then, the equivalent of the self is the female body; one to be covered – just about in its entirety – from the gaze of a non-intimate male.

The location of the self changes when the stories move to the examination itself. Fascinatingly, the self is no longer located in the entire body, but in the eyes, or the face. Or, we could say, the self is located where the doctor does not look during the examination. The shift from the entire body to the eyes/face ensures that, during the examination, the gynaecologist does not look at the person, the speaking woman. He is looking at the parts of the body that have been discursively disenfranchised for the duration of the narrative of the gynaecological examination.

Moreover, while in the case of undressing it is the physician's gaze that is constitutive of the self, in LG's story of examination it is the conversation with the physician that does it. While looking during the examination is discounted as the constituent of the self, it is conversation that takes over the power to constitute the self, being at the same time quite safe in the context, as one normally maintains eye contact and does not scrutinize the entire body.

Now, while embodiment and its relationship to identity is quite widely discussed in the social sciences (Lock, 1993; Farnell, 1999; van Dongen and Elema, 2001; Reischer and Koo, 2004; for review see Pitts, 2002; van Wolputte, 2004), and the body is seen as an 'unfinished project' (Shilling, 1993) within which major political and personal problems are both problematized and expressed (Turner, 1996), and, crucially, an intrinsic part of the project of self-identity (Giddens, 1991), the actual processes of embodiment are less frequently taken up by researchers (Mol, 2002; Budgeon, 2003).

Thus while Budgeon (2003) proposes that the indeterminacy of identity and the body makes the choice of the relationship between the two important, we are arguing here that it is not, in fact, the case of a choice, let alone the choice, but rather, ever-shifting choices which are made in response to and in interaction with the social situation in which the body is negotiated (see also Zitzelsberger, 2005). Our argument is that embodiment is not a process of 'the emergence of a specific (concept of the) body, and at the real-time having/being of this body' (Berg and Akrich, 2004: 3), but, rather, a set of processes in which various concepts of the body are at stake in the given situation. Embodiment in its medical context is, potentially at least, an ever-shifting experience of the body; it is a context-dependent experience and performance constructed for oneself in the local context. To put it differently, embodiment as an experience cannot be assumed to involve the entire body, its certain parts (see also Mol and Law, 2004) as a default way in which human actors negotiate their self in relation to their bodies. Rather, it is a much more fluid process subject to the contingencies of the local context and face concerns.

Embodiment and the ambiguous self

We have made two arguments in this article. First, we have shown that the women talking about their gynaecological examinations constructed their

selves ambiguously. The identity spaces that were opened in the narratives were not inhabited. They were a potential rather than an actuality. Second, we demonstrated that the embodiment of their identities – the inclusion of the body into the construction of self – fluctuates depending on the stage of the narrative of the examination. We see these two findings and argue that they are complementary, the ambiguity of identity spaces constructed for the self as enabling the constructions of the floating embodied self. As long as the speaking 'biological women' who are speaking are ambiguous in so far as their gender or patient identities are concerned, they can also construct the embodied self, which is ambiguous between an implicitly gendered self that must be modest and a body part that is ungendered.

Let us explore it in some detail. In his discussion of visual representations of the female body, Berger (1972) introduced a distinction between two statuses of being without clothes – nakedness and nudity. While he says that 'to be naked is to be oneself' (1972: 54), of being nude he says that it is 'a naked body [which] has to be seen as an object in order to become nude' (1972: 54). Thus, Berger continues, it is nudity that can be sexual, and not nakedness.

It seems to us that the way identities are constructed in the narratives we discussed earlier and the floating embodiment can be seen as constructing the woman as always naked and never nude. Thus, on the one hand, the never inhabited gender identity helps not to construct the informants' bodies as female. They are 'their' bodies, rather than women's bodies. The floating embodiment emphasizes that. When the woman is undressing, behind a screen, and away from the doctor's, and the man's, gaze, she is naked. When she is on the gynaecological chair, the doctor never looks at her; most of her body is disenfranchised and the issue seems not to arise. The medical gaze cannot make her body 'nude' as it is not hers.

Finally, what is quite fascinating is that the stories of the women and the doctors complement each other to a surprising degree (see also Galasiński and Ziólkowska, 2007). While, the undressing woman is off limits for the doctor's medical gaze, the women's narratives construct her as fully embodied. On the other hand, when the doctors' narratives construct the act of palpation and the actual examination only in terms of 'disenfranchised' body parts, the women's narratives underscore that by disembodying the woman. This complementarity is not only fascinating at the level of discourse analysis, but also at the level of social attitudes towards gynaecological examination and shows that its status, both for the doctor and the woman, is far more complex and geared towards the woman's comfort than it is likely to be assumed.

Note

1. The translations of the extracts we provide are ours. Translating the originals, we had two major aims. First, we wanted to make the Polish originals accessible to those who do not read the language. But, second,

we also wanted to render the 'flavour' of how the informant spoke. Thus, occasionally, the English of the translations might be strange or disjointed to the native speaker. Such language, together with any ambiguities in the translations were intended by us.
The analyses we offer are based on the originals. The process of translation therefore did not impact upon the process or the results of our analyses.

References

Areskog-Wijma, B. (1987). The gynaecological examination: Women's experiences and preferences and the role of the gynaecologist. *Journal of Psychosomatic Obstetric and Gynaecology*, *6*, 59–69.

Barker, C. and Galasiński, D. (2001). *Cultural studies and discourse analysis: A dialogue on language and identity*. London: Sage Publications.

Barthes, R. (1974). *S/Z*. New York: Hill & Wang.

Bavelas, J.B., Black, A., Chovil, N. and Mullett, J. (1990). *Equivocal communication*. Newbury Park, CA: Sage Publications.

Benedetti, T.J., Baldwin, L.-M., Holly, C., Andrilla, A. and Hart, L.G. (2004). The productivity of Washington State's obstetrician-gynecologist workforce: Does gender make a difference? *Obstetrics and Gynecology*, *103(3)*, 499–505.

Berg, M. and Akrich, M. (2004). Bodies on trial: Performances and politics in medicine and biology. *Body & Society*, *10(2–3)*, 1–12.

Berger, J. (1972). *Ways of seeing*. London: BBC & Penguin.

Braun, V. and Wilkinson, S. (2001). Socio-cultural representations of the vagina. *Journal of Reproductive and Infant Psychology*, *19(1)*, 17–32.

Budgeon, S. (2003). Identity as an embodied event. *Body & Society*, *9(1)*, 35–55.

Bury, M. (1982). Chronic illness and as biographical disruption. *Sociology of Health and Illness*, *4(2)*, 167–82.

Butler, J. (1990). *Gender trouble*. London: Routledge.

Cameron, D. (1997). Performing gender identity: Young men's talk and the construction of heterosexual masculinity. In S. Johnson and U.H. Meinhof (Eds.), *Language and masculinity*, pp. 47–64. Oxford: Blackwell.

Cameron, D. (1998). 'Is there any ketchup, Vera?': Gender, power and pragmatics. *Discourse & Society, 9(4)*, 437–55.

Charmaz, K. (1999). Stories of suffering: Subjective tales and research narratives. *Qualitative Health Research*, *9(3)*, 362–82.

Cheshire, J. and Ziebland, S. (2005). Narrative as a resource in accounts of the experience of illness. In J. Coates and J. Thornborrow (Eds.), *The sociolinguistics of narrative*, pp. 17–40. Amsterdam: John Benjamins.

Coleman, J. (1990). *Foundations of social theory*. Cambridge, MA: Harvard University Press.

Connell, R.W. (1999). Making gendered people: Bodies, identities, sexualities. In M.M. Ferree, J. Lorber and B.B. Hess (Eds.), *Revisioning gender*, pp. 449–71. Thousand Oaks, CA: Sage Publications.

Davies, B. and Harré, R. (1990). Positioning: The discursive production of selves. *Journal for the Theory of Social Behaviour*, *20(1)*, 43–63.

Delago, A., Lopez-Fernandez, L.A. and Luna, J.D. (1993). Influence of the doctor's gender in the satisfaction of the users. *Medical Care*, *31*, 795–800.

Ekeroma, A. and Harillal, M. (2003). Women's choice in the gender and ethnicity of her obstetrician and gynaecologist. *Australian and New Zealand Journal of Obstetric and Gynaecology*, *43(5)*, 354–9.
Elstad, J.I. (1994). Women's priorities regarding physician behaviour and their preference for a female physician. *Women Health*, *21(4)*, 1–19.
Emerson, J.P. (1970). Behaviour in private places: Sustaining definitions of reality in gynaecological examinations. In H.P. Dretzel (Ed.), *Recent sociology*, vol. 2, pp. 74–96. New York: Macmillan.
Farnell, B. (1999). Moving bodies, acting selves. *Annual Review of Anthropology*, *28*, 341–73.
Fox, N.J. (1993). *Postmodernism, sociology and health*. Buckingham: Open University Press.
Galasiński, D. (2004). *Men and the language of emotions*. Basingstoke: Palgrave.
Galasiński, D. (forthcoming). *Men's discourses of depression*. Basingstoke: Palgrave.
Galasiński, D. and Ziółkowska, J. (2007). Gender and the gynaecological examination: Women's identities in doctors' narratives. *Qualitative Health Research*, *17(4)*, 477–88.
Georgakopoulou, A. and Goutsos, D. (2000). Revisiting discourse boundaries: The narrative and non-narrative modes. *TEXT*, *20(1)*, 63–82.
Giddens, A. (1991). *Modernity and self-identity: Self and society in the late modern age*. Cambridge: Polity.
Gjerberg, E. (2002). Gender similarities in doctors' preferences – and gender differences in final specification. *Social Science & Medicine*, *54(4)*, 591–606.
Goffman, E. (1959). *The presentation of self in everyday life*. Garden City, NY: Doubleday.
Hall, J.A. and Roter, D.L. (2002). Do patients talk differently to male and female physicians? A meta-analytic review. *Patient Education and Counseling*, *48(3)*, 217–24.
Hall, S. (1996). Who needs identity? In S. Hall and P. du Gay (Ed.), *Questions of cultural identity*, pp. 1–17. London: Sage Publications.
Harré, R. and van Langenhove, L., Eds. (1999). *Positioning theory*: *Moral contexts of intentional action*. Oxford: Blackwell.
Henslin, J. and Biggs, M. (1978). Dramaturgical desexualisation: The sociology of the vaginal examination. In J.M. Henslin and J.E. Sagarin (Eds.), *The sociology of sex: An introductory reader*, pp. 141–70. New York: Schocken Books.
Hilden, M., Sidenius, K., Langhoff-Roos, J., Wijma, B. and Schei, B. (2003). Women's experiences of gynaecologic examination: Factors associated with discomfort. *Acta Obstetrticia et Gynaecologicia Scandinavica*, *82(11)*, 1030–6.
Hodge, R. and Kress, G. (1993). *Language as ideology*. London: Routledge.
Johnson, S. (1997). Theorizing language and masculinity: A feminist perspective. In S. Johnson and U.H. Meinhof (Eds.), *Language and masculinity*, pp. 8–26. Oxford: Blackwell.
Johnstone, B. (2001). Discourse analysis and narrative. In D. Schiffrin, D. Tannen and H.E. Hamilton (Eds.), *The handbook of discourse analysis*, pp. 635–49. Oxford: Blackwell Publishers.
Kapsalis, T. (1997). *The public privates*. Durham, NC: Duke University Press.
Kitzinger, C. (1999). Intersexuality: Deconstructing the sex/gender binary. *Feminism & Psychology*, *9(4)*, 493–8.

Lock, M. (1993). Cultivating the body: Anthropology and epistemologies of bodily practice and knowledge. *Annual Review of Anthropology*, *22*, 133–55.

McIlvenny, P. (2002a). Researching talk, gender and sexuality. In P. McIlvenny (Ed.), *Talking gender and sexuality*, pp. 1–48. Amsterdam & Philadelphia, PA: John Benjamins.

McIlvenny, P. (2002b). Critical reflections on performativity and the 'un/doing' of gender and sexuality in talk. In P. McIlvenny (Ed.), *Talking gender and sexuality*, pp. 111–50. Amsterdam & Philadelphia, PA: John Benjamins.

McKenna, W. and Kessler, S. (2000). Retrospective response. *Feminism & Psychology*, *10(1)*, 66–72.

Miller, W.I. (1997). *The anatomy of disgust*. Cambridge: Harvard University Press.

Mol, A. (2002). *The body multiple: Ontology in medical practice*. Durham, NC: Duke University Press.

Mol, A. and Law, J. (2004). Embodied action, enacted bodies: The example of hypoglycaemia. *Body & Society*, *10(2–3)*, 43–62.

Ochs, E. (1992). Indexing gender. In A. Duranti and C. Goodwin (Eds.), *Rethinking context: Language as an interactive phenomenon*, pp. 335–58. Cambridge: Cambridge University Press.

Oscarsson, M. and Benzein, E. (2002). Women's experiences of pelvic examination: An interview study. *Journal of Psychosomatic Obstetric and Gynaecology*, *23(1)*, 17–25.

Pearse, W.H., Haffner, W.H.J. and Primack, A. (2001). Effect of gender on the obstetric-gynecologic work force. *Obstetrics and Gynecology*, *97(5)*, 794–7.

Pitts, V. (2002). Reading the body through a cultural lens. *Journal of Contemporary Ethnography*, *31(3)*, 361–72.

Ragan, S. (1990). Verbal play and multiple goals in the gynaecological exam interaction. *Journal of Language and Social Psychology*, *9(1–2)*, 67–84.

Reischer, E. and Koo, K.S. (2004). The body beautiful: Symbolism and agency in the social world. *Annual Review of Anthropology*, *33*, 297–317.

Royal College of Obstetricians and Gynaecologists. (1997). *Intimate examinations: Report of working party*. London: RCOG Press.

Shilling, C. (1993). *The body and social theory*. London: Sage Publications.

Siann, G. (1994). *Gender, sex and sexuality: Contemporary psychological perspectives*. London: Taylor & Francis.

Stokoe, E.H. and Smithson, J. (2001). Making gender relevant: Conversation analysis and gender categories in interaction. *Discourse & Society*, *12(2)*, 243–69.

Swann, J. (2002). Yes, but is it gender? In L. Litosseliti and J. Sunderland (Eds.), *Gender identity and discourse analysis*, pp. 43–67. Amsterdam: John Benjamins.

Toolan, M. (1988). *Narrative: A critical linguistic introduction*. Routledge: New York.

Turner, B. (1996). *The body and society: Exploration in social theory*. London: Sage Publications.

Uskul, A.K. and Ahmad, F. (2003). Physician–patient interaction: A gynecology clinic in Turkey. *Social Science and Medicine*, *57(2)*, 205–15.

Van Dongen, E. and Elema, R. (2001). The art of touching: The culture of 'body work' in nursing. *Anthropology & Medicine*, *8(2/3)*, 149–62.

Van Dulmen, A.M. (1999). Communication during gynecological out-patient encounters. *Journal of Psychosomatic Obstetric and Gynaecology*, *20(3)*, 119–26.

Van Wolputte, S. (2004). Hang on to your self: Of bodies, embodiment, and selves. *Annual Review of Anthropology*, *33*, 251–69.
Weatherall, A. (2002). Towards understanding gender and talk-in-interaction. *Discourse & Society*, *13(6)*, 767–82.
Weiss, L. and Meadow, R. (1979). Women's attitudes toward gynecologic practices. *Obstetric and Gynecology*, *54(1)*, 110–14.
Wetherell, M. (1998). Positioning and interpretative repertoires: Conversation analysis and post-structuralism in dialogue. *Discourse & Society*, *9(3)*, 387–412.
Wodak, R., de Cillia, R., Reisigl, M. and Liebhart, K. (1999). *The discursive construction of national identity*. Edinburgh: Edinburgh University Press.
Ziółkowska, J. (2005). What, who and how? The reality of the gynaecological examination in patients and physician nouratives (translation). Unpublished MA dissertation, Institute of Psychology, University of Opole, Opole, Poland.
Zitzelsberger, H. (2005). (In)visibility: Accounts of embodiment of women with physical disabilities and differences. *Disability & Society*, *20(4)*, 389–403.

Author biographies

DARIUSZ GALASIŃSKI (DSc, PhD, MA) is Professor of Discourse and Cultural Studies at the University of Wolverhampton, UK. His current research interests focus on lived experience of mental illness, and particularly its relationship with masculinity and men's identities.

JUSTYNA ZIÓŁKOWSKA (MA) is Lecturer in Psychology at the Warsaw School of Social Psychology, Poland. She is currently working on her PhD thesis, which explores negotiations of depressive episodes in psychiatric interviews. Her main research interests concentrate on psychiatry and discourse analysis.